UCSF Benioff Children's Physicians **Policy and Procedures**	**Policy Number:** 5.01 **Policy Area:** Compliance **Owner:** Medical Director **Approvals:** Steering Committee
PHYSICIAN AND PROVIDER CREDENTIALING	**Effective:** May 2021 **Final Approval:** May 2021 **Next Review:** Jan 2022

I. PURPOSE:

To ensure that licensed health care providers meet the minimum credentials standards and performance standards for participation in UCSF Benioff Children's Physicians (BCP).

II. SCOPE

All contracted and/or employed providers participating with BCP must be credentialed. This includes, at a minimum, physicians (MD or DO), dentists – excluding those who do only primary dental care (DDS), Registered Dieticians (RD), podiatrists (DPM), and allied health practitioners such nurse practitioners and physician assistants (NP, PA) who are contracted and treat patients under BCP contracts.

IV. POLICY:

A. Credentialing is performed for all provider applicants prior to appointment to BCP. Each provider will have a confidential credentials file containing credentials information as well as quality and utilization improvement activities information. Quality improvement activities information will be contained in a separate area of the file.

B. The UCSF Medical Staff Office conducts credentialing for all licensed clinical venues within BCP and does not delegate credentialing to any outside entities. The BCP Credentials Committee recommends providers for appointment and reappointment to BCP and the UCSF Medical Staff Office members attest to conduct credentialing activities in a non-discriminatory manner.

B. Each provider has a confidential credentials file, as described in Appendix A, which contains verification and quality/peer review documents. These files are re-verified at least every three (3) years. Expirable documents are updated when appropriate. All required verifications and signatures for any applicant or re-applicant must be no more than 180 days old at the time of Credentials Committee review.

C. Credential files are treated as confidential and are kept within locked file rooms with key access by BCP and/or Medical Staff Office personnel. These files are protected from discovery pursuant to California Evidence Code Sections 1156 and 1157. Documents in these files may not be reproduced or distributed, except as permitted pursuant to State Law, including Sections 1156 and 1157.

D. Upon delegation of credentialing activities, file audits may be performed by health plan representatives and other payers, pursuant to delegated credentialing agreements, National Commission on Quality Assurance (NCQA) Credentialing Standards and the following guidelines:
   1. Audits must be scheduled in advance at a time mutually agreed upon by BCP and the auditing entity.
   2. The auditor will be asked to sign a confidentiality agreement.
   3. Auditors may not photocopy or remove documents.

   If credentialing is not delegated, the health plan/payer is responsible for credentialing providers for their health plan.

E. Notification of Provider Rights: By accessing the Medical Staff Office (UC Me) website, providers are notified of their rights to:
   - Review information submitted to support their credentialing application, except the following elements: National Practitioner Data Bank Reports, Letters of Reference, or documents related to peer review activities.
   - Correct erroneous information. The provider attests that all information submitted for the credentialing process are accurate and agrees to immediately report any changes in information. If any submitted items differ substantially from documentation disclosed throughout the verification process, the provider will be asked (via letter or email) to resolve this discrepancy. The provider may be allowed up to 30 days to resolve the discrepancies, with response to the Credentials Committee Chair.
   - Be informed of the status of their application upon request.

V. PROCEDURE

A. Initial Appointments

1. The following information is required to begin the Initial Appointment process:
   - Applicant Name
   - Curriculum Vitae/Resume including all professional work history
   - Medical Director Recommendation
   - Requested Start Date

2. Providers must complete the following items:
   - Application for BCP membership including Confidentiality Statement and Consent to Release Information
   - Review the necessary BCP policies, rules/regulations related to membership and appointment.
   - Health Plan Application forms (as applicable)

3. In addition to returning the above documents, providers must also submit any relevant licensure/certificates as applicable to the requested privileges or clinical activity, including but not limited to:
   - Copy of California License(s) (an on-line query is acceptable)
   - Copy of DEA Certificate and/or Furnishing certificate as appropriate (a query is acceptable)
     - Providers without a valid DEA certificate will need to submit an attestation statement declaring that they will not prescribe or furnish any medication that requires a valid DEA certificate and/or appropriate clinical privileges. Providers must attest that there is an alternative plan in place to have medication orders prescribed and furnished by a clinical colleague with a valid DEA certificate and/or clinical privileges.

Providers that hold a Fee Exempt Governmental DEA will not be permitted to prescribe under that DEA. The provider will be required to obtain a DEA at his/her own expense. In addition, during the transition of obtaining a DEA, the provider will be required to sign an attestation. The provider will have the supervising physician assign prescriptions and prescribe controlled substances. The attesting physician must be able to prescribe prescriptions within 48 hours.

- Board Certification
  - Providers must achieve board certification within 2 years of initial board eligibility and/or within two years of approval by this committee if board certification has lapsed. For applicable providers, active enrollment in the Maintenance of Certification (MOC) program, in their respective specialty, will satisfy this board certification requirement.

    Providers that are working towards board certification through MOC will go before UBCP Credentialing Committee yearly until they have obtained board certification. Providers will need to submit proof that they are actively working on their certification. Providers may submit MOC tests and MOC activities to UBCP Credentialing Committee, annually, at time of reappointment until board certification has been obtained.

- Evidence of Current Malpractice Coverage
- Fluoroscopy Certificate as appropriate
- Government-issued identification card (i.e. driver's license, passport)

4. The Medical Staff Office reviews the documents as follows:
   a. All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
   b. Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges within 30 days of receipt by the Medical Staff Services Department. Signatures must be no greater than 180 days prior to Credentials Committee review.
   c. Clinical venues where applicant is either employed or maintains clinical privileges are specified and appropriate.
   d. Complete addresses, phone and fax numbers as listed for:
      - Medical school, Internships, Residencies, Fellowships;
      - Hospitals and affiliations;
      - Peer references; and
      - Malpractice insurance company(ies)
   e. Continuing Medical Education (CME) information documents any courses relevant to area of practice.
   f. California License(s), DEA Certificate, Furnishing Certificate and any other required or relevant certifications are current.

5. Verification of information begins as soon as the application appears complete and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Oral verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification, and how it was verified.

   Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

6. File Quality Review and Triaging
   Once all of the information is gathered, the applicant's file is reviewed by the Medical Staff Office to ensure the file is complete, accurate and conflicting information is resolved. The Medical Staff Office assigns a triage category of green, yellow or red (see Appendix C-File Triaging Categories) for careful evaluation of potentially adverse information. (See Section C., Evaluation and Approval Process.)

B. Reappointments

1. Reappointment Application Packet
   At least four (4) months prior to the end of the appointment period, the provider is mailed an application for reappointment. Previously submitted information is queried to produce the reappointment application. The reappointment packet includes:
   - Reappointment Application pre-populated with already-submitted information from prior current appointment cycle.
   - Consent to Release information to Contracted Health Plans

2. The provider is required to return the application and supporting documents within thirty (30) days.

3. If the application is not returned within the designated time period, the will be notified for a delinquent reappointment and will receive a (15) day extension to complete the paperwork. Failure to submit a reappointment application at least 45 days before the expiration date of the current appointment shall be deemed to be a voluntary resignation from BCP, and the provider will be submitted as "Inactive" to the Credentials Committee.

4. The Medical Staff Office reviews the documents as follows:
   a. All items on application form. This includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanations for any irregularities on certain questions about practice issues, legal matters and health status.
   b. Applicant's signature is present and dated on all forms. Signatures must be no greater than 180 days prior to Credentials Committee review.
   c. Privileging forms are completed as appropriate.
   d. Clinical venues are specified and appropriate.
   e. Completed addresses, phone and fax numbers as listed for:
      - Hospitals and affiliations
      - Peer references; and
      - Malpractice insurance company(ies)

f. Continuing Medical Education (CME) information documents any courses relevant to specific area of practice.
g. California License(s) and applicable certificates (e.g. DEA, Furnishing Certificate) are current.
    i. Providers without a valid DEA certificate will need to submit an attestation statement declaring that they will not prescribe or furnish any medication that requires a valid DEA certificate and/or appropriate clinical privileges. Providers must attest that there is an alternative plan in place to have medication orders prescribed and furnished by a clinical colleague with a valid DEA certificate and/or clinical privileges.

5. Verification of Information
Verification of information begins as soon as the application appears complete, and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Oral verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification, and how it was verified.

Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

6. Quality and Performance Data
The results of performance monitoring, evaluation, and identified opportunities to improve care and service are included in the reappointment file. BCP is not delegated for quality events. All complaints and adverse incidents are forwarded and handled by the health plans. At a minimum, the following information from the following areas must be reviewed at the time of reappointment:
    - Member complaints
    - Information from quality improvement activities
    - Member satisfaction (as appropriate)

See Appendix D – Sources of Performance Improvement Data for details of the PI data types considered during the reappointment process.

7. File Quality Review and Triaging
Once all of the information is gathered, the applicant's file is reviewed by the Medical Staff Office to ensure the file is complete, accurate and conflicting information is resolved. The Medical Staff Office assigns a triage category of green, yellow or red (see Appendix C-File Triaging Categories) for careful evaluation of potentially adverse information. (See Section D., Evaluation and Approval Process.)

C. Reinstatement of Medical Staff Membership

It is the policy of UBCP to permit the reinstatement of a provider's credentials within ninety (90) days of an inactivation approved by the UBCP Credentialing Committee. The following criteria must be met:

- Written explanation from the physician requesting the reinstatement and the reason(s)
- Provider's latest reappointment has not lapsed
- Verification of licensure, certifications and sanctions are required with no findings

- Provider was not inactivated during any disciplinary action, summary suspension of privileges or termination
- Provider meets all credentialing requirements

All reinstatements are presented to the Credentials Committee. A provider's credentials are not re-activated until the reinstatement request has been reviewed and approved by the UBCP Credentials Committee.

D. Evaluation And Approval Process

1. Clinical Services Evaluation Process

   If an applicant's file is identified as a yellow or red category, the related documentation is flagged for the medical director to review and comment on the flagged issue. The complete file (including application and supportive documents) is sent to the appropriate medical director or designee for review and recommendation to the Credentials Committee. The medical director or designee may review the file independently or request a BCP member within the applicant's specialty to review a credentials file if desired. If the applicant's file was flagged as a yellow or red category, the reviewer must document sufficient information to support making a recommendation for appointment/reappointment.

   The UCSF Medical Staff Office facilitates the review of the file to the appropriate persons. If an applicant's file has not been reviewed prior to the Credentials Committee, the Medical Staff Office contacts the medical director or designee to determine the source of the delay and to help secure any additional information necessary to make a recommendation related to appointment/reappointment.

   An extension may be filed if the credentialing and approval process is anticipated to exceed 180 days. This extension is intended to allow for more thorough investigation and discussion.

   If the medical director or designee is disinclined to make a favorable recommendation based on:
   - a perceived medical disciplinary cause or reason, indicating the potential for a provider's conduct to be detrimental to patient safety or to the delivery of patient care; or

   perceived conduct or professional competence which affects or could adversely affect the health or welfare of a patient or patients, the medical director or designee drafts a report to the Credentials Committee indicating concerns with the appointment/reappointment.

   After the medical director or designee's recommendation, the file is prepared for the monthly Credentials Committee and the applicant is added to the next monthly Credentials Committee File Triage Report. An addendum is also included that lists all yellow and red category applications, with a brief description about the flagged issues. If the provider is not recommended for appointment/reappointment, the medical director's or designee report is flagged for Credentials Committee discussion.

2. Credentials Committee Evaluation Process

   The BCP Credentials Committee reviews the File Triage report and addendum and the Committee makes a recommendation for appointment/reappointment. If the Credentials Committee renders a decision different from the medical director's or designee, or decides to defer an application for further investigation, the Credentials Committee Report is modified immediately following the meeting. This report is then sent to the BCP board meeting.

3. BCP Board of Directors

The Credentials Committee File Triage Report is reviewed by the BCP Board of Directors. The BCP's Board of Director's decision is considered the final decision.

Actions on appointments/reappointments are updated in the credentialing database within ten (10) days of the final approval. Notification of the final decision is forwarded to the applicant within 30 days.

4. Provider Enrollment
   Upon final approval, providers participating in the BCP health plan contracts are added to the monthly health plan rosters. The provider's name and required information is sent to BCP for their contracted health plans.

E. Expirables/Ongoing Sanction Monitoring

Sanctions and expirables are monitored on a monthly basis as indicated in Appendix B - Verification Methods. Identified issues are forwarded to the medical director or designee for review, investigation and recommendation for appropriate action.

In compliance with CMS regulation (42 CFR § 422.204(b)(2) (ii); Medicare Managed Care Manual, Chapter 6 § 60.3, MMCD Policy Letter 02-03; DHCS Contract, Attachment 4, Exhibit A) - BCP prohibits membership for any individual who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

F. Nondiscriminatory Statement and Audit Process

BCP credentialing process acts in compliance with all federal, state and local laws and regulations governing discrimination involving patients, employees, vendors, visitors and other individuals and entities associated or involved with BCP. This policy reaffirms the commitment of the BCP to maintaining a discrimination-free credentialing process.

It is the policy of BCP not to engage in discrimination against or harassment of any person employed or seeking employment or membership credentialing with the BCP on the basis of race, color, national origin, religion, sex, physical or mental disability, medical condition (cancer-related or genetic characteristics), pregnancy, HIV status, ancestry, marital status, age, sexual orientation, gender identity, citizenship, or status as a covered veteran (special disabled veteran, Vietnam era veteran, or any other veteran who served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized) or the type of procedure or patients in which the practitioner specializes. BCP does not retaliate against a person for pursuing his or her right under this policy and/or for the purpose of investigatory proceeding. Non-discrimination information is available in alternative form of communication to meet the needs of persons with sensory impairments.

On an annual basis, each member of the BCP Credentials Committee will sign a confidentiality statement that will also include an affirmative statement that all decisions are made in a non-discriminatory manner.

BCP will monitor the compliance of this commitment by performing a quarterly audit of decisions made by the Credentials Committee, and report the findings to the Credentials Committee, and Board of Directors. The audit will include, but not limited to, decisions related to:

- Recommendation to appoint/reappointment less than the standard three-year cycle

- Recommendation to appoint/reappoint with conditions and stipulations (ie. obtaining board certification)

G. **Reporting to Medical Board of California, Health Plans and the National Practitioner Data Base**

BCP will comply with the reporting requirements of the California Business and Professional Code; Section 800-809.9, 805, 805.01; and the NPDB for reportable incidences for medical disciplinary cause or reason. A report to the Medical Board will be filed within fifteen (15) days from the final decision date regarding a disciplinary/adverse action or recommendation regarding disciplinary action was taken. Reports will also be filed when a member voluntarily resigns after receiving notice that an investigation has been initiated related to a medical disciplinary issue. The NPDB for reportable incidences of an adverse action will be filed within thirty (30) days of the final determination.

Adverse credentialing and peer review actions will be reported to health plans according to health plan contractual agreements.

An 805 report will be submitted to the Medical Board after any of the following events occurs for a medical disciplinary cause or reason:

1. A provider's application for membership is denied or rejected for a medical disciplinary cause or reason;
2. Summary suspension of a licensee's membership, staff privileges, or employment that remains in effect for more than fourteen (14) days;
3. A provider's membership, or employment is terminated or revoked for a medical disciplinary cause or reason;
4. Restrictions imposed, or voluntarily accepted on 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;
5. If the resignation, leave of absence, withdrawal or abandonment of application or for renewal of membership occurs after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason.

An 805.01 report is filed if a final decision or recommendation regarding disciplinary action is based upon a formal investigation performed by a peer review body based on an allegation that any of the acts listed below have occurred:

1. Incompetence, gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public;
2. The use of, or prescribing for or administering to him/herself, any controlled substance; or use of any dangerous drug, or of alcoholic beverages, that is dangerous or injurious to the provider, any other person, public, or that the provider's ability to practice safely is impaired by the use;
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 a good faith effort prior to examination of the patient and the medical reason. In no event shall a provider lawfully treating intractable pain be reported for excessive prescribing.
4. Sexual misconduct with one or more patients during a course of treatment or an examination.

The UCSF Medical Staff Office in consultation with the Office of Legal Affairs for BCP and UCSF, will prepare the appropriate report(s) and has the responsibility to submit an NPDB report, and the 805, or 805.01 report to the Medical Board of California once the report has been signed and approved by the following officers:

1. The Medical Director
2. The President and Chief Executive Officer of BCP (or designee);

The President and CEO of BCP and the medical director have been trained with regard to these reporting obligations and will receive ongoing updates and advice to ensure that all reporting requirements are properly followed.

H. **Notification to the Provider, Fair Hearing Rights, and Appeal Process**

The practitioner will receive a copy of the 805 et al. report and notice advising the practitioner of his or her right to submit additional statements or other information, electronically or otherwise to the board and that information submitted electronically will be publicly disclosed to those who request it, pursuant to Section 800 (c) of the Business Professions Code.

I. Provider On-Site Visit Evaluation

It is the responsibility of BCP to work with the contracted Managed Care Health Plan to meet all requirements and regulations for provider office site visits. BCP will train its staff to conduct office site audits and document that training. The BCP staff member conducting the site visit will be a qualified RN.

1. BCP will conduct site visits for complaints related to:
    a. Physical Accessibility (e.g., handicapped accessibility, ease of entry into the building or practice site, accessibility of space within the building or practice site)
    b. Physical Appearance (e.g., cleanliness and orderliness, well- lit waiting room, posted office hours)
    c. Adequacy of Waiting and Examining Room space (e.g., adequate waiting room size/space and seating, adequate number of examining rooms per practitioner, consider number of patient visits per hour and number of practitioners}
    d. Adequacy of Equipment (Applicable to CMS only} (e.g., current fire extinguisher, refrigerator housing, specimens and medications is correct temperature and separate from food and personal items, sterilization equipment ,current certifications for imaging equipment)

2. An office visit will be performed on any BCP provider office after receiving three (3) complaints. An on-site visit will not be required for complaints related to record keeping, or availability of appointments. When appropriate, complaints will be forwarded to the applicable Managed Care Health Plan upon receipt.

Site visit criteria will include:

a. Physical Accessibility
b. Physical Appearance
c. Adequacy of Waiting and Examining Room space
d. Adequacy of Equipment
e. Appointment Availability
f. Medical/treatment record keeping system

3. The BCP threshold will be three (3) complaints within a six (6) month period against a provider office. Therefore, when BCP receives three (3) complaints, taking into consideration the severity of the issue, an office site visit will be conducted. The site visit will be performed within 60 calendar days of the complaint threshold being met. The visit will include a review of the medical record keeping system and a structured physical site review.

4. All BCP provider offices must meet 90% of all requirements for the structured physical site review, and 90% of all requirements for the medical record-keeping system.

5. A model medical record will be reviewed and office documentation practices will be discussed with the practitioners or office staff. Deficiencies will be reported to the credentialing committee for recommendations and follow-up.

6. Medical/treatment record keeping practice elements may include:
    a. Records easily located
    b. Forms and methods for consistency (orderliness)
    c. Secure/confidential filing system

7. If a site does not meet BCP's performance thresholds, the site must develop an action plan for improvement. UCSF will evaluate the effectiveness of the action plan at least every six (6) months, until the office meets the required 90% threshold.

8. BCP will continually monitor member complaints for all practitioner sites and perform a site visit within 60 days of determining its complaint threshold was met.

9. BCP will conduct a follow-up office visit audit (within 60 calendar days) of a previously deficient office if the practice is identified as meeting the reasonable complaint threshold subsequent to correcting the previously identified deficiencies.

10. The completed provider site visit evaluation form, including documentation of any corrective action plan (CAP) and/or evaluation, is shared with the provider and filed in the Credentials Profile. The results of the audit including credentialing committee recommendations and follow up will be incorporated into credentialing and re-credentialing decisions, and the designated health plan as applicable.

11. Complaints will be forwarded to the applicable Health Plan upon receipt, when appropriate, for Health Plans that do not delegate site visits.

12. Medi-Cal facility site reviews are non-delegated to BCP. Scores are received from the health plans prior to credentialing and re-credentialing.

J. Delegation of Credentialing

BCP may delegate any part of its credentialing and re-credentialing activities. If BCP delegates all or part of its credentialing and re-credentialing activities to a contractor, e.g., Credentialing Verification Organization (CVO), BCP must have oversight and a documented evaluation of these activities and clearly written policies and procedures. If the contractor is NCQA Certified or NCQA Accredited, there is no further need to assess its ability to meet NCQA standards. The CVO may use any combination of paper records and secure electronic records in the credentialing activities.

BCP would have oversight of the delegated activities as follows:

1. Written Delegation Agreement is:
    a. Mutually agreed upon
    b. Describes the responsibilities of the organization and the delegated entity
    c. Describes the delegated activities
    d. Requires monthly or at a minimum semi-annual reporting to the organization
    e. Describes the process by which the organization evaluates the delegated entity's performance
    f. Describes the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

2. Right to Approve and to Terminate: BCP retains the right, based on quality issues, to approve, suspend, and terminate individual practitioners, providers and sites in situations where it has delegated decision-making. This right is reflected in the delegation document and the delegation agreement is mutually agreed upon.

3. Delegation Evaluation
    a. If the CVO is NCQA Certified or Accredited, CFMG will verify certification or accreditation. On an annual basis BCP will require that the CVO submit in writing verification of NCQA certification or accreditation.
    b. If the CVO is not NCQA Certified or Accredited, BCP will evaluate the CVO prior to delegation and annually according to the Annual File Audit described below.

4. Annual File Audit: If the CVO is not NCQA Certified or Accredited a file audit will be performed during BCP's annual on-site evaluation. In auditing files and at BCP's discretion, BCP may use NCQA's "8/30 methodology " to review files or audit a minimum of 10 credentialing and 10 re-credentialing files or audit either 5 percent or SO of its practitioner files, whichever is less, to ensure that information is appropriately verified.

5. Annual Evaluation
    a. If the CVO is not NCQA certified or accredited, BCP will perform an annual substantive evaluation of delegated activities against delegated NCQA standards and UCSF's expectations.
    b. Upon written notice from BCP, the CVO shall permit BCP in accordance with nationally accepted standards for delegated credentialing and re-credentialing and applicable state or federal laws and regulations to conduct an audit of the CVO's files and policies and procedures.
    c. The annual audit will take place at the CVO's facility during regular business hours and at a time which is mutually agreed upon.
    d. BCP will provide the CVO with advance notice of at least ten (10) business days.
    e. BCP will submit to the CVO a list of physician files that will be reviewed during the audit. The provider listing will be submitted to the CVO with advance notice of at least five (5) business days.
    f. The audit shall consist of a structured review using a written review tool. BCP may use the audit tool developed by the Industry Collaboration Effort (ICE) in cooperation with the NCQA, which is based on NCQA credentialing standards or an audit tool developed by UCSF that meets NCQA standards.
    g. After the audit BCP will provide the CVO with a written summary of its findings to include issues identified, action plans and implementation dates. In the event of any negative audit findings, a corrective action plan will be developed by both parties. The

CVO agrees to take all steps necessary to resolve any deficiencies with ninety (90) days of receipt of the report.

h. If deficiencies are not resolved within ninety (90} days BCP holds the right to terminate its agreement with the CVO.

6. Reporting: On a monthly basis or at a minimum on a semiannual basis the CVO reports to BCP the number of initial credentialed and re-credentialed practitioners it has processed.

7. Opportunities for Improvement: At least once every two (2) years BCP will identify and follow-up on opportunities for improvement, if applicable.

K. Identification of HIV/AIDS Specialist

To be compliant with AB 2168 that requires standing referrals to AIDS specialists for all BCP members infected with HIV, BCP surveys initial applicants to determine if they are HIV/AIDS Specialist.

As part of the initial application process and on an annual basis thereafter BCP will identify and/or reconfirm the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist according to California State regulations.

Identification/Reconfirmation of HIV/AIDS Specialists

1. Initial Screening: At the time of credentialing, BCP conducted an initial screening to determine which physicians in its network qualify as an HIV/AIDS Specialist according to California State regulations.

2. New Physicians: All physicians are notified in writing of approval of his/her initial credentials. The welcome letter is sent with in 60 calendar days of the committee's decision. If BCP's committee's approve, the physician's HIV/AIDS Specialist status it will be noted in the welcome letter.

3. Reconfirmation: On an annual basis, BCP will reconfirm the appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist according to California State regulation. During the second quarter of each year, BCP will send out a form to survey all contracted physicians. The form lists the approved criteria defined by the California Department of Managed Health Care.

4. The list of identified qualifying physicians will be provided to the department responsible for authorizing standing referrals on a quarterly basis.

Reporting of HIV/AIDS Specialists

1. Upon identification/reconfirmation of appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist according to California State regulations, the information is entered in the physician's record in the credentialing database.

2. On a quarterly basis, a report will be generated out of the credentialing database on all providers identified as a qualified HIV/AIDS Specialist by the Credentialing Department. The list of identified qualifying physicians will be provided to the department responsible for authorizing standing referrals.

This policy/procedure is reviewed annually and revised as indicated.

L. Physician Oversight of Nurse Practitioners (NP) and Physician Assistants (PA)

It is the responsibility of the BCP physician to ensure that required supervision is being conducted on non-physician practitioners, in all pertinent areas of care.

1. Process to ensure required supervision is being conducted on non-physician practitioners, (e.g., NPs, PAs), in all pertinent areas of care.
    a. The supervising physician has continuing responsibility for all medical services provided by the health professional under his or her supervision.
    b. Physicians must submit allied health professional licensure to the Provider Group prior to allowing these professionals to treat managed care members.

2. PAs may perform medical services set forth by the regulations of the MBC when the services are rendered under the appropriate supervision of a licensed physician.
    a. At all times the supervising physician will be physically, telephonically, or electronically available to the PA for consultation, except in emergency situations.
    b. In cases of emergency, the PA, to the extent permitted by the laws relating to license or certificate involved, may render emergency services to a patient pending establishment of contact with physician.
    c. The supervising physician will not supervise more than four (4) PAs at one time.

3. NPs who prescribe drugs and/or devices will do so in accordance with standardized procedures or protocols developed by the NP and supervising physician.
    a. At all times the supervising physician will be physically, or telephonically available to the NP for consultation, except in emergency situations.
    b. In cases of emergency, the NP, to the extent permitted by the laws relating to license or certificate involved, may render emergency services to a patient pending establishment of contact with the physician.
    c. The supervising physician will not supervise more than four (4) NPs at one time.

VI. RESPONSIBILITY

A. This policy resides in the BCP Policy and Procedure Manual. Copies are located in the BCP administrative office.

B. Review and Renewal Requirements: This policy will be reviewed annually and as required by change of law or practice, by the Credentials Committee. The review is facilitated by BCP and UCSF Medical Staff Office. Any changes must be approved by the Credentials Committee, and BCP's Board of Directors.

VII. HISTORY OF POLICY:

A. Revisions: 10/15, 12/17
B. Approvals:
- Credentials Committee: 10/15, 12/17
- Policy Steering Committee: 10/15, 12/17
- Board of Directors: 10/15, 12/17

This guideline is intended for use by BCP and personnel and no representations or warranties are made for outside use. Not for outside production or publication without permission.

VIII. APPENDIX A - CREDENTIALS FILES

The following documents are kept current and maintained in the Credentials file (as applicable):

1. Application for membership.
2. Current California State Medical (or other professional) License
3. Valid DEA certification, as applicable
4. Verification of graduation from medical (or other professional) school and completion of residencies and fellowships
5. Verification of previous affiliations prior to BCP appointment
6. Verification of clinical privileges in good standing from the applicant's primary admitting facility
7. Curriculum Vitae that includes a comprehensive work history
8. Evidence of current, adequate malpractice insurance
9. Professional liability claims history
10. Verification of Board Status Certification or Candidacy, as applicable
11. National Practitioner Data Bank Query Report (which includes Medicare and Medicaid Sanctions activity)
12. California Medical Board Status check for validation of license and sanction activity
13. Letters of Reference that attests to clinical competence and ethical character of the applicant.
14. Continuing Medical Education information
15. Consent to release relevant information to contract health plans.
16. Copies of the approval letters confirming membership appointment at BCP
19. Quality and Peer Review documents, such as:
    a. Any action taken as a result of a malpractice claim.
    b. Reports of disciplinary actions taken by hospitals and managed care organizations and the outcome of those actions.
    c. Results of peer reviews and health plan quality management reviews
    d. State Medical Board reports on any state sanction activity (e.g. 805 reports).
    e. Any supplemental information or documentation regarding quality of care.
20. Medicare Opt-Out Report
21. Office of Inspector General (OIG) Sanctions Report
22. Excluded Parties List System (EPLS) Sanctions Report

IX. APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event			
			Initial Appointment	New Privileges	Reappointment	Update as Expires
1.	**License/Certificate(s) to Practice in California** Includes information related to licensure sanctions monitored monthly	**Website query as available for the type of provider. If website that is considered primary source verification is not available, confirm in writing.**	**X**	**X**	**X**	**X**
2.	**DEA Registration** Provider attests if DEA is not applicable to scope of practice.	NTIS/DEA Website query (if applicable to Provider's scope of privileges) For pending DEAs, the practitioner signs an attestation agreeing not to prescribe controlled substances until a DEA certificate has been obtained, and has an alternative plan in place to have medication orders managed by a clinical colleague with a valid DEA certificate and/or clinical privileges.	**X**	**X**	**X**	**X**

IX. APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event			
			Initial Appointment	New Privileges	Reappointment	Update as Expires
3.	**Medical School (Domestic Graduates)** **Or Other Professional Schools (non-physician applicants)**	May be obtained (in writing or orally) from the institution(s) where medical school/other professional school completed or the AMA or AOA profile service, as applicable.	**X**			
4.	**ECFMG (Foreign Graduates)** For physicians who enter USA-based internship/residency programs.	www.ecfmg.org or in writing from ECFMG	**X**			
5.	**Internship/other professional training**	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	**X**			

IX. APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event			
			Initial Appointment	New Privileges	Reappointment	Update as Expires
6.	**Residency/other professional training**	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	**X**		**X** If any new training during the previous appointment period	
7.	**Fellowship/other professional training**	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	**X**		**X** If any new training during the previous appointment period	
8.	**Board Certification or other professional certification or registration**	Query of the ABMS database, AMA or AOA profile or confirmation (orally or in writing) directly from the certifying organization. AHP national certification queried.	**X**	**X**	**X**	**X**

IX. APPENDIX B – VERIFICATION METHODS

NUMBER	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT			
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES
9.	**Healthcare Organization Affiliations**	Confirm in writing via website or by telephone with affiliation. Confirm dates of affiliation, scope of privileges, restrictions and any disciplinary actions taken during the affiliation. If verification of an affiliation is not obtained after three requests (including a phone call to the facility), this will be noted in the file and the file may then move through the evaluation process without verification of the affiliation.	**X** Verify all affiliations for past 10 years.	**X** Verify as necessary to obtain information related to competency	**X** Verify current active affiliations	
10.	**Work History (Looking for gaps in training and work history)**	Applicant provides information on application form or curriculum vitae. Additional investigation occurs for 3 month gaps in work history. Gaps over 12 months will be documented in the file.	**X**			

IX. APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event			
			Initial Appointment	New Privileges	Reappointment	Update as Expires
11.	**Professional Liability Insurance**	Obtain information related to coverage and amounts of coverage directly with carrier. Minimum insurance: $1/million per claim and $3/million annual aggregate coverage.	**X**		**X**	**X**
12.	**Professional Liability Claims History:**	Applicant provides information about current and past claims, settlements and judgments; AND write to current carrier; AND request NPDB report.	**X**		**X** For past 3 years	
13.	**Continuing Medical Education**	Applicant provides information pursuant to licensing agency requirements	**X**		**X**	
14.	**National Practitioner Data Bank (NPDB)**	Query	**X**	**X**	**X**	

IX. APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event			
			Initial Appointment	New Privileges	Reappointment	Update as Expires
15.	**OIG Sanctions, and Excluded Parties List System (EPLS)** **Medi-Cal Suspended and Ineligible Providers**	OIG Sanction Report, GSA List On a monthly basis, verify that the latest Medi-Cal Suspended and Ineligible list is available through the CA DHCS. Files are downloaded, reviewed and tracked for ongoing monitoring.	**X**	**X**	**X**	**Monthly**

IX. APPENDIX B – VERIFICATION METHODS

NUMBER	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT			
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES
16.	**Medicare Opt-Out Report**	On a monthly basis, verify that the latest Medicare Opt-Out report for both Northern and Southern California are available for review and monitoring. The report is available through Noridian Healthcare Solutions. The file is downloaded, reviewed and saved in the department shared drive. At the time of initial and reappointment credentialing, Credentialers are responsible to include a verification of the Medicare Opt Out report for each credentialed provider.	**x**	**x**	**x**	

IX. APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event			
			Initial Appointment	New Privileges	Reappointment	Update as Expires
17.	**CMS Preclusion list**	On a monthly basis, verify that the latest version of the CMS preclusion list is available for review and monitoring. The report is available by logging into the CMS Enterprise Portal at https://portal.cms/gov. The file is downloaded, reviewed and saved in the departmental shared drive. This is used to compare against the active credentialing records and applicants in process. At the time of initial and Documentation of this process is recorded on a monthly basis, and any positive matches are further documented as part of an individual's credentialing application or file.				X Monthly

IX. APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event			
			Initial Appointment	New Privileges	Reappointment	Update as Expires
18.	**Peer/Professional References/ Recommendations** Peer means an individual in the same professional discipline (same type of license).	Peer references must be from individuals who have recently worked with the applicant, have directly observed his or her professional performance over a reasonable period of time, and who can and will provide reliable information regarding current clinical ability, ethical character, health status and ability to work with others. If the applicant has recently completed professional training (resident, fellowship, etc.), a reference from the program director must be requested.	**X** Obtain at least 2 Peer References		**X** Obtain at least 1 Peer Reference	

X. APPENDIX C – FILE TRIAGING CATEGORIES

File Category	Initial Appointment	Reappointment
Green	No issues have been identified with the provider's application, and the file meets the following criteria: • Satisfactory References • No record of malpractice payment or current pending claims • No disciplinary actions • No licensure restrictions • No unexplained time gaps in work history • Current licensure • No problems verifying information • No indication of investigations or potential problems • Information is returned in a timely manner and contains nothing that suggests the practitioner is anything but highly qualified	No issues have been identified with the provider's reappointment, and the file meets the following criteria: • Satisfactory References • No record of malpractice payments since the last appointment or current pending claims • No disciplinary actions • No licensure restrictions • Current licenses • No problems verifying information • No indications of investigations or potential problems • Information is returned in a timely manner and contains nothing that suggests the practitioner is anything by highly qualified • Applicant is not requesting a status change • Activity levels are appropriate • CME relates to privilege requests • QA data includes no Peer Review or Quality of Care issues • No health problems identified
Yellow	The provider's file may include questionable information, such as: • Peer references and prior affiliations indicate potential or minor problems • One malpractice claim • Maintains a Non-ACGME Fellow appointment • International Medical Graduate	The provider's file may include questionable information, such as: • Peer references and prior affiliations indicate potential or minor problems • One malpractice claim in past 3 years • Change in status requested • Low Clinical Activity • Minor Health problem identified which will likely have no impact on exercise of clinical privileges • Difficulty in obtaining monitoring reports • Maintains a Non-ACGME Fellow Appointment
Red	The provider's file shows potentially	The provider's file shows potentially

X. APPENDIX C – FILE TRIAGING CATEGORIES

File Category	Initial Appointment	Reappointment
	adverse information, including: • Unsatisfactory peer references or prior affiliations • Disciplinary actions or reports filed by any verification organization (NPDB, Federations, MBC, Medicare Sanctions, AMA) • Clinical privileges revoked, diminished or altered by another Healthcare organization • 2 or more malpractice claims • Multiple Healthcare organization affiliations during the past 5 years • Substantial number of medical licenses • Any existing QA information shows a quality of care issue • Any existing monitoring reports question competency	adverse information, including: • Unsatisfactory peer references or prior affiliations • Disciplinary actions or reports filed by any verification organization (NPDB, Federations, MBC, Medicare Sanctions, AMA) • Clinical privileges revoked, diminished or altered by another Healthcare organization • 2 or more malpractice claims in past 3 years • QA information shows a quality of care issue • Monitoring reports question competency • Major Health Problems identified • New privileges requested outside of normal scope of specialty • Substantial # of professional licenses (greater than 3)