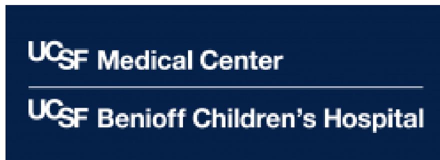

Medical Staff Organization
Credentialing Policy and Procedure

Office of Origin: Medical Staff Office (415) 885-7268

I. PURPOSE:

UCSF Medical Center (UCSF) and Langley Porter Psychiatric Institute (LPPI) ensure that licensed health care providers meet the minimum credentials standards for Medical Staff or Advanced Health Practitioner Staff membership. The Medical Staff Services Office serves as the CVO for LPPI.

II. REFERENCES:

- Medical Staff Bylaws, Rules and Regulations
- TJC Medical Staff Standards
- NCQA Credentialing Standards
- Committee on Interdisciplinary Practice (CIDP) Policy and Procedures

III. DEFINITIONS:

Practitioner: Any currently licensed physician (M.D. or D.O.), dentist/oral surgeons, clinical psychologist, or podiatrist, unless otherwise expressly limited.

Advanced Health Practitioner (“AHP”) means an advanced practice registered nurse: Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA); Physician Assistant (PA); Optometrists; Clinical Pharmacists practicing in an expanded role; non-physician Licensed Acupuncturists

Provider: For purposes of this document, provider means practitioners and AHPs.

Complete Application:
For the purposes of this document, a complete application, at the point that verifications are finished, means the following:

- all information was verified and there is nothing missing in the file;
- all gaps in time of three months or more are accounted for;
- any discrepancies between information provided by the applicant and the information verified by UCSF have been resolved.

IV. POLICY:

A. The Medical Staff Office conducts credentialing for all licensed clinical venues within UCSF and LPPI and does not delegate credentialing to any outside entities. The UCSF and/or LPPI Credentials Committee recommends providers for appointment and reappointment to the UCSF and/or LPPI Medical Staff and 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 two (2) 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 Medical Staff Office personnel. These files are protected from discovery pursuant to 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 UCSF 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 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
   - Faculty Appointment (if applicable)
   - Service Chief Recommendation
   - Requested Privileges
   - Requested Start Date

2. Providers must complete the following items:
   - Application for Medical Staff or AHP Staff appointment including Confidentiality Statement and Consent to Release Information, Privileges, or for AHPs - Standardized Procedures.

- Review the Medical Staff Bylaws, Rules and Regulations
- 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.
   - Evidence of Current Malpractice Coverage
   - Fluoroscopy Certificate as appropriate
   - CA Driver's License or Identification Card, or Passport
   - CPR, BLS/ACLS, PALS, NPR as appropriate for AHP Staff.

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 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. Privileging forms or Standardized Procedures are completed as appropriate.
   f. Continuing Medical Education (CME) information documents any courses relevant to specific privileges requested.
   g. California License(s), DEA Certificate, Furnishing Certificate and Fluoroscopy Certificate 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.)

7. Temporary Privileges for Initial Appointments:
   For Initial Appointments involving clinical urgency, a Service Chief may request temporary privileges up to 60 days (the timeframe allowed pursuant to the NCQA credentialing standards). Files triaged as "green" may be approved by CEO, or designee, President of the Medical Staff and Credentials Committee Chair (or their authorized designees), upon agreement with the Medical Staff Office and the Department Chair or designee that the file is correctly triaged as "green." The agenda of the next Credentials Committee meeting will list all "green" files that were approved for temporary privileges.

   Files flagged as "yellow" will be reviewed by the Credentials Chair and considered for temporary privileges at the discretion of the Credentials Chair. If the file is not eligible for temporary privileges, it will proceed through the normal credentialing process.

   Actions on temporary privileges are updated in the Medical Staff Office database upon approval and appropriate areas are notified. The Medical Staff Office database updates interfaced clinical systems within 24 hours and the applicant's status and privileges are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification is forwarded to the applicant within 10 days of the decision on the request for temporary privileges.

B. Reappointments

1. Reappointment Application Packet
   At least four (4) months prior to the end of the two (2) year appointment period, the provider is mailed an application for reappointment. Previously submitted information is queried to produce the reappointment application. The reappointment packet includes:
   - Preprinted Reappointment Application
   - Copy of current clinical privileges
   - Consent to Release information to Contracted Health Plans

2. The provider is required to return the application and supporting documents within thirty (30) days.
   - Evidence of Current Malpractice Coverage
   - Fluoroscopy Certificate as appropriate
   - CPR, BLS/ACLS, PALS, NPR as appropriate

3. If the application is not returned within the designated time period, the provider and Department Chair 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 the Medical Staff, 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 privileges requested.
g. California License(s) and applicable certificates (e.g. DEA, Fluoroscopy, 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.

All primary source verifications from other UCSF Medical Center Departments such as, but not limited to Risk Management, and Quality Services are strictly confidential and protected by California's Peer Review Evidence Code 1156 and 1157. As such, providers are not allowed access to this information.

6. Reappointment Ongoing Professional Practice Evaluation (OPPE) Report

The results of performance monitoring, evaluation, and identified opportunities to improve care and service are printed and included in the reappointment file. All OPPE data are provided by the eOPPE tool. OPPE data are collected and provided as evidence of the practitioner's current competence and suitability for medical staff membership. A reappointment may be deferred for further investigation and discussion as warranted or a Focused Professional Practice Evaluation (FPPE) may be triggered as a result of OPPE data.

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 C., Evaluation and Approval Process.)

C. 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 Department Chair or designee to review and comment on the flagged issue. The complete file (including application, supportive documents, and privileges request form) is sent to the appropriate Department Chair or designee for review and recommendation to the Credentials Committee. The Department Chair or designee may review the file independently or initiate a subcommittee to review an applicant's 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 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 Department Chair 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 Department Chair 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 Department Chair or designee drafts a report to the Credentials Committee indicating concerns with the appointment/reappointment.

   After the Department Chair's 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 Department Chair or designee report is flagged for Credentials Committee discussion.

2. Credentials Committee Evaluation Process

   The 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 Department Chair 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 Executive Medical Board (EMB).

3. Executive Medical Board and Governing Body Evaluation Process
   The Credentials Committee File Triage Report is reviewed by the Executive Medical Board, then the Chancellor of UCSF, as the delegated Governing Body of the UC Regents. The Chancellor's decision is considered the final decision.

   Actions on appointments/reappointments are updated in the Medical Staff Office database within 10 days of Governing Body approval. The Medical Staff Office database updates interfaced clinical systems within 24 hours and the applicant's status and privileges are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification of the Governing Body decision is forwarded to the applicant within 30 days.

4. Provider Enrollment
   Upon Governing Body approval, providers participating in the UCSF Medical Group are added to the UCSF Medical Group health plan roster. The provider's name and required information is sent to the contracted health plans.

D. Visiting Privileges (Urgent Patient Need)

1. In circumstances involving clinical urgency in which patients or an academic program require the services of a physician, dentist, podiatrist or clinical psychologist who is not a member of the Medical Staff, visiting privileges may be granted on a case by case basis to fulfill an important patient care need.

2. The following information is required to begin the Visiting Privileges process:
   - Applicant Name
   - Curriculum Vitae/Resume including all professional work history
   - Faculty Appointment (if applicable)
   - Service Chief Recommendation
   - Requested Privileges
   - Requested Start Date

3. Providers must complete the following items:
   - Visiting Application including Confidentiality Statement and Consent to Release Information, Privileges, or for AHPs, Standardized Procedures.
   - Review the Medical Staff Bylaws, Rules and Regulations
   - Health Plan Application forms (as applicable)

4. 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)
   - Evidence of Current Malpractice Coverage
   - Fluoroscopy Certificate as appropriate
   - CA Driver's License or Identification Card, or Passport
   - CPR, BLS/ACLS, PALS, NPR as appropriate
   - Current Curriculum Vitae (CV)

5. The Medical Staff Office reviews the documents as follows:
   - 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.
   - 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.
   - Clinical urgency and venues are specified and appropriate.
   - Complete addresses, phone and fax numbers as listed for:
     - Hospitals and affiliations;
     - Peer references; and
     - Malpractice insurance company(ies)
   - Privileging forms or Standardized Procedures are completed as appropriate.
   - California License(s), DEA Certificate, and Fluoroscopy Certificate are current.
     - 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.

6. 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.

7. File 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 prior to granting Visiting Privileges.

8. The CEO or designee, the President of the Medical Staff and the Credentials Committee Chair (or authorized designees) may grant Visiting privileges for a period not to exceed 120 days annually after the above information has been evaluated by the applicable Department Chair or designee and he/she has made an affirmative recommendation.

E. <u>Expirables/Ongoing Sanction Monitoring</u>

Sanctions and expirables are monitored on a monthly basis as indicated in Appendix B - Verification Methods. Identified issues are forwarded to the Department Chair or designee for review, investigation and recommendation for appropriate action. If warranted, Corrective Action procedures as outlined in the UCSF Medical Staff Bylaws are initiated.

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) the UCSF

Medical Staff Bylaws prohibits any individual from being part of the Medical Staff who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

F. Reinstatement of Medical Staff Membership and Privileges

It is the policy of the UCSF Medical Staff to permit the reinstatement of a provider's credentials and privileges within ninety (90) days of an inactivation approved by the Governing Body. The following criteria must be met in order for a reinstatement to occur:

- Written explanation from the Department Chair or his/her designee requesting the reinstatement and the reason(s)
- Provider's latest reappointment has not lapsed
- Verification of licensure, certifications and sanctions are re-queried with no findings
- Provider was not inactivated during any disciplinary action, summary suspension of privileges or termination
- Provider meets all credentialing requirements, such as annual TB/PPD screening, initial proctoring, etc.

All reinstatements are presented to the Credentials Committee. A provider's credentials and privileges are not re-activated until the reinstatement request has been reviewed and approved by the Executive Medical Board and Governing Body.

G. Nondiscriminatory Statement and Audit Process

UCSF Medical Staff credentialing and privileging 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 UCSF. This policy reaffirms the commitment of the UCSF Medical Staff to maintaining a discrimination-free credentialing and privileging process.

It is the policy of UCSF (Non-Discrimination Policy 1.01.04) not to engage in discrimination against or harassment of any person employed or seeking employment or medical staff credentialing and privileging or patient care with the UCSF 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. The Medical Staff 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 UCSF Medical Staff Credentials Committee will sign a confidentiality statement that will also include an affirmative statement that all decisions are made in a non-discriminatory manner.

The Department of Medical Staff Services 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, Executive Medical Board and Governing Body. The audit will include, but not limited to, decisions related to:

- Recommendation to appoint/reappointment less than the standard two-year cycle
- Recommendation to appoint/reappoint with conditions and stipulations (ie. obtaining board certification)
- Mandated Focused Professional Practice Evaluation (FPPE) plans
- Ad-hoc Committee review

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

UCSF Medical Center and the organized medical staff 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 privileges are voluntarily surrendered 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 staff privileges or 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, staff privileges, or employment/faculty appointment is terminated or revoked for a medical disciplinary cause or reason;
4. 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;
5. If the resignation, leave of absence, withdrawal or abandonment of application or for renewal of privileges 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 Director, in consultation with the Office of Legal Affairs, 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 President of the Medical Staff;
2. The President and Chief Executive Officer of the Medical Center (or designee);

The director of the UCSF Medical Staff Office, the President of the Medical Staff, and the CEO of the Medical Center 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.

F. <u>Notification to the Provider, Fair Hearing Rights, and Appeal Process</u>

UCSF Medical Staff members are provided notification of all reports filed to the Medical Board of California and NPDB. UCSF Medical Staff members are provided fair hearing rights and AHP members are provided an appeal process should action be taken against the provider's privileges as a result of the provider's quality of care or behavior. All Fair Hearing processes are outlined in the UCSF Medical Staff Bylaws, Article 3.15 and the AHP Appeal Process at Article 3.7.3. and 3.7.3.1.

VI. RESPONSIBILITY

A. This policy resides in the Medical Staff Organization Policy and Procedure Manual. Copies are located in the Medical Staff Services Department.

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 the Director of Medical Staff Services. Any changes must be approved by the Credentials Committee, the Executive Medical Board and the Governing Body.

VII. HISTORY OF POLICY:

A. Revisions: 9/97, 4/98, 9/00, 10/01, 2/02, 5/02, 4/04, 11/04,7/05, 11/05, 3/06, 4/07, 07/09, 06/10, 01/11, 09/11, 10/11, 03/14, 07/15, 01/16
B. Approvals:
   - Credentials Committee: 9/97, 09/00, 6/02, 12/05, 3/06, 5/07, 07/09, 6/10, 01/11, 09/11, 10/11, 12/13, 03/14, 07/15, 01/16
   - Executive Medical Board: 09/00, 12/05, 3/06, 5/07, 07/09, 6/10, 01/11, 09/11, 10/11, 12/13, 03/14, 07/15, 01/16
   - Governing Body: 09/00, 12/05, 3/06, 5/07, 07/09, 6/10, 01/11, 09/11, 10/11, 12/13, 03/14, 07/15

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VIII. APPENDIX A - CREDENTIALS FILES

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

1. Application for membership.
2. Delineation of privileges, including FPPE reports, recommended by the Department Chair or designee in the service which privileges are being requested.
3. Current California State Medical (or other professional) License
4. Valid DEA certification, as applicable
5. Current X-ray Supervisor and Operator Certificate, as applicable
6. Verification of graduation from medical (or other professional) school and completion of residencies and fellowships
7. Verification of previous affiliations prior to UCSF Medical Staff appointment
8. Verification of clinical privileges in good standing from the applicant's primary admitting facility (when this facility is not UCSF Medical Center or LPPI.)
9. Curriculum Vitae that includes a comprehensive work history
10. Evidence of current, adequate malpractice insurance
11. Professional liability claims history
12. Verification of Board Status Certification or Candidacy, as applicable
13. National Practitioner Data Bank Query Report (which includes Medicare and Medicaid Sanctions activity)
14. California Medical Board Status check for validation of license and sanction activity
15. Letters of Reference (including Service Chief Review) that attests to clinical competence and ethical character of the applicant.
16. Continuing Medical Education information
17. Consent to release relevant information to contract health plans.
18. Copies of the Governing Body Approval letters confirming Medical Staff appointment and/or approved privileges
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

UCSF Medical Center

UCSF Benioff Children's Hospital

IX. APPENDIX B – VERIFICATION METHODS

NUMBER	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT				
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES	VISITING PRIVILEGES
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	X

IX. APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappointment	Update as Expires	Visiting Privileges
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**	**X**

IX. APPENDIX B – VERIFICATION METHODS

NUMBER	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT				
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES	VISITING PRIVILEGES
3.	**X-Ray Certificate** Provider attests if X-Ray certificate is not applicable to scope of practice.	Radiologic Health Board website queryfor the following specialties when Fluoroscopy privileges are requested: • Cardiology • Gastroenterology • Neurosurgery • Orthopedics • Pulmonary • Radiation Oncology • Radiology • Surgery • Urology	**X**	**X**	**X**	**X**	**X**
4.	**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**				**X**

IX. APPENDIX B – VERIFICATION METHODS

NUMBER	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT				
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES	VISITING PRIVILEGES
5.	**ECFMG (Foreign Graduates)** For physicians who enter USA-based internship/residency programs.	www.ecfmg.org or in writing from ECFMG	**X**				
6.	**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**				
7.	**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		

IX. APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappointment	Update as Expires	Visiting Privileges
8.	**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		
9.	**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**	**X**

IX. APPENDIX B – VERIFICATION METHODS

NUMBER	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT				
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES	VISITING PRIVILEGES
10.	**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		**X** Verify at least one current affiliation
11.	**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**				**X**

IX. APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappointment	Update as Expires	Visiting Privileges
12.	**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**	**X**
13.	**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		**X** Do not write to current carrier
14.	**Continuing Medical Education**	Applicant provides information pursuant to licensing agency requirements	**X**		**X**		
15.	**National Practitioner Data Bank (NPDB)**	Query	**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	VISITING PRIVILEGES
16.	**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**	**X**

IX. APPENDIX B – VERIFICATION METHODS

NUMBER	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT				
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES	VISITING PRIVILEGES
17.	**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		x

IX. APPENDIX B – VERIFICATION METHODS

NUMBER	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT				
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES	VISITING PRIVILEGES
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** As necessary to obtain confirmation of clinical competency	**X** Obtain at least 1 Peer Reference		**X** One peer reference

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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 new privileges • Applicant is not requesting a status change • Applicant meets all criteria for privileges requested • Activity levels are appropriate • CME relates to privilege requests • QA data includes no Peer Review or Quality of Care issues • No health problems identified

X. APPENDIX C – FILE TRIAGING CATEGORIES

File Category	Initial Appointment	Reappointment
Yellow	The provider's file may include questionable information, such as: • Peer references and prior affiliations indicate potential or minor problems • One malpractice claim • Privileges vary from those typically requested by other practitioners in the same specialty • 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 • Additional Privileges requested • 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 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	The provider's file shows potentially 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

X. APPENDIX C – FILE TRIAGING CATEGORIES

File Category	Initial Appointment	Reappointment
		specialty • Substantial # of professional licenses (greater than 3)

XI. APPENDIX D – SOURCES OF ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) AND OTHER QUALITY/PERFOFRMANCE DATA
When available, information from these sources is integrated into the credentialing process:

1. **Office Site/Medical Record Audits:** UCSF Medical Center clinics accredited by TJC are recognized as compliant with NCQA requirements for office site/medical record reviews. Health plans may submit provider specific audit information for consideration as applicable.

2. **Patient Complaints and Grievances:** All patient inquiries and their resolution are managed by Patient Relations in coordination with the involved provider and Department Chair or designee. For monthly reappointment cycles, Patient Relations forwards a list of providers who have received patient inquiries during the prior two years. The inquiries are triaged by Patient Relations based on volume as well as the severity of the inquiries. When appropriate, complaints will be forwarded to the applicable health plan upon receipt.

   Between reappointment cycles, all serious inquiries are forwarded to Quality Improvement and/or Risk Management for further analysis with communication to the Department Chair or designee. If the Department Chair or designee determines immediate action is required, the President of the Medical Staff is notified and initiates appropriate resolution.

3. **Clinical Activity Reports:** For monthly reappointment cycles, the Quality Improvement department forwards physician volume statistics and comparative data analysis to the Medical Staff Office. Volume data are gathered from UCSF Medical Center/Medical Group billing systems and compared to the Service as well as UHC clinical databases. For providers with no clinical activity during the previous twelve months and who are requesting privilege(s), he/she must provide clinical activity from their primary hospital/ practice site that will provide supporting information for consideration by the Service Chief to ensure appropriate recommendation of membership/privileges. (Refer to form "Low or No Volume Competency Assessment Form)

4. **Quality Measures:** The Quality Improvement department tracks a variety of quality indicators, such as, sedation and surgical case and hospital mortality review. For monthly reappointment cycles, Quality Improvement forwards physician specific quality data flagged for Credentials Committee review as inappropriate. The Service QI Physician reviews any flagged files prior to further consideration by the Department Chair or designee.

5. **Peer Reviews:** Individualized profiling information or quality audits may also be included as appropriate. For example, a suspected issue may provoke an investigation and these findings will be reported and filed in the provider's quality file. In addition, the health plans may submit provider specific data for inclusion.

6. **Medical Record Delinquencies**: For monthly reappointment cycles, medical records delinquency reports for the prior two years are queried by the Medical Staff Office and triaged for Credentials Committee review.

7. **Risk Management/Malpractice Claims:** Risk Management reports UC Regents claims history. Providers are obligated to disclose past and pending liability actions and provide further details regarding these actions, including specific discussion with the Department Chair or designee. Claims histories are also requested from external professional liability insurance companies, as

applicable. Providers with one or more claims are flagged for review by the Department Chair or designee and the Credentials Committee.

8. **Suspensions/Sanctions**: Physicians may be suspended for non-compliance with policies as outlined in the Medical Staff bylaws, such as delinquent signature on medical records. In addition to citizenry suspensions, a physician may be suspended for more serious infractions, such as a license revocation or other action by the Medical Board or Governing Body (please see the Medical Staff bylaws for further information). These suspensions are monitored by the Medical Staff Office and flagged for Department Chair or designee and Credentials Committee review.

9. **Service Quality Indicators:** Each clinical service establishes and monitors quality indicators. The Department Chair or designee considers a provider's performance with applicable indicator's when recommending appropriate membership/privileges and indicates any issues for Credentials Committee consideration.