Rancho Los Amigos National Rehabilitation Center

MEDICAL STAFF POLICY AND PROCEDURE

SUBJECT:

MANAGE CARE POLICY

Policy No.: MS 107
Supersedes: 1/22/14
Revision Date: 12/17/14

PURPOSE

To ensure the Professional Staff Association of Rancho Los Amigos National Rehabilitation Center (RLANRC) Medical Center is in compliance with all Managed Care, state, federal, regulatory and/or accrediting entity standards that support the provision of quality health care for its assigned members.

POLICY

The PSA staff that provides care to managed care members will be held accountable to maintain compliance with all state, federal, regulatory and/or accrediting entity standards that support the provision of quality health care for assigned members. These standards include, but are not limited to: Joint Commission, National Committee for Quality Assurance Certification (NCAQ), Centers for Medicare and Medicaid Services (CMS), with all state, federal, regulatory and/or accrediting entity standards.

PROCEDURE

The PSA prepares for audits related to accreditation/certification and credentialing matters at least annually that include, but not limited to the following policy statements:

A. Advanced Health Practitioners
Certified Registered Nurse Anesthetist (CRNA)/Nurse Practitioners (NPs):
CRNA's/NP's are practitioners who are credentialed/recredentialed by RLANRC PSA.

- Verification sources for CRNA's/NP's Practitioners include: CA Registered Nursing License, Drug Enforcement Administration (DEA)-National Technical Information Service (NTIS), Nurse Practitioner Furbishing # from the Board of Registered Nursing (BRN) and Nurse Practitioner # from BRN.

- The Nurse Practitioner Furnishing Number is issued by the BRN to a nurse practitioner that allows him or her to "order" or furnish drugs and devices to patients using approved standardized procedures. A nurse practitioner with a furnishing number may obtain a DEA registration number if they want to order controlled substances as needed for patient care.

Physician Assistants (Pas):
PA's are practitioners who are credentialed/recredentialed by RLANRC PSA.

- The PSA confirms that the Physician Assistant holds a valid, current and unrestricted license, as appropriate, to practice in the State of California in effect at the time of the Credentialing Committee's decision.

- The PSA documents the verification of state licensure from primary-source, the entity that originally conferred or issued the credential. Verification time limit or licensure: 180 calendar days. The website must be from the State of California licensing or certification agency.

- Initial Primary-Source Verification of Drug Enforcement Administration (DEA) or Control Dangerous Substance Certificate (CDS). The certificate must be effective at the time of the credentialing decision.

- For Physician Assistants who prescribe medications, PSA will verify through one of the following: Verification of a DEA certificate; Confirmation with the DEA agency; confirmation of entry in the National Technical Information Service database (NTIS).

B. PSA reviews and approves this policy annually. These are documented in the Medical Executive Committee's minutes.

C. Practitioner Directory
PSA reviews listings in practitioner data bases and materials for members to ensure that data listed is consistent with information obtained during the credentialing process. The Medical Staff Coordinator reviews the Practitioner Directory monthly for accuracy. When any discrepancy is identified, the Medical Staff Coordinator immediately faxes the Change of Information Form (COIF) to the Network Administration Unit.

D. Credentialing/Recredentialing:
PSA ensures that licensed practitioners meet the credentialing and recredentialing performance standards for participation. The types of practitioners credentialed and recredentialed includes: medical doctors, osteopaths, podiatrists, dentists, clinical psychologists, physician assistants and nurse practitioners. Rancho Los Amigos does not credential/recredential or contract with Clinical Nurse Specialists and Chiropractors.

- Primary or NCQA accredited/certified verification sources will be used that credential decisions are based on the most accurate, current and complete information available.
- Verification sources must not be more than 180 calendar days of the Credentialing Committee decision.
- At a minimum, all practitioners must have: Current and valid license to practice medicine in California; current and valid DEA to practice in California; board certification certificate, if applicable; appropriate malpractice claim history, must not have engaged in any unprofessional conduct or unacceptable business practices; absence of sanctions or restrictions on licensure; absence of use of illegal drugs and of criminal history.
- Verifications are conducted by the Medical Staff Office (MSO) staff.
- Verifications are documented within the credential file.
- A signed and dated checklist including each verified element must be present in each practitioner credential file. (Refer to Credentialing/Recredentialing – Additional Procedures Table for the verification sources):
    - State License to Practice
    - DEA registration
    - Education, Training and Board Certification
    - Work History

- Malpractice Claims History
- Medical Board Sanctions
- Current Malpractice Coverage
- Hospital Privileges
- Medical Board Sanctions/State sanctions and restrictions on licensure and limitations
- Medicare/Medicaid Sanctions
- Medicare Opt-Out

- The credential file must contain a signed, dated and completed application, attestation and Curriculum Vitae.
- All credentialing information collected in the credentialing process will be kept confidential.
- PSA reviews and evaluates information submitted to support credentialing and recredentialing applications and information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards, etc.).
- The MSO ensures that the practitioners are notified via letter of the credentialing and recredentialing decision within 60 calendar days on the committee's decision.
- The MSO shall forward adverse information received from the MBC, DBC, NPDB, DEA, and any primary source verification immediately to the Medical Director and/or the PSA President, when applicable, for review and consideration.
- PSA ensures that practitioners have a Facility Site Review as a requirement for credentialing/recredentialing. Medical Office Staff Coordinator will ensure that all primary care practitioner files have a valid facility site visit at the time of the committee's review.

E. Credentials Committee (CC):
The Credentials Committee utilizes a peer-review process and makes recommendations regarding credentialing decisions. The CC includes representation from a diverse range of participating practitioners and representation from the types-medical specialties of practitioners it reviews. Specialists will be consulted when necessary and appropriate. The Committees reviews the credentials of practitioners being credentialed or recredentialed including those who do not meet the organization's criteria. The CC minutes reflect the actions of practitioners who meet and who does not meet the criteria. All practitioners (clean and not clean) files are submitted to the CC for the Committee's Chair review and approval. The CC may not make any decision on a practitioner unless all necessary credentialing information has been gathered within the specified timeframe. The Chair shall act as the designated Medical Director as defined by NCQA standards.

Nondiscrimination:
No applicant shall be granted or denied Association membership or clinical privileges on the basis of gender, race, age, creed, color, religion, ethnic/national origin, sexual orientation, gender identity or expression, or any other criterion not based upon professional qualifications, The Credentials Committee members make decisions based on character, competency, training, experience and Judgment NOT on basis of gender, race, age, creed, color, religion, ethnic/national origin, sexual orientation, gender identity or expression, or any other criterion not based upon professional qualifications. The PSA monitors and evaluates competency of each applicant when applying for and/or renewal of membership and clinical privileges based on the approved criterion which includes language to prevent any discriminatory practices during the credentialing and recredentialing process. The same routine credentialing process is followed for each applicant, utilizing the credentialing and recredentialing summary sheet. To ensure that credentialing decisions are made in a non-discriminatory manner the following processes are implemented annually:

- Periodic audits credentialing files (In process, denied and approved) to ensure that practitioners are not discriminated against. Credentialing files are reviewed and evaluated on a monthly basis; the credentialing and recredentialing tool (summary sheet) is to determine the competency requirements for appointments and reappointments.
- The CC maintains a heterogeneous committee membership and assures that practitioners responsible for credentialing decisions signs a statement affirming that they do not discriminate when making decisions.

F. Practitioner Rights

PSA recognizes the practitioner's rights in the credentialing and recredentialing process and provides the practitioner with notification of these rights in the PSA application:

- Right to review information submitted by the practitioner to support their credentialing application, attestation or CV – PSA notifies practitioner of the right to review information obtained to evaluate their credentialing application.
- Right to correct erroneous information – PSA promptly notifies the practitioner in writing of any problems in obtaining any information required or if any of the information obtained from primary sources varies substantially from that provided by the practitioner. Within two weeks or 14 days of identifying erroneous information, the practitioner must notify the Medical Staff Office Coordinator of the error and provide the correct information via certified mail. Receipt of information is documented by providing the practitioner with certified mail acknowledging receiving the corrected information.
- Right to be informed of the status of their credentialing application – PSA shall notify the applicant in writing of the status of their application upon request within 30 days of receipt of request.

G. Ongoing Monitoring

PSA monitors practitioners on an ongoing basis to assess occurrences of sanctions, complaints and adverse actions between recredentialing cycles and takes appropriate actions against practitioners when it identifies occurrence of poor quality.

- The PSA/MSO verifies for Medicare and Medicaid sanctions using the following source:
  - OIG Reports – run monthly
- PSA/MSO collects and reviews Medicare and Medicaid sanctions within 30 days of its release.
- PSA/MSO collects, monitors, and reviews Medi-Cal sanction information using the Medi-Cal Suspended and Ineligible Provider Reports within 30 days of its release.
- PSA/MSO collects and reviews sanctions or limitations of licensure within 30 days of its release using one of the following appropriate licensing agencies:
  - MBC – Subscriber Notification – Disciplinary Summary (As a subscriber – reports are sent daily).
  - Board of Podiatric Medicine – run monthly.
  - Board of Psychology – run monthly.
  - Board of Registered Nursing – run monthly.
  - Dental Board of California – run monthly.
  - Osteopathic Medical Board of California – run quarterly.
  - Physician Assistant Committee – run monthly.

- PSA/MSO will query sanction information at least every six months, if applicable, if reporting entities do not publish sanction information on a set schedule.

- PSA monitors practitioners who are excluded/sanctioned from participating in the Medicare Advantage Organization and ensures that it only contracts or employs physicians who have not opted out and that are not excluded/sanctioned from participation.
- Loss or limitation of license will result in termination of practitioner's ability to provide care in the Medicare Advantage Organization, in addition to suspension or limitation of practitioner's clinical privileges as described in PSA Bylaws.
- PSA/MSO will send a monthly communication requesting number of QI issues and patient complaints.
- This information is presented to the Credentials Committee in a cumulative matrix format and a record is maintained in the committee's minutes.

H. Reporting Actions

PSA complies with the reporting requirements of the California Business and Professions Code; Section 800-09.9, 805, 805.1 and National Practitioner Data Bank (NPDB) for reportable incidences (i.e., denials, suspensions, terminations, or recommendations) for medical disciplinary cause of reason. The PSA Peer Review process includes the following:

Rancho Los Amigos National Rehabilitation Center established an Executive Peer Review Committee (EPRC) as part of the Physician Staff Association to review issues brought forth regarding standards of care and/or professional conduct that either cannot be resolved at the departmental level or the issue is of such importance that the PSA Executive Committed is asked to be involved and determine a course of action. Several key hospital staff members can request an Executive Peer Review. These members include the Department Chairs, Risk Management, Patient Safety Officer, and the Chief Medical Officer.

When a decision is made to refer an issue to the EPRC then the following procedures will be followed:

1. If at all possible all Peer Reviews should be resolved at a departmental level.
2. Notify the PSA President and the Chair of the Executive Peer Review Committee (see member list below)
3. The EPRC will then select a minimum of three PSA staff members to review the case (this excludes the actual staff involved in the case)
4. Emails are not to be used as an avenue to vet discussions/opinions on the case. The use o email should solely be used to schedule meetings.

Once the case is reviewed through the above process the EPRC can request the following actions including:

1. Ask for external Experts
2. Initiate a multiple disciplinary M&M
3. Recommend a FFPE
4. Referral to the Well Being Committee
5. Refer matter to the Credential Committee
6. Recommend Coaching
7. Recommend corrective action if necessary.

A Health Facility/Peer Review Report form (805 and/or 805.01) report of disciplinary actions will be filed by the President of the PSA or designee within 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 adverse action (i.e., suspensions, terminations), will be filed within 30 days of the final determination.

- PSA is responsible for reporting to the appropriate authorities within the appropriate time frame and for the accuracy of the information reported.
- All adverse credentialing and peer review actions will be reported to health plans according to health plan contractual agreements.
- The practitioner has the right to meet with the Medical Executive Committee to refute any decisions made in regard to any corrective action issued.
- An 805 report will be filed after any of the following events occurs for a medical disciplinary cause or reason:
  - A practitioner's application for staff privileges or membership is denied or rejected for a medical disciplinary cause of reason;
  - Summary suspension of a practitioner's membership or staff privileges, that remains in effect for more than 14 days;
  - A practitioner's membership or staff privileges is terminated or revoked for a medical disciplinary cause or reason;
  - Restrictions are imposed, or voluntarily accepted, on staff privileges or membership for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

Notification to the practitioner:
The practitioner will receive a copy of the 805 report and notice advising the practitioner of his or her right to submit statements or other information, electronically or otherwise to the board and that information submitted electronically will be publically disclosed to those who request it, pursuant to section 800 (c) of the business Professions Code.
The information to be reported in an 805 report will include the name and license number of the licentiate (practitioner) involved; a description of the facts and circumstances of the medical disciplinary cause or reason and any other relevant information deemed appropriate by the reporter (the peer review body).

A supplemental report shall be made within 30 days following the date the practitioner is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body; in performing its dissemination functions required by Section 805.5. The agency shall include a copy of a supplemental report, if any, whenever it furnishes a copy of the original 805 report; in the instances where another peer review body is required to file an 805 report.

<u>805.01</u>
An 805.01 report is filed (distinct from an 805 report) with the appropriate agency as required by law within 15 days after the effective date the peer review group has made a final decision on a practitioner's behavior with regard to the following actions;

- Incompetence or gross deviation from the standard of care;
- The use of drugs or excessive alcohol abuse;
- Repeated acts of excessive prescribing controlled substances;
- Sexual misconduct with one of more patients during treatment

Notification to the practitioner:
The practitioner will receive a copy of the 805.01 report and notice advising the practitioner of his or her right to submit statements or other information, electronically or otherwise to the board and that information submitted electronically will be publically disclosed to those who request it, pursuant to Section 800 (c) of the Business Professions Code.

I. Hearing and Appellate Review
In all cases in which action has been taken or a recommendation has been made constituting grounds for a hearing, the PSA promptly gives written notice of its recommendation or action to the practitioner, his/her rights to request a hearing and hearing process.

- The notice shall state (1) what corrective action has been proposed against the practitioner (2) that the action, if adopted, must be reported under California Business and Professions Code Section 805 by following the instructions outlined in the Medical Board of California Health Facility Reporting Form (ENF-805) and must be reported to the National Practitioner Data Bank (NPDB) in accordance with the law by following the instructions outlined in the NPDB Reporting Requirements; brief indication of the reasons for the action proposed or taken; summary of the practitioner's appeal rights; summary of the practitioner's appeal process; that the practitioner may request a hearing within thirty (30) days following the date of receipt of notice; and that the practitioner may be represented by an attorney or a designee.
- Right to representation for hearing. The practitioner is notified of his or her right to be represented by an attorney or another individual of the practitioner's choosing.
- The practitioner cannot have an attorney if the PSA does not have attorney representation.
- PSA provides a written Notice of Hearing to practitioner and/or his representative. The Notice of Hearing specifies the place, time, a date of the hearing and the reasons for the recommended action, including the acts or omissions with which the practitioner is charged, a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the PSA.

J. Facility Site Review (FSR)
PSA identifies new practitioners.

- For the purpose of adding new practitioners to the Facility Site Review and arranging for a Medical Record Review, PSA will notify Health Plan of all new practitioners and all practitioners who need to be added to the FSR process.
- A full scope site review will consist of the site review survey and medical records review survey.
- DHS monitors the practitioner minimum hours requirement through FSRs on initial credentialing and every three (3) years thereafter and through any member complaints, or any other source received regarding their facility at any time.
- Health Plan will conduct office site reviews on behalf of DHS in response to member grievances related to practitioner site quality. The FSR will include, at a minimum, a review of the following: Physical accessibility, physical appearance and adequacy of waiting/examining room space.
- All new practitioners will be added to the FSR by the Medical Staff Office Coordinator.
- SR tools will be used to audit compliance with both Site and Medical Records requirements, with observed performance yielding a score for both elements that combined equal a total facility final

score. At a minimum, each component must score 80%. Locally, a corrective action plan (CAP) for each individual element scoring less than 100% will be generated. Follow-up audits will be repeated at no less than 6 month intervals until 100% compliance is achieved.

- Surveying agency (i.e. LA Care, Managed Care Services) will provide report of site visit, identifying areas that do not meet threshold scores (percentages). Specific areas to be scored pertaining to the Site survey may include, but not limited to: Access/Safety, Personnel, Office Management, Clinical Services, Preventive Services and Infection Control. Medical Record elements may include but not limited to: Format, Documentation, Continuity/Coordination, Pediatric Preventive, Adult Preventive, and OB/CPSP Preventive.
- There is ongoing monitoring of all sites to detect any deficiencies that may occur after the initial site visit. Monitoring methods may include but not limited to reviews of member complaints and grievances related to the quality of sites. Data from these activities is reviewed by the Quality Improvement & Patient Safety Program Committees at least every six months and any information relevant to the credentialing process is forwarded to the Credentials Committee.
- Site visits will be conducted within 60 days of determining that the threshold has been met.
- PSA will take the appropriate actions/Corrective Action Plan (CAP) to correct any scores which do not meet defined threshold levels, as identified through initial or repeat FSRs. The effectiveness of the corrective actions of the identified areas will require approval by the reviewing agency and will be monitored by the Credentials Committee and reviewed at least every six months until the threshold is met.
- Documentation of all initial and subsequent follow up site visits will be reviewed by the Credentials Committee.

K. Identification HIV/AIDS Specialists
On an annual basis, Department of Health Services (DHS) will identify and/or reconfirm the qualified physicians who meet the definition of HIV/AIDS Specialist according to the California Standing Referral Law, Division of HIV and STD Programs (DHSP). All HIV/AIDS Specialist are to complete and meet the requirements outlined in the HIV/AIDS Physician Specialist Form – Verification of Qualifications.

ATTACHMENTS

Attachment A – "Credentialing Guidelines"
Attachment B – "Credentialing Verification Methods and Requirements Licensed Independent Practitioners"
Attachment C – "Credentialing Verification Methods and Requirements Mid-Level Provders"