Rancho Los Amigos National Rehabilitation Center

MEDICAL STAFF POLICY AND PROCEDURE

SUBJECT:		
CREDENTIALING AND RECREDENTIALING	**Policy No.:**	**MS 109**
	Supersedes:	**New**
	Revised:	**11/18/15**
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PURPOSE

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

POLICY

The PSA will be accountable to maintain compliance with all state, federal, regulatory and/or accrediting entity standards that support the provision of quality health care. RLANRC does not delegate credentialing. The PSA ensures compliance with Joint Commission, National Committee for Quality Assurance Certification (NCQA) Centers for Medicare and Medicaid Services (CMS), with all state, federal, regulatory and/or accrediting entity.

PROCEDURE

General Principles

- The Medical Center's Medical Staff Office ensures that licensed practitioners meet the credentialing and recredentialing performance standards for participation.
- The types of practitioners credentialed and recredentialed includes: licensed medical doctors, osteopaths, podiatrists, dentists, clinical psychologists, Physician Assistants and Certified Registered Nurse Anesthetists, Nurse Practitioners. Clinical Pharmacists, and Clinical Nurse Specialists.
- RLANRC does not credential/recredential or contract with chiropractors.
- Primary or NCQA accredited/certified verification sources will be used to ensure 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 (CC) decision.
- Verifications are documented within the credential file.
- The CC reviews this policy annually and forwards recommendation for approval to the Medical Executive Committee. Credentials and Medical Executive Committee documents the review in the minutes.
- The credential file must contain a signed, dated and completed application, attestation and Curriculum Vitae.
- The CC 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 Medical Staff Office (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.
- CC 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.

- MSO 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.
- A clean file is defined as the following:
  - A current and valid, unencumbered license to practice medicine in his/her state of practice
  - Appropriate malpractice claims history
  - No engagement in any unprofessional conduct or unacceptable business practices
  - Absence of sanctions or restrictions on licensure
  - Current and valid DEA practice in California
  - Absence of use of illegal drugs

A. Credentialing criteria

Credentialing criteria applied uniformly to all practitioners requesting privileges, regardless of specialty. At a minimum all practitioners must have:

- current and valid license to practice in California
- current and valid DEA) (if applicable
- current BLS/ACLS (if applicable)
- board certification (if applicable)
- appropriate malpractice claims history- All malpractice claims are reviewed by the Credentialing Committee. The committee determines appropriate claims history, based upon the provider's specialty, type of claim and circumstances of the claim.
- 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
- absence of criminal history
- clinical privileges in good standing

B. Credentialing Verifications

The following primary source verifications are utilized.

a. Current Licensure:

Primary source verification of licenses is required. Primary source verification is obtained from the appropriate State licensing agencies:

- Physicians – Medical Board of California
- Dentists – Dental Board of California
- Optometrists – California Board of Optometry
- Podiatrist - California Board of Podiatry
- Clinical Psychologist – California Board of Psychology
- Doctor of Osteopathy – Osteopathic Medical Board of California
- Nurse Practitioners – California Board of Registered Nursing
- Certified Registered Nurse Anesthetist – California Board of Registered Nursing
- Clinical Nurse Specialist - California Board of Registered Nursing
- Physician Assistant – Physician Assistant Committee
- Clinical Pharmacist – California Board of Pharmacy

C. DEA

DEA certificates must be verified by primary source verifications from the Drug Enforcement Administration.

D. Radiography & Fluoroscopy X-ray and Supervisor Operators Certificates

Verified with the California Radiologic Health Branch.

E. Relevant Education, Training and Experience:
- Information concerning applicants' credentials may be obtained from approved Credentials Verifying Organizations (CVOs); e.g., the AMA, or primary source verification of professional education is obtained from the appropriate professional school.
- Residency or other professional training program verification may be obtained from, the AMA, or primary source verification is obtained directly from the training program (from the Program Director if possible) where applicable.
- Current and previous affiliations and work history is verified by reviewing the following documents and obtaining primary source verification:
- Listing of previous (the last five years) institutional affiliations
- Work History Tracking Form – Chronological list of all work history since completion of professional training with required written explanation for time gaps of more than six months.

F. Peer References

Names and contact information of three (3) Peer References are required.
- These references should not be relatives in practice, and should include at least one member from the professional staffs of other institutions with which the applicant is (or has been) affiliated, if applicable.
- At least one reference should be the applicant's current or most recent clinical supervisor. At least one, but ideally two or more, references for mid-level providers (e.g., NP, PA, etc.) should be physicians.
- For recent graduates in the past three years, one reference must be from the applicant's program director.
- Each peer reference is sent a "Recommendation for Initial Privileges" form to complete

G. Board Certification

Eligibility, or work experience in a specific field. Primary source verification is obtained from the individual granting board, such as American Board of Medical Specialties (via CertiFacts Online), American Osteopathic Association, American Board of Podiatric Orthopedics and Primary Podiatric Medicine, American Board of Physician Specialties, etc., or work experience is verified with evidence of competency by at least two peers in the chosen field with firsthand knowledge of the applicant's practice.
- Special permits or certificates of training required to support the privileges requested.

H. Current Hospital or other Institutional Affiliations. Delineation of the applicant's current privileges and any history of loss of privileges or other disciplinary action are requested from the organization as well as admitting privilege status, and if the applicant is in good standing.

I. Abilities to Perform Procedures Requested

All applicants are required to complete a series of "Attestation Questions" which include questions about the applicant's health status, professional disciplinary actions, and drug or alcohol use and malpractice history.

J. Other Information Required for Application
- Professional liability insurance information and coverage, if applicable.
- Explanation of previous professional liability actions and malpractice claims history.
- Information obtained through a National Practitioner Data Bank query.

K. Credentials Committee (CC):

The CC 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 all medical specialties of practitioners it reviews. Specialists will be consulted when necessary and appropriate. The Committee 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 do 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 decisions 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.

L. 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 CC monitors and evaluates competency of each applicant when applying for and/or renewing 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:

Semi Annual audits of 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. (Check List) is to determine the competency requirements for appointments and reappointments.

Annual audit of practitioner complaints to ensure that there are no complaints alleging discrimination.

The CC maintains a heterogeneous committee membership and assures that practitioners responsible for credentialing decisions sign a statement affirming that they do not discriminate when making decisions.

M. Practitioner Directory
MSO 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 MSO at RLANRC reviews the Practitioner Directory monthly for accuracy. When any discrepancy is identified, the MSO notifies the Network Administration Unit.

N. Practitioner Rights
PSA recognizes the practitioner's rights in the credentialing and recredentialing processes 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 - MSO notifies practitioner of the right to review information obtained to evaluate their credentialing application.
- Right to correct erroneous information — MSO 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 MSO-Credentials Specialist 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 and recredentialing application – CMO shall notify the applicant in writing of the status of their application upon request within 30 days of receipt of request.

O. Ongoing Monitoring

PSA/MSO 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 Pharmacy – run monthly
- Board of Podiatric Medicine — run monthly
- Board of Psychology — run monthly
- Board of Registered Nursing — run monthly
- California Medical Board of Optometry — 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.
- 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.
- This information is presented to the Credentials Committee in a cumulative matrix format and a record is maintained in the committee's minutes.

P. Reporting Actions

PSA President 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. 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 President 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 President 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.
- 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 or 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.

805.01
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.

Q. 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 President 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.

- In the event of an appeal, the decision shall be presented to a hearing (peer review) committee for its recommendations. As with other recommendations, these may or may not be accepted by the Medical Director and/or the Governing Body.
- The PSA cannot have attorney representation if the practitioner does not have attorney representation.
- PSA President 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.

R. 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.
- The Department of Health Services (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.
- The FSR will be retrieved from the LA Care Portal and placed on all credentialed/recredentialed practitioner files prior to presentation to the Credentialing Committee.
- 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. Health Plan, Credentialing Services) will provide a report of a site visit, identifying areas that do not meet threshold scores (percentages). Specific areas to be scored pertaining to the Site survey may include, but are 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.

S. Identification of HIV/AIDS Specialists
RLANRC does not credential/recredential or contract with HIV/AIDA Specialists.

T. Confidentiality
- Credentialing files and credentialing material shall be kept confidential and maintained in a secure location.
- Members of the MSO & CC are bound by the confidentiality policies of DHS.
- Access to online credentialing information will be limited to members of the MSO & CC.

U. Maintenance of Credentials
It is the responsibility of all licensed independent practitioners to maintain current and valid practitioner licenses and certifications required in order to perform their job duties.
    1. At the time of renewal all practitioner licenses and certification should be presented to the CC.
    2. The MSO or designee will maintain a database of all licensed independent practitioners with expiration dates for applicable licenses or certifications. Providers will be notified within 30 days of expiration of their practitioner license or certification with a request made to supply the MSO with the updated license or certification.
    3. Upon renewal of practitioner license or certification, applicable primary source verification will be obtained within 5 days of receipt.
- In the event the provider does not provide an updated practitioner license or certification prior to expiration, the matter will be referred to the CMO or designee for further action as deemed necessary.
- Practitioners without a current and valid practitioner license will not be allowed to provide direct patient care; failure to maintain a current and valid practitioner license is grounds for disciplinary action, up to and including termination.
- The Department Chair ensures arrangement/coverage for the practitioners who choose not to have a DEA. The Department Chair allows a practitioner with a valid DEA certificate (Service Chief or Senior Resident on the service) to write all prescriptions requiring a DEA number for the prescribing practitioner's patients until the practitioner has a valid DEA certificate.

V. Utilization Management (UM) Practitioners and Physician Reviewer Making Medical Decisions:
- The PSA includes our Utilization Management practitioners and physicians reviewers making medical decisions in their scope of practitioners to credential and recredential. DHS prohibits financial incentives for Utilization Management Decision-makers.
- DHS is committed to ensure that our members receive the best and most appropriate care possible.
- Utilization management decisions are based only on appropriateness of care and existence of coverage.
- DHS does not directly or indirectly reward practitioners or other individuals for issuing denial of coverage, service or care.
- DHS does not offer financial incentive or compensation to encourage underutilization of services.
- Each medical staff member will be expected to provide annually a personal statement attesting to recognition of and compliance with this standard. Affirmative statements will be collected annually and will be considered integral to a complete credentials file.