



PNO-CR-01 Credentialing Program
Provider Network Operations

CR-01 Credentialing Program

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Committee Chair

Date

1. Credentialing Program

San Francisco Health Plan (SFHP) credentials providers, including telemedicine consultants, who have an independent relationship with the Health Plan and provide care under SFHP's medical benefit. Providers who practice within the inpatient setting or free-standing facilities while providing care to SFHP members are exempt from the SFHP credentialing and re-credentialing process.

Credentialing and recredentialing standards used by SFHP are based on federal and state requirements, and comply with SFHP's contract with the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS). SFHP meets all DMHC and DHCS requirements, and adopts current National Committee for Quality Assurance (NCQA) credentialing accreditation standards.

Credentialing and recredentialing requirements are applied to all licensed practitioners credentialed by SFHP and its delegated medical groups, including non-physician medical practitioners as described in Section 10 of this program. SFHP requires every practitioner contracted to provide care to SFHP members to be credentialed according to the appropriate standards before delivering care to SFHP members.

SFHP assures that all information obtained during credentialing and recredentialing activities remains confidential, except as required by law.

The Physician Advisory/Peer Review/Credentialing Committee (PAC) and SFHP Governing Board review the Credentialing Program annually and applicable SFHP Credentialing Policies and Procedures.

1.1. Credentialing Program Goals and Objectives

- A. Ensures that the credentialing and recredentialing process is conducted in a manner that is non-discriminatory.
- B. Ensures that the credentialing verification process does not exceed the prescribed time limit of 180 days.
- C. Ensures that practitioners' recredentialing occurs at least every 36 months.
- D. Meets industry standards for credentialing.
- E. Complies with federal and state requirements.
- F. Regularly evaluate organizations delegated for credentialing functions through an objective review process.
- G. Ensures the confidentiality of all applications received.
- H. Ensures that all practitioners providing care to members under SFHP's medical and behavioral care benefits are credentialed.

1.2. Credentialing Department Staff

Under the direction of the Chief Medical Officer and the Director of Provider Network Operations, the Manager of Delegation Oversight and Credentialing is responsible for the development, effective coordination, and maintenance of the Credentialing Program. The Manager of Delegation Oversight and Credentialing oversees the work of the Delegation Oversight Credentialing Coordinator, who is responsible for the day-to-day activities of the department, including initial application processing, recredentialing, practitioner updates, and audit preparation. Please see attached job descriptions for complete details of staff responsibilities.

The Chief Medical Officer (CMO) interacts with the Credentialing Department by chairing the PAC, participating in the development and review of credentialing policies and procedures, and by reviewing credentialing and recredentialing files.

2. Credentialing Committee

The SFHP Physician Advisory/Peer Review/Credentialing Committee (PAC) is a forum for network physicians that provide comments and recommendations to SFHP on standards of care; this committee is a subcommittee of the Quality Improvement Committee (QIC).

PAC serves a twofold goal:

- A. To serve as the Peer Review Committee to address concerns or identified problems related to issues of quality of medical care,
- B. To review credentials and approve practitioners for participation in the SFHP network and review the credentialing policies and activities of entities delegated for credentialing.

For additional information regarding the Physician Advisory/Peer Review/Credentialing Committee (PAC), review SFHP policy and Procedure *QI-11 Physician Advisory Peer Review Credentialing Committee*. See Appendix 1 for a list of participating committee members and their specialty.

3. Credentialing Guidelines

The PAC ensures that licensed health care practitioners meet credentialing and performance standards for participation in the SFHP practitioner panel. Practitioners must maintain a valid California state license at all times. All independent health professionals participating on the practitioner panel and published in any external directories (e.g. delegated medical groups) must be credentialed.

3.1. Types of practitioners

3.1.1. SFHP and its delegates credential and recredential the following types of practitioners:

- A. Medical Practitioners:

- Allopathic medical doctors
- Osteopathic medical doctors
- Chiropractors
- Podiatrists
- Anesthesiologists with independent pain-management practices
- B. Non-physician practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision), and treating members as independent practitioners:
 - Nurse Practitioners
 - Nurse Midwives
 - Dentists providing care under medical benefits
- C. Telemedicine consultants interacting with members
- D. Oral surgeons
- E. Physical Therapists
- F. Occupational Therapists
- G. Speech and language therapists
- H. Behavioral healthcare practitioners:
 - Psychiatrists and other physicians
 - Addiction medicine specialists
 - Doctoral or master's-level psychologists who are state certified or licensed
 - Master's-level clinical social workers who are state certified or licensed
 - Master's-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
 - Other behavioral healthcare specialists, who are licensed, certified or registered by the state to practice independently

3.1.2. Practitioners who do not need to be credentialed by SFHP:

- A. Practitioners who practice exclusively within the inpatient setting (hospital based), and who provide care for SFHP members only as a result of members being directed to the hospital or another inpatient setting.
 - Pathologists
 - Radiologists
 - Anesthesiologists
 - Neonatologists
 - Emergency room physicians
 - Hospitalists
 - Locum Tenens
 - Resident Physicians
- B. Practitioners who practice exclusively within free-standing facilities and who provide care for SFHP members only as a result of members being directed to the facility.
 - Mammography centers
 - Urgent-Care centers

- Surgical centers
 - Ambulatory behavioral healthcare facilities
 - Psychiatric and addiction disorder clinics
- C. Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates' utilization management (UM) functions.
 - D. Covering practitioners (e.g. locum tenens). Locum tenens that do not have an independent relationship with the organization are outside NCQA scope of credentialing.
 - E. Practitioners who do not provide care for members in a treatment setting.

3.2. Verification Sources

The following documents should be current and maintained in the credentialing files in the Credentialing Department along with other documents required by DMHC, DHCS, NCQA, and SFHP:

- A. Practitioners' license with the Medical Board of California;
- B. Clinical privileges in good standing from the applicant's primary admitting facility;
- C. Valid DEA certification with a California address. If a practitioner does not have a California address, he/she must send, in writing, who will prescribe for the practitioner until he/she has his/her California DEA.
- D. Graduation from graduate clinical school and completion of a post-graduate training (e.g. internship, residency or fellowship);
- E. Work history (e.g. curriculum vitae);
- F. Proof of current and adequate malpractice insurance with minimum coverage as determined by NCQA;
- G. Professional liability claims history;
- H. Initial Application, including a statement consistent with applicable laws, and signed by the applicant which attests to the following: any inability to perform the essential functions of the position, with or without accommodation; absence of illegal drug use; history of loss of license and/or felony conviction(s); and history of loss or limitations of privileges or disciplinary activity. Once the Initial Application is signed, the practitioner attests that the Initial Application is accurate and complete;
- I. Board certification is not required by NCQA; however, SFHP verifies current certification status of practitioners who state that they are board certified;
- J. National Practitioner Data Bank Query report; and
- K. Medicare (OIG) /Medi-Cal (No-Pay List) Sanctions information.

3.3. Decision-Making Criteria and Process

The Physician Advisory/Peer Review/Credentialing Committee (PAC) holds the responsibility for reviewing credentialing activities of SFHP and of its delegates.

All practitioners participating in the SFHP network must be approved by the SFHP PAC. The PAC may approve all clean files. When issues are found during the credentialing process, the PAC reviews the file and makes the determination to approve or reject the practitioners' application. The PAC may not approve practitioners with an active accusation under review by the Medical Board of California.

The CMO, as chair of the PAC, has the authority to approve practitioners' credentialing or recredentialing files only when they are considered clean. The CMO may exercise this authority only when the reason for the exception is in benefit of member care, or when the timeline for Committee review exceeds the established schedule. The PAC will review and provide final approval on all of the clean files approved by the CMO.

Provisional credentialing may be granted to practitioners applying to the SFHP network for the first time. All provisionally credentialed practitioners must complete a credentialing application, attestation, and have at minimum a valid California license to practice. The Credentialing Staff will complete primary source verification of the previous five (5) years from National Practitioner Data Bank (NPDB), and review malpractice claims and settlements from malpractice carriers prior to submitting recommendation for committee approval. A follow up plan for obtaining full credentialing status must be approved by the PAC, and a follow up review must be conducted within 60 days of the original credentialing decision.

3.4. Managing Files That Meet Criteria

Credentials files are treated as confidential and are kept electronically in a SharePoint site with restricted access to the Credentialing Staff, Provider Network Director, and Compliance Department. The files are protected from discovery by Section 1157 of the Evidence Code. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes consistent with Section 1157. The Peer Review/Credentials file is open to review by Federal and State agencies.

Queries are run on a monthly basis to determine which practitioner's license, DEA, and malpractice insurance will expire for that month. Primary source verification is obtained and the provider file is updated.

3.4.1. The following documents will be current and maintained in the practitioner's file:

- A. Current State Medical License.
- B. Verification of clinical privileges in good standing from the applicant's primary admitting facility. If practitioner has no privileges, a plan of admission/coverage (i.e., uses hospitalist program, group will handle admins & coverage, etc.)
- C. Valid DEA certification, if applicable.
- D. Verification of education and training.
- E. Verification of board certification, candidacy, as applicable.
- F. Work history-including gap inquiry.
- G. Current, adequate malpractice insurance.
- H. Professional liability claims history.

- I. Application for membership including a statement consistent with applicable laws, signed by the applicant regarding any reasons for any inability to perform the essential functions the position, with or without accommodation, lack of present illegal drug use, history of loss of license, and/or felony convictions, and history of loss or limitations of privileges or disciplinary activity.
- J. National Practitioner Data Bank Query report, which includes Medicare/Medi-Cal sanction activity.

3.4.2. In addition to the above listed, each file contains an signed and dated checklist that includes:

- A. The source used.
- B. The date of verification.
- C. The signature or initials of the person who verified the information
- D. The report date, if applicable.

3.4.3. CREDENTIALING files are considered clean when the following criteria are met:

- A. The application and attestation are complete, signed, and dated.
- B. All the required documentation is present in the file.
- C. All information requiring verification has been verified within the specified time limits.
- D. The documentation and verifications sources reveal:
 - Active License to Practice with no limitations or sanctions.
 - Active DEA/CDC certificate.
 - Education, training, Board Certification as applicable.
 - Continuous work history without a gap of more than 6 months.
 - No malpractice claims history.
 - No Reasons for Inability to Perform Role.
 - Absence of illegal drug use.
 - No history of loss of license / felony conviction.
 - No history of loss / limitations of privileges / disciplinary action.
 - Current adequate malpractice insurance coverage.
 - Attestation to correctness and completeness of application.
 - No state sanctions or restrictions on licensure.
 - No Medicare/Medicaid sanctions (See section 2).
 - Hospital admitting privileges or an alternative way to admit a SFHP member.

3.4.4. RECREDENTIALING files are considered clean when the following criteria are met:

- A. The application and attestation are complete, signed, and dated.
- B. All the required documentation is present in the file.
- C. All information requiring verification has been verified within the specified time limits.
- D. The recredentialing cycle has been completed within 36-month time frame.
- E. The documentation and verification sources reveal:
 - Active license to practice with no limitations or sanctions.

- Active DEA/CDS certificate.
- Board certification as applicable.
- No malpractice claims history.
- No reasons for inability to perform.
- Lack of present illegal drug use.
- No history of loss of license / felony conviction.
- No history of loss / limitations of privileges /disciplinary action.
- Current adequate malpractice insurance coverage.
- Correctness and completeness of application.
- No state sanctions or restrictions on licensure.
- No Medicare/Medicaid sanctions.
- Hospital admitting privileges or an alternative way to admit a SFHP member.
- Performance monitoring (e.g. member grievances, adverse events, HEDIS, etc.).

A file is considered *not clean* when one or more of the *clean* file criteria above are not met.

3.5. Non-discriminatory Credentialing and Recredentialing

Credentialing and recredentialing decisions are made solely based on the results of the verification process. Annually, the PAC signs an affirmation confirming that credentialing decision are not made based on an applicant's race, ethnicity/national identity, gender, age, sexual orientation, or area in which the practitioner specializes. Applicants' demographic information is not provided to the PAC.

All Credentialing Applications are logged and their status (Approved/Denied) recorded. Annually, the credentialing staff provides a summary report to the PAC. The purpose of this report is to review all denials; PAC member are instructed to assess whether or not discrimination played a role in any case. The CMO is responsible for finding trends in discrimination, and the Governing Board is responsible for ensuring that a plan corrective action has been implemented and followed.

3.6. Discrepancies in Credentialing Information

In the event that verification information obtained by the credentialing staff substantially differs from that supplied by practitioners, the credentialing staff will contact practitioners to have them either correct or explain the differences. Practitioners have the right to correct erroneous information submitted during the application process; corrections must be submitted in writing to the Credentialing Department within 15 calendar days of the notification.

3.7. Notification of Decisions

SFHP notifies, in writing, applicants of initial credentialing and recredentialing decisions within 60 days from the date the decision was made.

3.8. Provider Directory Listings

After a practitioner is approved by SFHP, the following information is entered in the system; information marked with an asterisk (*) is published in the directory:

- Last and First Name and Middle Initial (*)
- Degree (*)
- Date of Birth
- Gender
- CA License Number
- NPI Number
- Clinic / Practice Address (*)
- Hospital Affiliations
- Specialty (*)
- Board Status (Certified, Eligible, N/A)
- Provider Language Abilities (other than English)
- Provider Type (PCP, Specialist, Mid-Level) (*)
- If Mid-Level, List Supervising PCP Name

Members can find the provider in SFHP's online directory at www.sfhp.org. In addition, SFHP updates the printed directory semiannually.

For a detail description of the process for managing provider data, refer to policy and procedure *PR-21 Provider Data Maintenance*.

3.9. Practitioner Rights

Practitioners have the right to review the information submitted in support of their credentialing applications. Additionally practitioners have the right to:

- 3.9.1. Practitioners have the right to review information obtained by SFHP for the purpose of evaluating their credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure. Practitioners may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at:

Provider Network Operations
San Francisco Health Plan

P.O. Box 194247
San Francisco, CA 94119-4247

The Credentialing Department will notify the practitioner within 72 hours of the date and time when such information will be available for review.

3.9.2. Practitioners have the right to be informed of the status of their credentialing /
recredentialing application. The practitioner may request this information by sending a
written request by letter, email or fax to the Credentialing Department of the Healthcare
Organization's offices.

Practitioners will be notified in writing by fax, email or letter no more than seven working
days of the current status of the application with respect to outstanding information
required to complete the application process.

3.9.3. Practitioners will be notified in writing via fax, email or certified letter, when information
obtained by primary sources varies substantially from information provided on the
practitioner's application. Examples of information at substantial variance include reports
of practitioner's malpractice claims history, actions taken against a practitioner's
license/certificate, suspension or termination of hospital privileges or board certification
expiration when one or more of these examples have not been self-reported by the
practitioner on his/her application form. Practitioners will be notified of the discrepancy at
the time of primary source verification. Sources will not be revealed if information
obtained is not intended for verification of credentialing elements or is protected from
disclosure by law.

3.9.4. If a practitioner believes that erroneous information has been supplied to SFHP by primary
sources, the practitioner may correct such information by submitting written notification
to the Credentialing Department. Practitioners must submit a written notice, via certified
letter, along with a detailed explanation to the Credentialing Department at:

Provider Network Operations
San Francisco Health Plan
P.O. Box 194247
San Francisco, CA 94119-4247

within 48 hours of SFHP's notification to the practitioner of a discrepancy or within 24
hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-
verify the primary source information in dispute. If the primary source information has
changed, correction will be made immediately to the practitioner's credentials file. The
practitioner will be notified in writing, via certified letter, that the correction has been
made to his/her credentials file. If, upon review, primary source information remains
inconsistent with practitioner's notification, the Credentialing Department will so notify

the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Practitioners have the responsibility to produce adequate information for proper evaluation of professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications to the satisfaction of the PAC. Applicants must supply all information to satisfy the definition of a complete application within 60 days of being sent an application packet. Failure to do so without good cause will result in their applications being nullified. Practitioners may submit corrections to their application, in writing via fax, email, or mail.

3.10. Practitioners Termination and Reinstatement

If a practitioner's contract is terminated and later it is reinstated, the practitioner must be initially credentialed prior to reinstatement if there is a break in service of more than 30 calendar days.

SFHP re-verifies credentials that are no longer within re-verification time limits (credentials that will not be in effect when the PAC or CMO make the credentialing decision).

4. Credentialing Verification

SFHP conducts timely verification of credentialing information to ensure that practitioners have the legal authority and relevant training and expertise to provide quality care. SFHP verifies this information through primary sources, unless otherwise indicated. See Appendix 4 for a copy of the Credentialing Check List. Credentialing staff will note the date when verification of the required items has occurred, and will sign and date when the verification process is complete.

4.1. Verification of Credentials

SFHP verifies that the following are within the prescribed time limits:

4.1.1.A current and valid California license to practice:

- A. Verification time limit: 180 calendar days; license must be in effect at the time of the decision.
- B. SFHP confirms that the practitioner holds a valid, current California license. Verification must come directly from the Medical Board of California or the California Department of Consumer Affairs' BreEZe licensing verification system.

4.1.2.DEA or CDS Certification, if practitioner prescribes controlled substances:

- A. Verification time limit: Prior to the credentialing decision
- B. If a practitioner has a pending DEA certificate application, the practitioner may be provisionally credentialed. To award a provisional credentialing status, SFHP must obtain documented evidence that another practitioner with a valid DEA certificate will write all prescriptions until the applicant has a valid DEA certificate.

- C. SFHP uses any of the following to verify the DEA (Drug Enforcement Agency) certificate:
- DEA or Controlled Dangerous Substance (CDS) agency.
 - DEA or CDS certificate.
 - Documented visual inspection of the original DEA or CDS certificate.
 - Confirmation from the National Technical Information Service (NTIS) database.
 - Confirmation from the American Medical Association (AMA) Physician Masterfile (DEA only).
 - American Osteopathic Association Official Osteopathic Physician Profile Report or Physician Master File (DEA only)

4.1.3. Education and Training:

- A. Verification time limit: Prior to the credentialing decision.
- B. Re-verification during recredentialing is not required.
- C. SFHP verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate:
- Board certification.
 - Completion of Residency.
 - Graduation from medical or professional school.
- D. Specialists must provide a copy of Specialty Board certification/recertification.
- E. SFHP uses any of the following to verify education and training:
- Sealed transcripts.
 - AMA Physician Masterfile.
 - American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.
- F. Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986. For chiropractors, dentists, and other non-physician practitioners, highest level of education and other training must be verified.
- G. For practitioners who are not Board certified, SFHP verifies the highest level of education.
- H. For those individuals who have not completed an AMA accredited residency program, verification of graduation from medical school meets this requirement.

4.1.4. Board Certification Status

- A. Verification time limit: 180 calendar days.
- B. Board certification is not required by NCQA; however, SFHP verifies current certification status of practitioners who state that they are board certified.
- C. SFHP documents the expiration date of the Board certification within the credentialing file. If a practitioner has a "Lifetime" certification status and there is no expiration date for certification, SFHP verifies that Board certification is current and documents the date of verification.
- D. SFHP uses any of the following to verify Board certification status:

- American Board of Medical Specialties (ABMS) or its member Boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided.
- AMA Physician Masterfile.
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.

4.1.5. Work History:

- A. Verification time limit: 180 calendar days. SFHP verifies practitioners' work history through the practitioner's application, resume, or CV. If the practitioner has fewer than five (5) years of work history, the time frame starts at the initial licensure date.
- B. If a gap in employment exceeds six (6) months, the practitioner must clarify the gap verbally or in writing. SFHP will document a verbal clarification in the practitioner's credentialing file by noting the name of the individual who provided the clarification, organization, title, email, phone number, and date the clarification was made.
- C. If the gap in employment exceeds one (1) year, the practitioner clarifies the gap in writing.
- D. If a practitioner has a gap in employment that exceeds one (1) year, PAC may request that practitioner be subject to proctoring; practitioner must submit written, and signed, confirmation that proctoring has occurred.
- E. PAC may request employment verification from primary sources if employment gap is longer than one (1) year.

4.1.6. Malpractice History:

- A. Verification time limit: 180 calendar days.
- B. SFHP obtains written confirmation of the past five (5) years of history of malpractice settlements from the malpractice carrier or by querying the NPDB (National Practitioner Data Bank).

4.2. Sanction Information

SFHP verifies that the following sanction information for credentialing:

4.2.1. State sanctions, restrictions on licensure or limitations on scope of practice:

- A. Verification time limit: 180 calendar days.
- B. SFHP queries the Medical Board of California, the NPDB, and Medi-Cal Suspended and Ineligible Provider List (available from www.medi-cal.ca.gov and maintained by update on SFHP's servers), to obtain complete information on malpractice history, actions taken to limit, suspend or abolish hospital privileges, State Board actions, and sanctions or limitations on licensure.

4.2.2. Medicare and Medicaid Sanctions:

- A. Verification time limit: 180 calendar days.
- B. SFHP queries the List of Excluded Individuals/Entities (LEIE) maintained by the US Office of the Inspector General in the Department of Health and Human Services to confirm that the applicant has not been excluded from participation in Medicare and Medi-Cal. SFHP updates this list every three (3) months to confirm no new additions to the LEIE are participating or credentialed providers of SFHP.

4.3. Credentialing Application

SFHP uses the California Participating Practitioner Application published by the Industry Collaboration Effort (ICE).

Upon receipt of the application, the credentialing staff verifies that the application is signed and dated. Applications that are missing signature and date are returned to the practitioner. All applications must have a wet signature; electronic signatures are not accepted by SFHP. The application should be typed or legibly printed in black or blue ink. The following documents must be submitted along with the application:

- A. California Participating Practitioner Application Addendum A
- B. California Participating Practitioner Application Addendum B - Professional Liability Action Explanation
- C. State Medical/Professional License(s)
- D. DEA/CDS/NPF Certificate
- E. Face Sheet of Professional Liability Policy or certification
- F. Curriculum Vitae (Resume)
- G. Educational Commission for Foreign Medical Graduates (ECFMG - if applicable)
- H. Board Certification (if applicable)
- I. Specialty Board Certification (if applicable)
- J. Explanation of use of Hospitalist or Documentation of Hospital Privileges

NCQA does not require receipt of the attestation before beginning the credentialing verification process and queries required for other elements. However, the attestation must be received (signed and dated) before the credentialing decision is made.

If the signed attestation exceeds the time limit before the credentialing decision, the practitioner must attest that the information on the application remains correct and complete, but is not required to complete another application. SFHP will send a copy of the completed application with the new attestation form when it requests the practitioner to update the attestation.

4.3.1. SFHP's credentialing application includes at minimum the following responses:

- A. Inability to perform the essential functions of the position.

- When this statement is answered “yes” in the attestation, practitioners must submit in writing the reason for their inability to perform the essential functions of the position.
- The CMO will review the credentialing file, conduct further investigation, and will submit recommendations for next steps to the PAC.
- The PAC makes the final decision in the credentialing process.
- B. Ability to practice impaired by chemical dependency or substance abuse.
 - When this statement is answered “yes” in the attestation, the CMO will review the credentialing file, conduct further investigation, and will submit recommendations for next steps to the PAC.
 - The PAC makes the final decision in the credentialing process.
- C. History of loss of license.
 - At initial credentialing, practitioners attest to any loss of license since their initial licensure. At recredentialing, practitioners attest to any loss of licensure since the last credentialing cycle.
 - When this statement is answered “yes” in the attestation, the CMO will review the credentialing file, conduct further investigation, and will submit recommendations for next steps to the PAC.
 - The PAC makes the final decision in the credentialing process.
- D. History of felony convictions.
 - At initial credentialing, practitioners attest to any felony convictions since their initial licensure. At recredentialing, practitioners attest to any felony convictions since the last credentialing cycle.
 - When this statement is answered “yes” in the attestation, the CMO will review the credentialing file, conduct further investigation, and will submit recommendations for next steps to the PAC.
 - The PAC makes the final decision in the credentialing process.
- E. Limitation of privileges or disciplinary actions.
 - At initial credentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since their initial licensure. At recredentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since the last credentialing cycle.
 - When this statement is answered “yes” in the attestation, the CMO will review the credentialing file, conduct further investigation, and will submit recommendations for next steps to the PAC.
 - The PAC makes the final decision in the credentialing process.
- F. Current malpractice coverage.
 - Practitioner must submit a copy of the most current certificate of insurance and malpractice liability coverage. A group policy for staff practitioners is acceptable.
 - For practitioners with federal tort coverage, the file includes a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage.
 - Coverage must be effective at the time of the credentialing decision.

5. Practitioner Office Site Visit

An on-site office visit report is required of new PCPs and OB/GYN offices. Office visits are performed by the nurse reviewer prior to credentialing committee approval. The visit includes a review of the medical record practice-keeping system and a structured physical site(s) review. The site visit form used will be the standard site visit form provided by the Industry Collaboration Effort (ICE). Deficiencies will be reported to the Provider Network Operations (PNO) Department for recommendations and follow-up. The completed practitioner site(s) visit evaluation form, including documentation of any recommendations, is shared with the practitioner; results of the site review are noted in the Credentialing Check List. The results of the audit including the PNO Department recommendations and follow up will be incorporated into credentialing decisions.

Ongoing monitoring of practitioner sites is also performed between recredentialing cycles for the following member grievances:

- A. Physical accessibility-ease of entry into building & practice sites, along with accessibility of space w/in the building or practice site and accessibility of space within the building or practice site, to accommodate physically disabled members.
- B. Physical appearance-addressing issues involving cleanliness, lighting & safety for members.
- C. Adequacy of waiting & exam room space-is the size & seating in waiting room adequate for the number of patient visits per hour for the number of practitioners in office.
- D. Availability of Appointments
- E. Adequacy of medical/treatment record keeping-are all member records/medical information kept in an orderly fashion, secure, confidential and documentation practices.

When three (3) complaints have been received in a rolling 12 month time frame, related to the items listed above, a site visit request will be sent to PNO Department, and a visit will be performed within 60 days. Regional Services will use the site visit form provided by the ICE (Industry for Collaboration) Provider office quality site visit tool & Corrective action plan (CAP), when conducting the site visit.

6. Ongoing Monitoring and Interventions

SFHP continuously monitors practitioners between recredentialing cycles and takes appropriate action when it identifies occurrences of poor quality of member care and service. Practitioners with an **expired clinical license to practice** are terminated or suspended.

In addition, SFHP monitors the Medical Board of California Action Alerts, US Department of Health and Human Services' List of Excluded Individuals/Entities, Medi-Cal Suspended and Ineligible Provider List, member complaints and grievances, and potential quality issues.

On a weekly basis, SFHP reviews **Medical Board of California Alerts** against providers in the network. Search findings are noted in the *MBOC Hot Sheet Log*. Practitioners with an open case with the Medical

Board are brought to the attention of the PAC. Based on the severity of the case, the PAC may decide to close the practitioner's panel or reassign memmmbers while the Medical Board makes a final determination; or PAC may decide to terminate the practitioner. Once the Medical Board has made a decision on the case, the PAC may revisit its decision, uphold it or adopts the decision made by the Board.

On a monthly basis, SFHP reviews the **US Department of Health and Human Services' List of Excluded Individuals/Entities** against providers in the network. Search findings are noted in the *OIG Hot Sheet Log*. With the approval of the Compliance Officer and the CMO, practitioners with sanctions by the Office of the Inspector General are terminated from the SFHP network; these practitioners are brought to the attention of the PAC.

On a monthly basis, SFHP reviews the **Medi-Cal Suspended and Ineligible Provider List** against providers in the network. Search findings are noted in the *Medi-Cal No Pay Hot Sheet Log*. With the approval of the Compliance Officer and the CMO, practitioners on the list are terminated from the SFHP network; these practitioners are brought up to the attention of the PAC.

Every six (6) months, SFHP monitors **members' complaints and grievances** and **potential quality issues (PQI)** for trends on dissatisfaction with the quality of the care received from practitioners. Please refer to *QI-6 Member Grievances and Appeals*, *QI-12 Peer Review Process*, and *UM-56 Potential Quality Issues* for details on how these cases are handled.

7. Notification to Authorities and Practitioner Appeal Rights

SFHP uses objective evidence and patient-care considerations when deciding the course of action for practitioners who do not meet quality standards. SFHP notify authorities as appropriate of practitioners' terminations or suspension. SFHP's policy and procedure CR-03 Notification to Authorities of Practitioner Disciplinary Actions describes the process for handling quality of care issues and related decisions.

8. Assessment of Organizational Providers

Please refer to Policy and Procedure CR-02 Credentialing of Organizational Providers for an explanation of the assessment process.

9. Delegation of Credentialing Functions

SFHP conducts a pre-delegation evaluation prior to establishing a credentialing delegation agreement with a medical group, health plan, or vendor. SFHP delegates credentialing to the following organizations:

Type	Organization Name	SFHP Contract Date	NCQA / TJC Accreditation Date
Health Plan	Kaiser Foundation Health Plan	05/01/2012	06/08/2015
Health Plan	Beacon Health Strategies	01/01/2015	11/30/2015
Medical Group	Brown and Toland Physicians	09/01/2010	N/A
IPA	Chinese Community Health Care Association	06/21/1996	N/A
IPA	Hill Physicians Medical Group	06/01/2010	N/A
MSO	North East Medical Services	04/01/2012	N/A
Hospital	UCSF	10/01/2002	08/04/2015
Hospital / Clinics	San Francisco Health Network (SFHN)	01/07/2003	07/18/2014
Vendor	Teladoc	10/27/2016	04/29/2015

Where SFHP delegates credentialing and recredentialing to a medical group, health plan, or vendor, SFHP assures through regular audits and reports that the delegated party and its sub-delegates perform these functions in compliance with industry-approved requirements. Credentialing Verification Organizations (CVOs) Health Plans, and Hospitals that hold current NCQA or The Joint Commission (TJC) accreditation are deemed in compliance with standards.

Please refer to SFHP policy and procedure *DO-06 Delegation of Credentialing and Provider Training* for details regarding delegation of credentialing functions.

Please refer to each delegate's Responsibilities and Reporting Requirements Grid for scope of delegated functions.

10. Credentialing of Non-Physician Medical Practitioners (NPMP)

If a NPMP accepts member assignment as a Primary Care Provider (PCP), SFHP and its delegated medical groups follows the full credentialing procedures as outlined in this document. NPMP applicants must provide name and specialty of the supervising physician.

If the NPMP does not accept member assignment as a PCP, SFHP and its delegated medical groups follow only the credentialing requirements listed below:

- Verification time limit: must be in effect at the time of the decision.
- NPMPs hold a current license or certificate from the State of California.
- Nurse Practitioner:
 - California registered Nursing License, Nurse Practitioner number, and BRN Nurse Practitioner Furnishing number.
 - If the nurse practitioner prescribes controlled substances, a DEA number is required and verified by the same method as for physicians.
- Certified Nurse Midwife:
 - California Registered Nursing License, Nurse Midwife certification, and BRN Furnishing number.
 - If the nurse midwife prescribes controlled substances, a DEA number is required and verified by the same method as for physicians.
- Clinical Nurse Specialist:
 - California Registered Nursing License and BRN Clinical Nurse Specialist certification number.
- Physician Assistant:
 - California Physician Assistant license and DEA number.
- SFHP confirms the NPMP is associated with a provider in the SFHP network that has hospital privileges.
- Applicants must provide the name and specialty of their supervising physician.

11. Definitions

- **Independent Physician Association (IPA):** an association of independent physicians, or other organization that contracts with independent physicians, and provides services to managed care organizations on a negotiated per capita rate, flat retainer fee, or negotiated fee-for-service basis.
- **Practitioner:** a licensed or certified professional who provides medical or behavioral healthcare services (source NCQA).
- **Provider:** an institution or organization that provides services, such as a hospital, residential treatment center, home health agency, or rehabilitation facility (source NCQA).
- **Medical Group:** provision of health care services by a group of at least three (3) licensed physicians engaged in a formally organized and legally recognized entity sharing equipment, facilities, common records and personnel involved in both patient care and business management."
- **Management Services Organization (MSO):** an entity formed by, for example, a hospital, a group of physicians or an independent entity, to provide business-related services such as marketing and data collection to a grouping of providers.

Appendix 1 – Physician Advisory/Peer Review/Credentialing Committee (PAC) Membership

NAME	SPECIALTY
James Glauber, MD, MPH - Chair	Pediatrics
Joseph Woo, MD	Emergency Medicine
Daniel Chan, MD	Internal Medicine, Cardiology
Jeffrey Critchfield, MD	Internal Medicine, Rheumatology
Todd May, MD	Family Medicine
Jaime Ruiz, MD	Pediatrics
Kenneth Tai, MD	Internal Medicine, Pediatrics
Albert Yu, MD	Family Medicine
Dennis McIntyre, MD	Pediatrics
Luke Day, MD	Internal Medicine, Gastroenterology
Ellen Chen, MD	Family Medicine
Ana Valdes, MD	Family Medicine

Appendix 2 – Conflict of Interest Agreement

CONFLICT OF INTEREST AGREEMENT FOR MEMBERS OF SAN FRANCISCO HEALTH PLAN QUALITY IMPROVEMENT COMMITTEE

The San Francisco Health Authority and the San Francisco Community Health Authority (hereinafter “Plan” or “SFHP”) are committed to upholding the highest ethical standards. Employees, contractors or committee representatives involved in Plan activities must disclose potential conflict of interest in accordance with all government codes, state practice Acts and Plan policy and procedures. Any member of the Plan’s Quality Improvement Committee (such Committee along with any subcommittees collectively, “QIC”) with a conflict of interest or any involvement which impairs objectivity must also refrain from casting a vote on any related issue and shall absent him/herself from any proceedings in which such issues are raised for consideration.

In accordance with all applicable rules and regulations including but not limited to the Fair Political Practice Act, participation and influence in decision making activities and committees that result in any of the following are expressly prohibited:

- a personal or professional conflict
- a violation of a fiduciary relationship or duty
- a financial gain for the party in question

Any violation of applicable statutes, regulations, policies, and/or procedures designed to prevent conflicts of interest will constitute grounds for immediate disciplinary action, up to and including discharge from QIC. After any expiration or termination of employment or contractual relationship, all QIC members remain obligated to comply with the requirements referenced in this Agreement. Failure to comply with these requirements and all applicable statutes, regulations, policies and procedures may result in potential legal liability.

I have read the above agreement and agree to comply with all its terms.

Name: _____

Signature: _____

Title: _____ Date: _____

Appendix 3 – Confidentiality Agreement

CONFIDENTIALITY AGREEMENT FOR MEMBERS OF SAN FRANCISCO HEALTH PLAN QUALITY IMPROVEMENT COMMITTEE

The San Francisco Health Authority and the San Francisco Community Health Authority (hereinafter “Plan” or “SFHP”) have a legal and ethical responsibility to safeguard the privacy of all members and providers, and to protect the confidentiality of their health and other information. Additionally, the Plan has both legal and ethical responsibilities to assure the confidentiality of its managed care rates, human resources, payroll, fiscal, research, computer systems, and management information (collectively, along with member and provider information referenced above, the “Confidential Information”).

In the course of my participation on the Plan’s Quality Improvement Committee (such Committee along with any subcommittees collectively, “QIC”), I understand that I may come into the possession of Confidential Information. As a condition of my participation on QIC, I agree that:

1. I will not intentionally or unintentionally disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. Should I have any doubts as to whether information is Confidential Information or not, I seek clarification from the Chair of QIC and/or the Chief Executive Officer.
2. I will not access or view any Confidential Information other than that required for my duties on QIC.
3. I agree to abide by all laws, rules and regulations protecting the confidentiality of the Confidential Information including but not limited to the requirements set forth in the Health Insurance Portability and Accountability Act of 1996, as amended and attendant privacy and security regulations.
4. Upon termination of my participation on QIC, I will immediately destroy or return any documents or other media containing Confidential Information to SFHP.
5. I agree that my obligations under this Agreement will continue after the termination of my participation on QIC.
6. I understand that violation of this Agreement may result in termination of my participation on QIC, as well as potential legal liability.

I have read the above agreement and agree to comply with all its terms.

Signature _____

Print name _____

Date _____

Appendix 4 – Credentialing Check List

NAME		DEGREE	
SPECIALTY		<input type="checkbox"/> PCP	<input type="checkbox"/> SPC

CREDENTIALING APPLICATION	RECEIVED DATE	VERIFIED BY
Identification information		
Practice Information		
Practice Description (Allied Health Prof.)		
Licensure and Certifications		
Provider NPI		
Hospital Privileges Letter		
HIV Specialization		
Attestation Signed		
Information Release Form Signed		
Addendum A Practitioner's Right Signed		
Addendum B Liability Action Signed		
Supervising Physician Letter (if RN, NP, FNP, PA)		
Language Self-assessment (if applicable)		
New Provider Orientation Attestation Signed		
Copy of CA Clinical License		
Copy of DEA		
Copy of CV		
Copy of Diploma		
Copy of Board Certification		
Liability Insurance		

CREDENTIALING VERIFICATION	VERIFICATION DATE	VERIFIED BY
Education		
Work History		
CA Clinical License		
DEA		
Board Certification		
NPDB		
OIG		
Medi-Cal No Pay		
Hospital Privileges		

QUALITY MONITORING:	Practice Location:	
	Completed FSR:	

CREDENTIALING VERIFICATION	Name:		Date
	Title:		

REVIEWED AND APPROVED BY	See meeting minutes	
	Peer Review, Advisory, and Credentialing Committee	Meeting Date

APPROVED BY	James Glauber, MD, MPH	Date
	Chairman, Credentialing Committee	