2. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

1. Credentialing Policies

APPLIES TO:

A. This policy applies to all IEHP Covered Providers contracted under IEHP's Direct Network.

POLICY:

A. IEHP has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent Practitioners to provide care to its Members.[1]

B. IEHP notifies Practitioners about their right to review information submitted to support their credentialing application.[2]

C. IEHP has a process that describes how primary source information is received, dated and stored; how modified information is tracked and dated from its initial verification; the staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate; the security controls in place to protect the information from unauthorized modification; and how the organization audits the processes and procedures.[3]

D. IEHP has an annual documented process on monitoring its compliance with its CR (Credentialing) controls.[4]

E. IEHP's documented process for pre-screening credentialing applications from Behavioral Health, Mental Health, and/or Substance Use Disorder Providers.

PURPOSE:

A. IEHP promulgates credentialing and recredentialing decision guidelines for Practitioners directly contracted with IEHP and Practitioners credentialed and contracted by IEHP, to perform these activities.

B. IEHP adheres to all procedural and reporting requirements under state and federal laws and regulations regarding the credentialing and recredentialing process, including the confidentiality of Practitioner information obtained during the credentialing process.

C. IEHP must demonstrate a rigorous process to select and evaluate Practitioners.

D. IEHP must offer to contract with at least one each of the following mandatory Provider types in each of our services counties, where available: Certified Nurse Midwife (CNM) and Licensed Midwife (LM).

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[1] National Committee for Quality Assurance (NCQA), 2024 Health Plan Standards and Guidelines, CR 1, Element A, Factors 1-11
[2] NCQA, 2024 HP Standards and Guidelines, CR 1, Element B, Factors 1-3
[3] NCQA, 2024 HP Standards and Guidelines, CR 1, Element C, Factors 1-5
[4] NCQA, 2024 HP Standards and Guidelines, CR 1, Element D, Factors 1-3

2. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

1. Credentialing Policies

DEFINITION:

A. Attestation: A signed statement by a Practitioner confirming the validity, correctness, and completeness of a credentialing application.[5]

B. Automated Verification: Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.

C. Board-certified: A Practitioner has satisfied the requirements/standards of a nationally recognized specialty board and received the board's specialist certification.[6]

D. Board-certified consultant: A Practitioner external to an organization who holds certification from an American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA) or other specialty board and acts in an advisory capacity to the organization.[7]

E. Clean files: Credentialing files that meet the organization's criteria for participation and are not required to be sent to the credentialing committee for review.[8]

F. Clinical Privileges: A Practitioner is authorized by a health care facility to provide defined patient care services at the facility, based on the Practitioner's license, education, training, experience, competence, and ability.[9]

G. National Practitioner Data Bank (NPDB): A federally mandated agency that is the repository of information about settled malpractice suits and adverse acts, sanctions, or restrictions against the practice privileges of a Physician.[10]

H. Peer review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (e.g., evaluation of a Physician's credentials and practice by another Physician).[11,12]

I. Primary source: The entity that originally conferred or issued a credential.[13]

J. Primary source verification: Verification of credentialing information directly from the entity (e.g., state licensing board) that conferred or issues the original credential.[14]

K. Qualitative analysis: An examination of the underlying reason for or cause of results, including deficiencies or processes that may present barriers to improvement or cause failure

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[5] NCQA, 2024 Health Plan Standards and Guidelines, Glossary
[6] NCQA, 2024 Health Plan Standards and Guidelines, Glossary
[7] Ibid.
[8] Ibid.
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Business and Professions Code § 805
[13] NCQA, 2024 Health Plan Standards and Guidelines, Glossary
[14] Ibid.

to reach a stated goal. Qualitative analysis must draw conclusions about why the results are what they are and involves staff responsible for executing a program or process.[15]

L. Quantitative analysis: A comparison of numeric results against a standard or benchmark, trended over time. Quantitative analysis must draw conclusions about what results mean. Unless specified, tests of statistical significance are not required, but may be useful when analyzing trends.[16]

M. Verification Time Limit (VTL): National Committee for Quality Assurance (NCQA) counts back from the decision date to the verification date to assess timeliness of verification.

N. Verbal Verification - Requires a dated, signed document naming the person at the primary source who verified the information, his/her title, the date, and time of verification and include what was verified verbally.

O. Written Verification - Requires a letter or documented review of cumulative reports. IEHP must use the latest cumulative report, as well as periodic updates released by the primary source. The date on which the report was queried, and the volume used must be noted.

PROCEDURES:

A. IEHP has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent Practitioners to provide care to its Members that includes Practitioner Credentialing Guidelines that specify:[17]

   1. The types of Practitioners it credentials and recredentials. Credentialing requirements apply to:[18]

      a. Practitioners who are licensed, certified, or registered by the State of California to practice independently (without direction or supervision).

      b. Practitioners who have an independent relationship with the organization. An independent relationship exists when the organization directs its Members to see a specific Practitioner or group of Practitioners, including all Practitioners whom Member can select as PCPs.

      c. Practitioners who provide care to Members under the organization's medical benefits.

      d. The criteria listed above apply to Practitioners in the following settings:

         1) Individual or group practices;

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[15] NCQA, 2024 Health Plan Standards and Guidelines, Glossary
[16] NCQA, 2024 Health Plan Standards and Guidelines, Glossary
[17] 42 CFR § 422.204
[18] NCQA, 2024 HP Standards and Guidelines, CR 1, Element A, Factor 1

2) Facilities; and
3) Telemedicine.

e. IEHP is required to contract with and credential all Practitioners defined as PCPs, Specialists, Non-Physician Practitioners, and Physician Admitters, including employed Physicians participating on the Provider Panel and published in external directories who provide care to Members. At minimum, they include:

1) Doctor of Medicine (M.D.)
2) Doctor of Osteopathic Medicine (D.O.)
3) Doctor of Podiatric Medicine (D.P.M.)
4) Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.), who provide medical services only
5) Occupational Therapists (O.T.)
6) Physical Therapy (P.T.)
7) Physician Assistants (P.A.) or Physician Assistants Certified (P.A.-C)
8) Certified Nurse Midwives (C.N.M.)
9) Nurse Practitioners (N.P.)
10) Speech Pathologists (S.P.)
11) Audiologists (Au.)
12) Registered Dieticians (R.D.) and Nutritionists
13) Psychiatrists (M.D.)
14) Licensed Marriage and Family Therapists (L.M.F.T.)
15) Licensed Clinical Social Workers (L.C.S.W.)
16) Psychologists (Ph.D., Psy.D.)
17) Doctor of Chiropractic (D.C.)
18) Licensed Acupuncturists (L.Ac.)
19) Optometrists (O.D.)
20) Licensed Midwife (L.M.)
21) Other Behavioral Healthcare Practitioners
    - Addiction Medicine Specialists
    - Master Level Clinical Nurses

- License Professional Clinical Counselors (L.P.C.C.).[19]

f. Practitioners who do not need to be Credentialed:

1) Practitioners who practice exclusively in an inpatient setting and provide care for organization Members only because Members are directed to the Hospital or another inpatient setting;

2) Practitioners who practice exclusively in free-standing facilities (i.e. Free-standing Surgery Centers) and provide care for organization Members only because Members are directed to the facility;

3) Pharmacists who work for a pharmacy benefit management (PBM) organization to which the organization delegates utilization management (UM) functions;

4) Covering Practitioners (e.g., locum tenens), who do not have an independent relationship with the organization are outside NCQA's scope of credentialing;

5) Practitioners who do not provide care for Members in a treatment setting (e.g., board-certified consultants);

6) Rental network practitioners who provide out-of-area care only, and Members are not required or given an incentive to seek care from them; and

7) Practitioners that are Hospital-based and do not see Members on a referral basis.

2. Listed below are the sources used by IEHP to verify credentialing information. All verification sources are included in policy to ensure compliance.[20]

a. All Practitioners must be licensed by the appropriate state licensing agency in the state where they practice. The following license verifications must be obtained by the licensing board or their designated licensing and enforcement systems.

1) The following licensures may be verified through BreEZe Online services or directly with the licensing board via phone or mail:

- Medical Board of California (M.D.)
- Osteopathic Medical Board of California (D.O.)
- Board of Podiatric Medicine (D.P.M.)
- Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C., L.P.C.C.)
- Board of Psychology (Ph.D., Psy.D.)
- Dental Board of California (D.D.S., D.M.D.)

[19] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Chapter 6 § 60.3
[20] NCQA, 2024 HP Standards and Guidelines, CR 1, Element A, Factor 2

- California Board of Occupational Therapy (O.T.)
- California State Board of Optometry (O.D.)
- Physical Therapy Board of California (P.T.)
- Physician Assistant Committee (P.A., P.A.-C)
- California Board of Registered Nursing (C.N.M., N.P.)
- California Board of Chiropractic Examiners (D.C.)
- Speech-Language Pathology & Audiology Board (S.P., Au)
- Acupuncture Board (L.Ac.)

2) Arizona practitioner licensures may be verified through the Arizona Medical Board (M.D., D.O., P.A.).

b. Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). All Practitioners who are qualified to write prescriptions, except non-prescribing Practitioners, must have a valid and current DEA certificate verified through one (1) of the following sources:

1) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision.

2) American Medical Association (AMA) Physician Master File

3) American Osteopathic Association Official Osteopathic Physician Profile Report or Physician Master File

4) IEHP may credential a Practitioner whose DEA certificate is pending or pending a DEA with a California address, by obtaining written documentation that the Practitioner with a valid DEA certificate will write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate. The prescribing Practitioner’s name, DEA Number, and NPI number will be documented within the Practitioner’s file; or

5) If a Practitioner does not have a DEA or CDS certificate, IEHP must have a documented process to require an explanation why the Practitioner does not prescribe medications and to provide arrangements for the Practitioner’s patients who need prescriptions requiring DEA certification.

6) If Practitioners practicing in Arizona, IEHP may credential a Practitioner whose DEA certificate is pending or pending a DEA with an Arizona address, by obtaining written documentation that the Practitioner with a valid DEA certificate will write all prescriptions requiring a DEA number for the

prescribing Practitioner until the Practitioner has a valid DEA certificate. The prescribing Practitioner's name, DEA Number, and NPI number will be documented within the Practitioner's file.

c. Education and Training (VTL: Prior to the Credentialing Decision) IEHP may use any of the following to verify education and training:

1) The primary source from the medical school; or

2) The state licensing agency, or specialty board or registry, if the state agency and specialty board, respectively, perform primary source verification. IEHP:

- Obtains written confirmation of primary source verification from the primary source, at least annually; or
- Provides a printed, dated screenshot of the state licensing agency or specialty board or registry website displaying the statement that it performs primary source verification of Practitioner education and training information; or
- Provides evidence of a state statute requiring the licensing agency, specialty board or registry to obtain verification of education and training directly from the institution; or
- National Student Clearinghouse may be considered an agent of the medical or professional school if the school has a contract with the Clearinghouse to provide verification services.
    - IEHP must provide documentation that the specific school has a contract with the Clearinghouse, to ensure compliance with NCQA.

3) Sealed transcripts, if the organization provides evidence that it inspected the contents of the envelope and confirmed that Practitioner completed (graduated from) the appropriate training program; or

4) Below are acceptable sources for Physicians (M.D., D.O.) to verify graduation from Medical School:

- American Medical Association (AMA) Physician Master File;
- American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File; and
- Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

Below are acceptable sources for Physicians (M.D., D.O.) to verify completion of residency training:

- Primary source from the institution where the postgraduate medical training was completed;
- AMA Physician Master File;
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File; and
- Federation Credentials Verification Service (FCVS) for closed residency programs.
    - o NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.

5) Below are the acceptable sources for Licensed Professional Clinical Counselors (L.P.C.C.'s) to verify training in Couples and Families:
    - Licensed Clinical Counselors (LPCCs) the additional requirements to Assess or Treat Couples and Families and the requirement for 150 hours of clinical experience in a Hospital or community mental health settings were eliminated; therefore, are no longer required by IEHP.[21]

6) Below is the acceptable source for Nurse Practitioners (NPs) with a Behavioral Health (BH) designation, to verify training in Psych/Mental Health.
    - The qualification must be recognized and verified through the BreEZe Online services website or directly with the licensing board via phone or mail; or
    - Psychiatric Mental Health Nurse Practitioner certification issued by American Nurses Credentialing Center (ANCC)

7) Below is the acceptable source for Registered Dietician (R.D.s):
    - Commission on Dietetic Registration

d. Board Certification (VTL: 180 calendar days prior to Credentialing decision date). Below are the acceptable sources to verify board certification:

1) For all Practitioner types
    - The primary source (appropriate specialty board); or
    - The state licensing agency if the primary source verifies board certification.

[21] Assembly Bill 462

2) For Physicians (M.D., D.O.)

- American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS Display Agency, where a dated certificate of primary-source authenticity has been provided.
    - The ABMS "Is your Doctor Board Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.
- AMA Physician Master File.
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
- Boards in the United States that are not members of the ABMS or AOA if the organization documents within its policies and procedures which specialties it accepts and obtains annual written confirmation from the boards that the board performs primary source verification of completion of education and training.

3) For other health care professionals

- Registry that performs primary source verification of board that the registry performs primary source verification of board certification status.

4) For Podiatrists (D.P.M.)

- American Board of Foot and Ankle Surgery (formerly The American Board of Podiatric Surgery).
- The American Board of Podiatric Medicine.
- American Board of Multiple Specialties in Podiatry.

5) For Nurse Practitioners (N.P.)

- American Association of Nurse Practitioners (AANP).
- American Nurses Credentialing Center (ANCC).
- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties (NCC).
- Pediatric Nursing Certification Board (PNCB).
- American Association of Critical-Care Nurses (AACN).

6) For Physician Assistants (P.A.-C).

- National Commission of Certification of P.A.'s (NCCPA).

7) For Certified Nurse Midwives (C.N.M.).
   - American Midwifery Certification Board (AMCB).

8) For Psychologists (Ph.D., Psy.D.).
   - American Board of Professional Psychology (ABPP).

e. Work history (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date) IEHP must obtain a minimum of the most recent five (5) years of work history as a health professional through the application, Curriculum Vitae (CV) or work history summary/attachment, providing it has adequate information.

f. Malpractice Claim History. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the Practitioner. (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). IEHP will obtain confirmation of the past seven (7) years of malpractice settlements through one (1) of the following sources:

1) Malpractice Insurance Carrier;

2) National Practitioner Data Bank Query; or

3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within one hundred-eighty (180) calendar days of the initial credentialing decision. Evidence must be documented in the file or on checklist.

g. Current Malpractice Insurance Coverage. IEHP requires that a copy of the insurance face sheet or Certificate of Insurance (COI) or written verification from the insurance carrier directly, be obtained in conjunction of collecting information on the application. (VTL: Must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee date and remain valid and current throughout the Practitioner's participation with IEHP).

1) For Practitioners with federal tort coverage, (e.g. Health Resources & Services Administration (HRSA)), the Practitioner must submit:
   - A copy of the face sheet or a federal tort letter as an addendum to the application. The face sheet or federal tort letter must include the:
     - o Insurance effective and expiration dates (future effective dates are acceptable)
   - A roster that lists the practitioners covered under the federal tort coverage.

h. Hospital Admitting Privileges: IEHP must verify that Practitioners have clinical privileges in good standing. Practitioner must indicate their current Hospital affiliation or admitting privileges at a participating Hospital. Verification that all

clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be confirmed with the Hospital, in writing, via approved website or verbally.

1) If a published Hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the Practitioner is in "good standing."

2) If the Practitioner does not have clinical privileges, IEHP must have a written statement delineating the inpatient coverage arrangement documented in the Providers file. See Policy 5B, "Hospital Privileges".

3) Allied Health Professionals (Non-physicians i.e. Chiropractors, Optometrists) will not have Hospital privileges and documentation in the file is not required for these types of Practitioners.

4) Advanced Practice Practitioners (Physician Assistants (PA), Nurse Practitioners (NP), Certified Nurse Midwives (CNM)) may not have Hospital privileges. However, if they provide IEHP their Hospital privileges, IEHP will be responsible for verifying if those privileges are active and ensure they are in good standing.

5) Specialists (MDs, DOs and DPMs) may not have Hospital privileges. Documentation must be noted in the file as to the reason for not having privileges (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).

i. State Sanctions and Restrictions on Licensure and Limitation on Scope of Practice. State sanctions, restrictions on licensure or limitations on scope of practice (VTL: 180 calendar days prior to Credentialing decision).

1) Verification sources for sanctions or limitations on licensure include:

- Chiropractors: State Board of Chiropractic Examiners, Chiropractic Information Network/Board Action Databank (CIN-BAD, or NPDB.
- Oral Surgeons: State Board of Dental Examiners, or State Medical Board, NPDB.
- Physicians: Appropriate state board agencies, Federation of State Medical Boards (FSMB), NPDB.
- Podiatrists: State Board of Podiatric Examiners, Federation of Podiatric Medical Boards, NPDB.
- Non-Physician Healthcare Professionals: State licensure or certification board, appropriate state agency, NPDB.

- For practitioners screened using the Continuous Query (formerly Proactive Disclosure Service (PDS))
  - o Evidence of current enrollment must be provided.
  - o Report must be reviewed within 180 calendar days of the initial credentialing decision.
  - o Evidence of review must be documented in the file or on checklist.

j. Medicare/Medicaid Sanctions. Verification Sources for Medicare/Medicaid Sanctions:

1) OIG must be the one (1) of the verification sources for Medicare sanctions, to ensure compliance with CMS.
2) The Medi-Cal Suspended and Ineligible list must be one (1) of the verification source for Medicaid sanctions, to ensure compliance with DHCS.
3) NPDB
4) FSMB
5) Federal Employees Health Benefits Program (FEHB) Program Department Record, published by the Office of Personnel Management, OIG.
6) List of Excluded Individuals and Entities (maintained by OIG).
7) Medicare Exclusions Database.
8) State Medicaid Agency or intermediary and the Medicare intermediary.
9) For practitioners screened using the Continuous Query (formerly Proactive Disclosure Service (PDS)).

k. National Provider Identifier (NPI) Number: Practitioners must hold and maintain a valid and active individual National Provider Identification Number (NPI) that can be verified through the NPPES website.

1) Group NPI Numbers may be requested by IEHP, in addition to the mandatory individual NPI number.

l. Medi-Cal Enrollment. IEHP uses the California Health & Human Services Agency's portal to confirm the Providers enrollment status with the Medi-Cal Program through DHCS, prior to the Provider beginning the credentialing process.

3. IEHP verifies that the following are within the prescribed time limits, for all credentialing applications, before Practitioners can provide care to Members. IEHP does not allow provisional credentialing. Policies must define the criteria required to reach a credentialing decision and must be designed to assess the Practitioner's ability to deliver care. Practitioners who do not meet the criterion set forth in this policy are subject for

review by the Credentialing Subcommittee and/or Peer Review Subcommittee. This criterion is used to determine which Practitioners may participate in its network, which may include, but are not limited to:[22]

a. Verification of Credentials

1) A current and valid, unencumbered license to practice medicine in the state they practice (i.e. California or Arizona), at the time of Credentialing decision.

2) Current and valid DEA registered in the state the practice (i.e. California and/or Arizona), applies to Practitioners who are required to write prescriptions.

- If the Practitioner designates another Practitioner to write all prescriptions on their behalf, while their DEA is still pending, the Practitioner must provide the following information for the designated Physician to ensure compliance with NCQA:
  - Practitioner Name
  - NPI (IEHP requirement)
    - Used as a unique identifier for the prescribing practitioner
  - DEA copy (IEHP requirement)
    - Used to validate that the DEA is current, active and registered in California.

3) Education and Training. Medical Doctors (M.D.) and Doctor of Osteopathic (D.O.) must meet the education and training requirements set forth by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) and additional criterion set by IEHP and noted below, if applicable. All IEHP specific specialty requirements are subject for review by the IEHP Chief Medical Officer (CMO) or an IEHP Medical Director as designated by the CMO. Further review may be completed by the Peer Review Subcommittee.

IEHP will consider all relevant information including practice site demographics, Provider training, experience, and practice capacity issues before granting any such change.

- If the Practitioner is not board certified in the subspecialty in which he/she is applying, there must be evidence of verification of residency and training in the subspecialty (e.g. Fellowship in Cardiology, Rheumatology, Pediatric Endocrinology, etc.), as relevant to the credentialed specialty, and meet the training requirements as set forth by ABMS or AOA.

[22] NCQA, 2024 HP Standards and Guidelines, CR 1, Element A, Factor 3

- Practitioners who do not meet graduate medical training requirements as set forth by ABMS or AOA for the Provider's requested subspecialty, will be subject to review by the IEHP Credentialing Subcommittee for review. Review may be completed by the IEHP Peer Review Subcommittee.

- IEHP requires Practitioners to meet the internship and residency requirements to be a Pediatric, Internal Medicine, Family Practice, or Public Health and General Preventive Medicine Provider in order to be credentialed as a PCP in IEHP's network.
  - A Practitioner may be grandfathered from the requirements of this policy if:
    - The Practitioner was a participating Physician with IEHP or its Delegate prior to January 1, 2017; and
    - The Practitioner's participation with IEHP or its Delegate did not lapse or terminate for any reason.
      - If the Practitioner's participation lapses or terminates for any reason, then the Practitioner is considered a new Practitioner and is not grandfathered. The Practitioner may not reapply or be reinstated as a PCP.
  - A Practitioner may be exempt from the requirements listed above, to improve primary care access for members residing in the impacted rural regions of IEHPs service areas. The exempted practitioners will be available for members ages 16 and above, if all criteria listed below are met:
    - Successful completion of a one (1) year internship;
    - Practicing at a clinic with a safety net designation that includes, but is not limited to:
      - Federally Qualified Health Clinic (FQHC)
      - Rural Health Clinic (RHC)
      - Indian Tribal Clinic (ITC)
    - Provider is in a rural area, as defined by the U.S. Census Bureau
    - Lack or limited number of practitioners in geographic area
  - Provide primary care services using a team approach of Physicians (MD or DO), and must include at least one (1) Nurse Practitioners (NPs) or Physician Assistants (PAs), in the practice, who is working at

the clinic at least fifty (50%) of the time the clinic operates

IEHP designated specialty requirements:

- **Bariatric Surgery** requirements effective January 1, 2019. Meet the education and training requirements for General Surgery; and one (1) of the following criteria:
    - Completion of an accredited bariatric surgery fellowship.
    - Documentation of didactic training in bariatric surgery (IEHP recommends the American Society for Metabolic and Bariatric Surgery Course). This information will be verified through:
        - Bariatric training certificate and/or supporting letter from supervising bariatric surgeon, which will be verified by Credentialing. Supporting letter will include the minimum criteria:
            - Supervising bariatric surgeon qualifications.
            - Supervising bariatric surgeon relationship with applicant.
            - Duration of relationship of supervising bariatric surgeon with applicant; and
            - Assessment of applicant's competency to perform bariatric surgery by supervising bariatric surgeon.
    - Attestation of bariatric surgery case volume signed by applicant. See "Attachment/Bariatric Surgeon Case Volume Attestation" found on the IEHP website,[23] of case volume from the last three (3) years:
        - Volume of applicant's proctored cases; and
        - Volume of cases where applicant was the primary surgeon.
            - IEHP requires a minimum of 20 cases where applicant was the primary surgeon.[24]
    - Current or past "Regular or Senior Member" of American Society for Metabolic and Bariatric Surgery (ASMBS). Verification of membership will be obtained by the Credentialing Department; or

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[23] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

[24] American Society for Metabolic and Bariatric Surgery, Joint Task Force Recommendations for Credentialing of Bariatric Surgeons, published June 2013, accessed on 07/15/18 at: https://asmbs.org/resources/joint-task-force-recommendations-for-credentialing-of-bariatric-surgeons.

- IEHP recommends applicant actively participates with the MBSAQIP (Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program) or an equivalent regional or national quality improvement program.
  - Supportive documentation of participation with program is to be submitted with Credentialing application and/or request

- **Family Practice 1: Family Practice Providers with Obstetrics (OB) services**, must meet the education and training requirements for Family Practice, set forth by ABMS or AOA and provide the following:
  - Provide a copy of a signed agreement that states Member transfers will take place within the first 28 weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.
    - The OB must be within the same network as the Family Practice Provider and hold admitting privileges to the IEHP contracted Hospital linked with that Plan network.
- **Family Practice 2: Family Practice that includes full OB services and delivery)** must meet the education and training requirements for Family Practice, set forth by ABMS or AOA and provide the following:
  - Have and maintain full delivery privileges at an IEHP contracted Hospital.
  - Provide a written agreement for an available OB back up Provider is required.
  - The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP Hospital linked with the Family Practice Provider; and
  - Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc.).
- **Internal Medicine Providers** may not expand their age range to all ages unless they have board eligibility or board certification in Pediatrics.
- **Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a Primary Care Provider only**, will provide outpatient well woman services only with no Hospital or surgical privileges, must provide the following information for consideration:
  - Twenty-five (25) Continuing Medical Education (CME) units for most

recent three (3) year period, which must be in primary care related areas.

- In lieu of having full Hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed and that the OB will provide prenatal care after twenty-eight (28) weeks gestation including delivery (See Attachment, "Patient Transfer Agreement" found on the IEHP website).[25]
  - The Agreement must include back-up Physician's full delivery privileges at IEHP network Hospital, in the same network as the non-admitting OB Provider.
  - The OB Provider must be credentialed and contracted within the same network.

These OB/GYNs provide outpatient well woman services only with no Hospital or surgical privileges. This exception must be reviewed and approved by IEHP Medical Director or Chief Medical Officer (CMO). Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

- **Pediatric Providers** may not expand their age range to all ages unless they have board eligibility or board certification in Internal Medicine.
- **Specialties not recognized by either board (ABMS or AOA)** are subject to Chief Medical Officer (CMO) or IEHP Medical Director designated by CMO review**.** Further review may be completed by the Credentialing Subcommittee or Peer Review Subcommittee.
- **Urgent Care Providers** must meet the education and training requirements set forth by ABMS or AOA for at least one (1) of the following Specialty boards:
  - American Board of Pediatrics.
  - American Board of Family Practice.
  - American Board of Internal Medicine.
  - American Board of Emergency Medicine.
  - Osteopathic Board of Pediatrics.

[25] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

- Osteopathic Board of Family Physicians.
- Osteopathic Board of Internal Medicine.
- Osteopathic Board of Emergency Medicine; or
- If the Practitioner is board certified or eligible in a specialty and/or subspecialty recognized by the American Board of Medical Specialties or American Osteopathic Association not referenced above, then those Providers are subject to review by the Chief Medical Officer or IEHP Medical Director designated by the CMO. Further review may be completed by the Peer Review Subcommittee. For their review and consideration, the following documents must be submitted:
  - One (1) year of experience in an Urgent Care or Emergency Room setting
  - Provide evidence of 100 CME units in Urgent Care Topics; and
  - Three (3) letters of recommendation from a Physician coworker, clarifying:
    - Relationship with the applicant; and
    - Endorsement for scope of care; and
    - Summary of direct observation with urgent care environment

- **Wound Care Specialists** must be M.D., D.O., D.P.M.'s or N.P.'s who have three (3) or more years of clinical wound care experience or specialize in:
  - Dermatology
  - General Surgery
  - Plastic Surgery
  - Podiatry
  - Vascular Surgery
  - If the Practitioner is board certified or eligible in a specialty and/or subspecialty not referenced above, then those Providers are subject to review by the Chief Medical Officer (CMO) or IEHP Medical Director designated by the CMO. Further review may be completed by the Credentialing and/or Peer Review Subcommittee.

4) Board Certification. IEHP does not require board certification; however, IEHP must verify the certification status of the Practitioners who state that they are board certified, to include that board eligibility requirements are met.

5) Work History. IEHP must obtain a minimum of the most recent five (5) years of

work history as a health professional through the Practitioner's application or Curriculum Vitae (CV). If the Practitioner has fewer than five (5) years of work history, the time frame starts at the initial licensure date.

The application or CV includes the beginning and ending month and year for each position if employment experience, unless the Practitioner has had continuous employment for five (5) years or more with no gap. In such a case, providing the year meets the intent of this factor.

6) Malpractice history. IEHP obtains confirmation of the past seven (7) years of malpractice settlements from the malpractice carrier or queries the National Practitioner Data Bank (NPDB). Appropriate Malpractice History. For Practitioners with a history of malpractice suits or decisions, the following criteria warrants full Credentialing Subcommittee Review of the history and should be applied in making credentialing and recredentialing decisions:

- Number of claims - any claims within the prior seven (7) years.
- Results of cases - any settlements within the prior seven (7) years.
    - Settlements with a minimum payout of $30,000 or more.
    - Settlements resulting in major permanent injury or death.
- Trends in cases - Practitioners with multiple malpractice claims in a similar area (e.g., missed diagnosis, negative surgical outcomes, etc.).

7) Hospital Admitting Privileges. Practitioner must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation(s) or admitting privileges at a participating hospital. Practitioners must have appropriate admitting privileges or arrangements with IEHP's contracted Hospitals, if applicable See Policy 2B, "Hospital Privileges" and "Attachment/ Hospital Admitting Privileges Reference by Specialty" found on the IEHP website.[26]

- Providers are not required to maintain Hospital admitting privileges if they are only practicing at an Urgent Care or providing Telehealth Services only.

8) NPI: Must confirm Provider has an active Individual NPI with a Primary address must be registered to an address in the state they practice (i.e. California or Arizona (as applicable)).

- Group NPI may be submitted to IEHP in conjunction to the Individual NPI.
- Telehealth Providers are not required to have an NPI registered with a primary address in California or Arizona (as applicable).

[26] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

9) Grievance History (if applicable).
    - Provider Grievance Rate lower than IEHPs Grievance Rate
    - Absence of grievance trend

10) All Primary Care Provider (PCP) and Urgent Care Providers must meet the Facility Site Review (FSR)/Medical Record Review (MRR) guidelines to include scoring above 80% for the following Medical Record Review elements:
    - Coordination of Care
    - Pediatric Preventive Care
    - Adult Preventive
    - OB/CPSP Preventive Criteria [27]

b. Sanction Information. IEHP must verify the following sanction information for credentialing.

1) State Sanctions, restriction on licensure and limitations on scope of practice:
    - Any actions, restrictions or limitations on licensure or scope of practice, are presented for review and discussion to the Credentialing Subcommittee and/or Peer Review Subcommittee.

2) Medicare and Medicaid Sanctions:
    - Providers Excluded/Sanctioned by Medicare or Medicaid (OIG). IEHP prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners found on OIG report). Providers identified on the OIG report will not be credentialed or contracted and terminated from our network if they are existing Providers.
    - Medi-Cal Suspended & Ineligible List Providers are deemed suspended and ineligible from Medi-Cal will be terminated or not be credentialed and contracted with for Medi-Cal line of business. IEHP does not allow Medi-Cal Suspended & Ineligible List Providers to participate in the IEHP network.
    - Medicare Opt-Out Providers who are:[28]
        - Behavioral Health (BH) Practitioners are not allowed to participate in the IEHP network for any lines of business due to contract limitations

[27] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Chapter 6 § 60.3
[28] Medicare Managed Care Manual, Chapter 6, "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks," § 60.2

and system design, therefore are administratively terminated for all lines of business. All Members will be assigned to new Practitioners.

  - o Practitioners outside of BH are not allowed to participate in the IEHP network for Medicare Lines of business. Medicare Members are reassigned to new Practitioners.

- Preclusions List: Providers identified on the preclusions list will be terminated or not be credentialed and contracted.[29]

c. Credentialing Application. Practitioners must submit an application or reapplication that includes the following:

1) Attestation to:

- Reasons for inability to perform the essential functions of the position.
- Lack of present illegal drug use.
- History of loss of license and felony convictions.
- History of loss or limitation of privileges or disciplinary actions.
- Malpractice Insurance Coverage: Must have current and adequate malpractice insurance coverage that meets the following criteria:
  - o Minimum $1 million per claim/$3 million per aggregate.
  - o Coverage for the specialty the Provider is being credentialed and contracted for.
  - o Coverage for all locations the Provider will be treating IEHP patients.[30]
- Current and signed attestation confirming the correctness and completeness of the application.

2) Release of Information used for primary source verification.

3) Addendum A:

- Practitioner Type
- Practice Type
- Name(s) of any employed Advanced Practice Practitioners (e.g. Nurse Practitioners, Nurse Midwives, or Physician Assistants)
- Age Limitations

[29] Centers for Medicare & Medicaid Services, "Preclusion List Requirements", 11/02/2018
[30] NCQA, 2024 HP Standards and Guidelines, CR3, Element C, Factor 5

- Practitioner Office Hours
- Practitioner's written plan for continuity of care if they do not have hospital privileges
- Languages spoken by Physician
- Languages spoken by staff

4) Addendum B, used for Professional Liability Action explanation(s).
5) Addendum C, used to confirm Practitioner's status as a:
   - Certified Workers Compensation Provider
   - Reservist
6) Addendum D, Notice to Practitioners of Credentialing Rights/Responsibilities
7) Addendum E, applicable to General Practice and Obstetrics/Gynecology providers who are PCP's.
8) Verification of Qualifications for HIV/AIDS Physician Specialist form. See Attachment/Verification of Qualifications for HIV/AIDS Physician Specialists" found on the IEHP website,[31] required for Practitioners who would like to be designated as an HIV/AIDS Specialist.
9) Behavioral Health (Area(s) of Expertise Form. To ensure Practitioners are listed with the types of services they offer, this form is required for all Practitioners with a Behavioral Health Affiliation/Designation, to include but are not limited to:
   - Psychiatrists
   - Psychologists
   - Addiction Medicine Specialists
   - Master Level Clinical Nurses
   - Licensed Clinical Social Workers
   - Licensed Marriage Family Therapists
   - License Professional Clinical Counselors
   - Nurse Practitioners with a Behavioral Health (BH) designation
   - PAs with a BH designation

[31] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

10) The Transgender Questionnaire, See "Attachment/Transgender Questionnaire" found on the IEHP website,[32] is required for all Practitioners who are or would like to be designated as a Transgender Competent Provider. At minimum, the Practitioner must meet and provide evidence of the following for consideration:

    - 10 Continuing Medical Education (CME) hours within the last three (3) years
    - Certification through WPATH
    - Evidence of the following annual staff training on transgender care, that includes:
        - Agenda
        - Sign in sheet
        - Policies and Procedures

11) Licensed Midwife Attestation: Plan for Consultation, Emergency Transfer, & Transport. See "Attachment/Licensed Midwife Attestation," found on the IEHP website,[33] required for all Licensed Midwife Practitioners.

    - IEHP requires the backup Licensed Physician, engaged in active clinical obstetrical practice and with whom the Licensed Midwife consults when there are significant deviations from the normal, in either mother or infant, is an active Obstetrics/Gynecology Practitioner within the IEHP network.

12) Attachment I: Statement of Agreement by Supervising Provider. IEHP requires a completed Attachment I: Statement of Agreement by Supervising Provider, for all Advanced Practitioner and Supervising Physician arrangements, to ensure arrangements are documented appropriately, which will be collected at the time of credentialing, recredentialing and upon relationship change.

    - If these arrangements are clearly described on the Delegation of Services Agreement, Practice Agreement, or Standardized Procedures, those documents may be used in lieu of submitting an Attachment I form.

13) Practitioner offices who employ Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) must ensure written arrangements are in place between the Advanced Practice Practitioner and the practice where they treat IEHP members. These documents must be readily available to IEHP upon request.

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[32] Ibid.

[33] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

- IEHP requires all Advanced Practice Practitioners to practice at the same site as their Supervising Physician.
- PAs with a Behavioral Health Designation must be supervised by a licensed Physician who specializes in Psychiatry.

The following written arrangements must be provided to IEHP upon request for:

- PAs must provide one (1) of the following:
  - Delegation of Services Agreement and Supervising Physician Form. See "Attachment/Delegation of Services Agreement and Supervising Physician Form" found on the IEHP website.[34,35] This agreement must:
    - Define specific services identified in practice protocols or specifically authorized by the supervising Physician., and
    - Both the Physician and PA must attest to, date and sign the document.
    - An original or copy must be readily accessible at all practice sites in which the PA works.
  - Practice Agreement, effective January 1, 2020,[36] written and developed through collaboration among one or more Physicians and Surgeons and one or more PAs, that defines the medical services the PA is authorized to perform[37] and that grants approval for Physicians and Surgeons on the staff of an organized health care system to supervise one or more PAs in the organized health care system. Any reference to a Delegation of Services Agreement relating to PAs in any other law shall have the same meaning as a practice agreement. The Practice Agreement must include provisions that address the following:[38]
    - The types of medical services a PA is authorized to perform.
    - Policies and procedures to ensure adequate supervision of the PA, including, but not limited to, appropriate communication, availability, consultations, and referrals between a Physician and Surgeon and the PA in the provision of medical services.
    - The methods for the continuing evaluation of the competency and qualifications of the PA.

[34] Title 16 California Code of Regulations (CCR) § 1399.540(b)
[35] https://www.providerservices.iehp.org/en/resources/provider-resources/forms
[36] Senate Bill 697
[37] Bus. & Prof .Code § 3502
[38] Bus. & Prof .Code § 3502.3

- The furnishing or ordering of drugs or devices by a PA.[39] Any additional provisions agreed to by the PA and Physician and Surgeon.

- A practice agreement shall be signed by both of the following:
  - The physician assistant.
  - One or more Physicians and Surgeons or a Physician and Surgeon who is authorized to approve the practice agreement on behalf of the staff of the Physicians and Surgeons on the staff of an organized health care system.
- A delegation of services agreement in effect prior to January 1, 2020, shall be deemed to meet the requirements of this subdivision.
- A practice agreement may designate a PA as an agent of a supervising Physician and Surgeon.
- Nothing in this section shall be construed to require approval of a practice agreement by the board.
  - Notwithstanding any other law, in addition to any other practices that meet the general criteria set forth in this chapter or regulations adopted by the board or the Medical Board of California, a practice agreement may authorize a PA to do any of the following:
    - Order durable medical equipment, subject to any limitations[40] or the practice agreement. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.[41]
    - For individuals receiving home health services or personal care services, after consultation with a supervising physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.
    - After performance of a physical examination by the PA under the supervision of a Physician and Surgeon consistent with this chapter, certify disability of the Unemployment Insurance Code. The Employment Development Department

[39] Bus. & Prof. Code § 3502.1
[40] Bus. & Prof Code § 3502
[41] Bus. & Prof Code § 3502.3 (1)

shall implement this paragraph on or before January 1, 2017.[42]

- NPs and CNMs are required to have Standardized Procedures. Standardized Procedures must be on-site site specific and:
  - o To meet the requirements, reference textbooks and other written sources, which must include:[43]
    - ▪ Book (specify edition) or article title, page numbers and sections.
  - o NP and/or CNM must be practicing at a site assigned to their supervising Physician; and
  - o Standardized Procedures must be signed by both the Practitioner and the supervising Physician, initially and annually; and provided to IEHP, upon request. At minimum, the documents must include:
    - ▪ Table of Contents of the Standardized Procedures used, between the NP and/or CNM and supervising Physician, that references the textbook or written sources to meet the requirements of the Board of Registered Nursing.
    - ▪ Evidence that the Standards of Care established by the sources were reviewed and authorized by the Nurse Practitioner, Physician and administrator in the practice setting (i.e., signature page that includes all parties involved).
- Standardized Procedures written using the Practice Agreement or PAs Delegation of Services Agreement and Supervising Physician Form format and/or verbiage is not accepted by IEHP.[44,45,46]

d. Adverse History Guidelines: IEHP will review all Practitioners with evidence of adverse history are presented to Credentialing Committee for review and documented in the meeting minutes, that may include, but is not limited to Providers who have:

1) Restrictions on licensure

2) Restrictions on DEA

3) Loss of Clinical privileges or negative privilege actions

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[42] California Code, Unemployment Insurance Code (UIC) § 2708
[43] 16 CCR § 1474 (3)
[44] NCQA, 2024 HP Standards and Guidelines, CR 1, Element A, Factor 3
[45] Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3
[46] 16 CCR § 1474 (3)

4) Sanction History

5) Other negative actions may include, but are not limited to:
   - Use of illegal drugs
   - Criminal history
   - Engaged in any unprofessional conduct or unacceptable business practices.
   - Higher than average grievance rate or trend in grievances.

e. Provider Network:

1) Advanced Practice Practitioners are allowed to increase only one (1) supervising PCPs enrollment capacity per location with a maximum of two (2) unique locations allowed. Advanced Practice Practitioners must be practicing at a site assigned to their supervising Physician.

2) **Patient age ranges for Primary Care Providers (PCP)** must be specifically delineated as part of the credentialing process. The guidelines for PCP age ranges are provided below:

SPECIALTY	AGE RANGE
Pediatrics	• 0 – 18 • 0 – 21
Family Practice	• All Ages • 14 and above
Internal Medicine	• 14 and above • 18 and above • 21 and above
Public Health and General Preventive Medicine	• 18 and above • 21 and above
Obstetrics/Gynecology	• 14 and above; restricted to females
General Practice	• 16 and above

Guidelines for age ranges for Non-Physician Practitioners which include Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Licensed Midwives (LMs), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Opticians, Optometrists (OD), Chiropractors (DC), Dieticians and Nutritionists are as applicable to the training and certification of the Non-Physician Practitioner.

Patient age ranges for specialty Physicians are specific to the specialty involved, training, and education of the Physician.

4. All Practitioners who do not meet the criterion set forth above, must be reviewed by the IEHP Credentialing Subcommittee and/or IEHP Peer Review Subcommittee. IEHPs Credentialing Subcommittee will review, discuss, and document their findings in the respective Subcommittee minutes. At a minimum:[47]

    1) The Credentialing Committee must receive and review the credentials of the Practitioners who do not meet IEHP's established criteria for the Practitioners applying directly to IEHP to provide advice and expertise for credentialing decisions.

    2) If retrospective review by IEHP's Credentialing Department reveals that a Practitioner approved by a Delegate does not meet the above requirements, IEHP can submit the Practitioner to the Peer Review Subcommittee for review.

5. IEHP utilizes a clean file process. All Practitioners who meet the criterion set forth above, are determined as "clean" and may be submitted to the IEHP Medical Director for sign-off. The sign-off date is the Committee date and evidence of the IEHP's Medical Director signature will be documented in the Practitioners file or on a list of all Practitioners who meet the established criteria.[48]

    a. The IEHP Medical Director, who is responsible for oversight of the credentialing process, has been identified as the individual with the authority to determine that a file is "clean" and to sign off on it as complete, clean, and approved.

6. IEHP's credentialing and recredentialing decisions are not based solely on the applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient in which the Practitioner specializes and describes the steps for monitoring and preventing discriminatory practices during the credentialing/recredentialing process.[49,50]

    IEHP's procedures for monitoring and preventing discriminatory credentialing decisions may include, but are not limited to:

    a. Monitoring: Periodic audits of Practitioner complaints to determine if there are complaints alleging discrimination are conducted annually.

    b. Preventing: Maintaining a heterogeneous Credentialing Committee membership and requiring those responsible for credentialing decisions to sign an affirmative statement on, which is included on the sign-in sheet, to make decisions in a non-discriminatory manner.

7. Practitioners are notified in writing, when credentialing information obtained from other

[47] NCQA, 2024 HP Standards and Guidelines, CR 1, Element A, Factor 4
[48] NCQA, 2024 HP Standards and Guidelines, CR 1, Element A, Factor 5
[49] 42 CFR § 422.205
[50] NCQA, 2024 HP Standards and Guidelines, CR 1, Element A, Factor 6

sources varies substantially from that provided.[51]

a. The Credentialing Specialist notifies the Practitioners by fax or email, within 10 business days of any information obtained during the credentialing process that varies substantially from the information provided by the Practitioner that includes but is not limited to:

   1) Actions on license.
   2) Malpractice history.
   3) Board certification, education, and training.
   4) Any incomplete or blank sections on the application

   IEHP is not required to reveal the source of the information if the law prohibits the disclosure.

   1) The notification to the Practitioner includes the following:
      - Identification of the discrepancy.
      - Identification of the source of the discrepancy.
      - Informs the Practitioner that the Practitioner has 10 business days to submit the missing and/or corrected information.
      - The format for submitting the correction.
      - The person to whom the corrections must be submitted; and
      - Where to submit the information.
   2) The Practitioner has 10 business days from the receipt of the notification to correct the erroneous information and is responsible for submitting additional or corrected information including any other supporting or pertinent information in writing, to the IEHP Credentialing Specialist.
   3) Upon receipt, the Credentialing Specialist stamps the document with the date received, to include the name of the reviewer, and verifies the information is correct. If its correct, the document is included in the Practitioners credentialing file for review and approval.
      - For Credentialing files: If the requested information is not received within 10 business days, the Provider is notified that their credentialing process is ceased due to an incomplete credentialing application.
      - For Recredentialing files: If the requested information for recredentialing by the recredentialing deadline, the Practitioner is notified that without this

[51] NCQA, 2024 HP Standards and Guidelines, CR 1, Element A, Factor 7

information, the Practitioner will be administratively terminated due to an incomplete recredentialing application.

- For Recredentialing files: If the requested information is not received within ten (10) business days, the Provider Services Representatives (PSRs) and Contracts Managers (CMs) are notified that the Provider has outstanding items and are approaching their recredentialing due dates. Failure to provide all recredentialing documents timely may result in an administrative termination due to non-compliance to recredentialing.

8. Practitioners are notified of their credentialing and recredentialing decisions within 60 calendar days of the Committee's decision or Medical Director sign off.[52]

9. IEHPs Medical Director's overall responsibility and participation in the credentialing program includes, but is not limited to:[53]

    a. Possession of a current license to practice in his/her state of practice

    b. His/her role in implementation, development, and coordination in the functions of the Credentialing Program.

    c. Oversight of the Credentialing Program, policies, and procedures.

    d. Membership, attendance and/or chairmanship at all Credentialing Committee meetings; and

    e. Description of the reporting structure and responsibilities for Medical Director/physician designee, Committee and Board of Directors for final recommendation for participation, as applicable.

10. The information obtained in the credentialing process is kept confidential and IEHP mechanisms to ensure confidentiality of the information collected during the credentialing process includes, but is not limited to:[54]

    a. Confidentiality statements are signed by the Committees and Credentialing staff.

    b. Practitioner files (hard copies, as applicable) are maintained in locked file cabinets and are only accessible by authorized personnel, if applicable; and

    c. Security for database systems is maintained through passwords or other means to limit access to Practitioner information to authorized staff only.

11. All information provided by IEHP for Member materials and practitioner directories is consistent with the information obtained during the credentialing and recredentialing process, regarding Practitioner education, training, certification, and designated specialty.

[52] NCQA, 2024 HP Standards and Guidelines, CR 1, Element A, Factor 8
[53] NCQA, 2024 HP Standards and Guidelines, CR 1, Element A, Factor 9
[54] NCQA, 2024 HP Standards and Guidelines, CR 1, Element A, Factor 10

Information collected and verified during the credentialing and recredentialing process and requests received in between cycles, is entered and maintained by the Credentialing Department to ensure consistency.[55]

B. IEHP notifies Practitioners of their rights to review information submitted to support their credentialing application, correct erroneous information, and receive the status of their credentialing and recredentialing application, upon request, through the Provider Manual, and Provider application.[56]

1. Practitioners may review information submitted to support their credentialing application that are obtained from outside sources (e.g. malpractice insurance carriers, state licensing boards) to support their credentialing application.

    a. IEHP is not required to make available:

        1) References.

        2) Recommendations.

        3) Peer-Review protected information.

2. Practitioners have the right to correct erroneous information (submitted by another source) and must clearly state:

    a. Practitioners have 10 business days of notification of discrepancy from the date the Credentialing Department provides notice to correct any erroneous information. Erroneous information may include substantial variation in information on:

        1) Actions on a license

        2) Adverse history

            - Malpractice Claim History
            - Criminal History
            - Sanction History
            - Clinical Privileges History

        3) Board Certification

        4) Education and Training

            - Insufficient years of training in desired specialty

    b. Practitioners must submit their corrections in writing.

    c. Practitioners must send their written requests via confidential fax, email, or letter to

[55] NCQA, 2024 HP Standards and Guidelines, CR 1, Element A, Factor 11
[56] NCQA, 2024 HP Standards and Guidelines, CR 1, Element B, Factor 1-3

the Credentialing Department:

P.O. Box 1800
Rancho Cucamonga, CA 91729-1800
Fax: (909) 890-5756
E-mail: credentialing@iehp.org.

IEHP is not required to reveal the source of information that was not obtained to meet the verification requirements or if federal or state law prohibits disclosure. IEHP documents receipt of corrected information in the Practitioners credentialing file.

3. Practitioners have the right to be informed, upon request, of the status of their credentialing or recredentialing application. Following receipt of the Practitioner's request, the Practitioner will be contacted by the Credentialing Department with their status.

C. IEHPs process for both paper and electronic processes for Credentialing System Controls for Credentialing Team Members include:

1. Credentialing applications, supporting documents, and verifications are received, reviewed and handled by the Credentialing Team. Documents are:

a. Received via;

1) Mail are handled by hand by our Mailroom Department then forwarded to the Credentialing Department via Inter-office delivery;

2) Email, fax, electronic applications are handled electronically by the Credentialing Specialist;

3) Online portal, internet website or web crawler documents are handled electronically by the Credentialing Specialist; and

b. Dated electronically or date stamped when they are received by the Credentialing Team; when they are

c. Reviewed by Credentialing Team Members; and (see table below); and are identified with rights to;

Credentialing Team Member Roles	Network Drive			Network Development Database		
	Access	**Modify**	**Delete**	**Access**	**Modify**	**Delete**
Credentialing Manager	Yes	Yes	No	Yes	Yes	No
Credentialing Supervisor	Yes	Yes	No	Yes	Yes	No
Credentialing	Yes	Yes	No	Yes	Yes	No

Auditor						
Credentialing Specialist II	Yes	Yes	No	Yes	Yes	No
Credentialing Specialist I	Yes	Yes	No	Yes	Yes	No
Healthcare Informatics Analysts	No	No	No	Yes	No	Yes

d. Tracked via internal credentialing checklist and electronic database by the Credentialing Team; and

e. Stored in a password protected database and network drive.

2. If a modification needs to be made to:

a. Credentialing information, the Credentialing Specialist will document:

1) The date the modification was made; and

2) An explanation of the modification; and

3) Reason for modification; and

4) Who made the modification within the credentialing system

b. Primary Source Verification (PSV), the Credentialing Specialist will document:

1) The change; and

2) Who they spoke with; and

3) Initial and date the PSV; and

4) A note will also be placed in the appropriate section of the credentialing database and/or documented in the practitioners file and checklist (as applicable).[57]

3. Only IEHP Team Members with direct involvement in the Credentialing are assigned user roles based on areas of responsibility as defined in their job description and listed on the table above. Each user role is assigned specific read/write system access as needed to perform their duties which may include modifying and deleting information.

a. Verification information may be modified by Credentialing Specialists, Supervisors, Auditors and Managers when verification information changes. If Credentialing information changes, new verifications will be obtained, the reason why the change is being made and description of the changes made will be documented and initialed/dated by Credentialing Team Members, then stored in the practitioner's

[57] NCQA, 2024 HP Standards and Guidelines, CR 1, Element C, Factor 2

credentialing electronic file.

b. Appropriate modifications to credentialing information include, but are not limited to:

1) Updates to expired licensure or other documents;

2) Changes/updates to education, training or privileges;

3) To correct data entry errors (i.e verification dates)

4) Duplicate profiles

5) Documents appended to incorrect provider profile

c. Inappropriate modifications to credentialing information are distinguished by not having the appropriate documentation supporting the modification that include:

1) Altering credentialing approval dates;

2) Altering dates on verifications;

3) Whited out dates or signatures on hard copy documents;

4) Unauthorized deletion of provider files or documentation.

d. All credentialing database deletions requests must be submitted to Healthcare Informatics (HCI) via email, with the reason for deletion i.e incorrect data, data correction).[58]

4. IEHP limits physical access to credentialing information, protecting the accuracy of information gathered from primary and approved sources. IEHPs IT Department monitors the controls in place to address the risk of system tampering and the software housed on each credentialing staff's computer. The Credentialing database has user groups implemented to further limit access to information that can be inserted and updated through the credentialing database, Network Development Data Base (NDDB). These database groups, or user groups, are specific to the departments that maintain the provider data. The database groups are controlled by HCI.

a. Hard copy data (any printed confidential/sensitive document or file) is stored in locked cabinets. Credentialing Team Members shall secure all practitioner files and information when not in process and during non-work hours in locked cabinets that is only accessible to authorized staff. Credentialing Leaders have control and/or responsibility for locking and unlocking file cabinets. File cabinets and workstations are in physically secure areas that require badge access to enter. Computer screens are positions to prevent viewing by unauthorized individuals.

b. All password-based systems on workstations must mask, suppress, or otherwise

[58] NCQA, 2024 HP Standards and Guidelines, CR 1, Element C, Factor 3

obscure the password, so that unauthorized personal are not able to observe them. Authorized users are prohibited from allowing others to access computer systems or restricted areas with their account, password, badge, or unique ID information.

1) Password protecting electronic systems, including user requirements, are in accordance with and enforced through IEHP's Information Technology (IT) Department, that requires:
   - Use strong passwords
   - Avoid writing down passwords
   - Use different passwords for different accounts
   - Change passwords periodically
   - Password Construction Guidelines for IEHP Team Members and affiliates to create strong passwords for accessing IEHP networks and applications, include:
     - Password length:
       - IEHP Active Directory (AD) accounts must be at least 13 characters or longer
       - Other IEHP system and application accounts must be at least eight (8) characters or longer
       - Passphrases containing several words to create a sentence, or a phrase should be used wherever possible over single word passwords
   - Password complexity: IEHP passwords must contain at least one (1) character from three (3) of the four (4) following categories:
     - English upper-case letters [A, B, C, ... Z]
     - English lower-case letters [a, b, c, ... z]
     - Westernized Arabic numerals [0, 1, 2, ... 0]
     - Non-alphanumeric characters such as punctuation symbols [! @, $,…*].
   - IEHP passwords cannot be:
     - A single dictionary word in any language
     - A person's name
     - Based on personal information i.e. family member names, pet's names, birth places etc.

- A single dictionary word or a person's name with simple permutations, i.e. Password1, Christmas17, Jonathan2017, etc.
- A keyboard pattern, i.e. QWERTY, 123454321, qazwsxedc, etc.

- Password change frequency
  - IEHP Active Directory (AD) passwords must be changed every 180 days.
  - Other IEHP account passwords should be changed every 90 days.
  - When requested or if password(s) are compromised.

2) Changing or withdrawing passwords, including alerting appropriate staff who oversee computer security, such as IEHP IT Department, to:
   - Change passwords when appropriate
   - Disable or remove passwords of employees who leave the organization
     - User account access will be revoked within 24 hours of notification of a Team Member's departure by IEHP senior leadership or authorized Human Resources representatives. Accounts may be suspended or deleted as necessary

3) IEHP does not contract with an external entity to outsource storage of credentialing information.
   - Delegates who are delegated Credentialing responsibilities, IEHP will review the delegate contracts to confirm if it is System Control requirements are addressed.
     - If the contract does not address it, the Delegate may submit policies and procedures for review. This applies to both the Delegate's and each external entity they contract with.
     - This will be reviewed at the Pre-Delegation and any Annual audits thereafter.[59]

c. IEHPs IT department is responsible for preventing unauthorized access and changes that include:
   1) Limiting login attempts
   2) Multifactor authentication
   3) Use of firewalls

[59] NCQA, 2024 HP Standards and Guidelines, CR 1, Element C, Factor 4

4) Assigning user rights and leveling (permission tiers)

5. IEHP monitors its compliance with its own policies and procedures for Credentialing System Controls and takes appropriate actions when applicable.

   a. At least annually, the Credentialing Subject Matter Experts (SMEs), which includes: the Credentialing Manager, Credentialing Supervisor, Credentialing Auditor, Credentialing Specialists IIs), perform the audit process and have oversight responsibility for monitoring and reporting, which include, but are not limited to:

      1) Review of data additions/modification/changes/updates to credentialing data (both electronic and paper as applicable) into file Q&A process, will be done by the Credentialing SMEs, which will assess and document findings for:

         - Accuracy;
         - Appropriateness; and
         - Compliance with policies

      2) Review of all modifications made to credentialing data to confirm accuracy and appropriateness using the electronic systems audit trail function or change tracking reporting capability, will be done in conjunction with Credentialing Leadership and HCI.

      3) Review of job roles and current user access to ensure system access is still appropriate for the role requirements, which will be done in conjunction with Credentialing Leadership and HCI.

      4) For paper documents/files, conduct periodic walk-throughs of department to ensure confidential/sensitive documents are being handled and stored properly during and after business hours, i.e. in locked drawers/filing cabinets, not left on fax machines, will be done by the Credentialing Team.

      5) Findings will be shared with the Credentialing Manager and evaluated for the Credentialing Systems Controls Oversight Annual Review.[60]

D. At least annually, IEHP demonstrates that it monitors compliance with its CR (Credentialing) controls, by:

   1. Identifying all modifications or unauthorized access to credentialing and recredentialing information that did not meet the organizations policies and procedures for modifications.

      a. HCI will provide a report of database records that were modified within the look back period for the Credentialing SMEs to pull a sample, and ensure the records modified, included:

[60] NCQA, 2024 HP Standards and Guidelines, CR 1, Element C, Factor 5

1) Information verified is aligned with the data entered in NDDB; and

2) Appropriate documentation within the practitioners file and/or database that specifies:

- Date verified;
- Reason for modification;
- Verified and reviewed by a Credentialing Team member

b. The Credentialing SME will provide the Credentialing Manager, who is responsible for the oversight of the monitoring process, a summary of the finding that identifies the modifications reviewed, with emphasis on the modifications that were deemed inappropriate.

2. Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications, by conducting qualitative and quantitative analysis of all modification that did not meet its policies and procedures.

a. The Credentialing SME will examine the results and identify the underlying reason(s) for or cause of the results, including deficiencies or processes that may present barriers to improvement or cause failure to ensuring the modifications were appropriate then make recommendations on what can be adjusted to ensure the modification standards are trending towards being met.

3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three (3) consecutive quarters

a. The Credentialing SME will present a quarterly monitoring process to assess the effectiveness of its actions on all findings until improvement is demonstrated for one (1) finding over at least three (3) consecutive quarters. This report will be presented to the Credentialing Manager and Director of Provider Network for review.[61]

E. Upon receipt of credentialing applications from Behavioral Health, Mental Health, and/or Substance Use Disorder Providers: [62]

1. IEHP will notify the applicant within seven (7) business days of receiving the application to confirm receipt and inform the applicant whether the application is complete.

a. If the application is incomplete or requested supporting documents were not provided, IEHP will notify the practitioner within seven (7) business days of receiving the Practitioner's application noting the application received date and that the application was deemed incomplete and withdrawn from the credentialing process due to the missing information.

[61] NCQA, 2024 HP Standards and Guidelines, CR 1, Element C, Factor 1-3
[62] Health & Safety. Code § 1374.197

1) The practitioner must submit the incomplete or requested documentation along with a current application for reconsideration.

2) Once the additional information is received, the application will be deemed complete.

b. If the application is deemed complete, the practitioner will be notified that their application will be forwarded to the Initial Application process.

1) The processing time for an initial application starts on the day the Practitioner is notified of their completed application.

2. Practitioner qualifications will be assessed and verified within 60 calendar days after receiving a completed credentialing application. The 60 day timeframe only applies to credentialing process for Behavioral Health, Mental Health, and/or Substance Use Disorder Providers and does not include contracting completion.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
Revision Effective Date:		

APPLIES TO:

A. This policy applies to all IEHP Covered Providers contracted under IEHP's Direct Network.

POLICY:

A. IEHP's Credentialing Subcommittee reviews the credentials for Providers who do not meet established thresholds and gives thoughtful consideration of the credentialing information. IEHP's Credentialing Subcommittee obtains meaningful advice and expertise from participating Practitioners when it makes credentialing decisions in accordance with National Committee for Quality Assurance (NCQA) guidelines.
   1. Assessment of Timeliness. IEHP uses the Credentialing Subcommittee or Medical Director decision date to assess timeliness in the file review elements if a review board or governing body reviews decisions made by the Credentialing Subcommittee or Medical Director.
   2. Providing care to Members. IEHP does not permit Practitioners to provide care to its Members before they are credentialed.

B. IEHPs Credentialing Subcommittee ensures files that meet established criteria are reviewed and approved by a medical director or designated Physician.

PURPOSE:

A. IEHP designates the Credentialing Subcommittee, that uses a peer-review process, to make recommendations regarding credentialing decision. Activities of the Subcommittee are reported to Quality Management (QM) Committee on a quarterly basis or more frequently for issues of a more serious nature.

DEFINITIONS:

A. Clean files: Credentialing files that meet the organization's criteria for participation and are not required to be sent to the credentialing committee for review.[1]

B. Credentials Committee Minutes: A document from a peer review committee which includes thorough discussion of credentialing files, decisions/recommendations, and follow-up of issues.

C. Peer review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (e.g. evaluation of a physician's credentials and practice by another physician).[2]

D. Timeliness: A term used when auditing file elements to confirm they are within 180 calendar

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[1] National Committee for Quality Assurance (NCQA), 2024 Health Plan Standards and Guidelines, Glossary
[2] NCQA, 2024 HP Standards and Guidelines, Glossary

days of the credentials committee decision.

PROCEDURES:

A. The Credentialing Subcommittee is structured to provide review of Practitioners applying for participation with IEHP and to ensure compliance with IEHP requirements.[3]

1. IEHP uses participating Practitioners to provide advice and expertise for credentialing decisions. IEHPs voting rights are restricted to the appointed Subcommittee Members, who are Physicians only. Participating Practitioners are external to the organization and are part of the organization's network, as defined by NCQA.

   a. IEHP Medical Director or designee as Chairperson;

      1) IEHP's Medical Director is directly responsible for the credentialing process, Credentialing policies and procedures, and has overall responsibility and participation in the credentialing process.

   b. Chief Medical Officer (CMO);

   c. At least four (4) multidisciplinary participating Primary Care Providers (PCPs) or specialty Physician representative of network Practitioners;

      1) Any other specialty not represented by Subcommittee membership including vision and behavioral health serves on an ad hoc basis for related issues.

         - Prospective appointed Physician Members of the Subcommittee are subject to verification of licensure, Drug Enforcement Agency (DEA) and malpractice history prior to participating on the Subcommittee.
         - Prospective Physician Members not providing requested information to perform verification in a timely manner, or who do not meet IEHP's requirements upon verification may not participate on the Subcommittee.
         - The full term for practicing primary care and specialists Subcommittee voting Members is two (2) years, with replacements selected from network Practitioners.
           - The determination of whether any Practitioner Member may serve additional terms is at the sole discretion of the CMO and Medical Director, with approval of the Subcommittee.
           - The initial term(s) of Subcommittee Members are staggered to ensure consistent Subcommittee operations.

   d. IEHP's non-physician staff on the Subcommittee do not have voting rights and

[3] NCQA, 2024 HP Standards and Guidelines, CR 2, Element A, Factor 1

consist of the following:

1) Director of Provider Relations;
2) Director of Quality Management;
3) Director of Provider Network;
4) Credentialing Manager;
   - Credentialing ensures the timeframe for notifying applicants of their credentialing decisions for both credentialing and recredentialing, does not exceed 60 calendar days from the committee's decision.
5) Quality Manager;
6) Other IEHP staff, as necessary; and
   - IEHP staff attend as permanent Members of the Credentialing Subcommittee.
7) Provider Services Administrative Assistant.
   - Acts as secretary to the Credentialing Subcommittee.

B. IEHP's Credentialing Subcommittee reviews the credentials for Providers who do not meet established thresholds and give thoughtful consideration of the credentialing information. IEHP's Credentialing Subcommittee obtains meaningful advice and expertise from participating Practitioners when it makes credentialing decisions.[4]

1. The committee's discussion must be documented within its meeting minutes. The Credentialing decision date is used to determine the timeliness requirements for credentialing.

   a. Credentialing Subcommittee meetings and decision making may take place in form of real-time virtual meetings (e.g. through video conferencing or web conferencing with audio). Meetings may not be conducted only through email.

   b. Voting cannot occur unless there is a quorum of voting Members present. For decision purposes a quorum can be composed of one of the following:

      1) The Chairperson, (who is the IEHP Medical Director or designee), Chief Medical Officer, and three (3) appointed Subcommittee Members; or

      2) The Chairperson (who is the IEHP Medical Director or designee), or Chief Medical Officer and two (2) appointed Subcommittee Members.

   c. Credentialing Subcommittee decisions cannot be based on applicant's race, ethnic/national identity, gender, age, sexual orientation, type of procedure, or patient

[4] NCQA, 2024 HP Standards and Guidelines, CR 2, Element A, Factor 2

type (i.e. Medicaid) in which the Practitioner specializes. Policies and procedures must describe specific steps that the organization prevent and monitor discriminatory practices. This does not preclude the organization from including in its network Practitioners who meet certain demographic or specialty needs (i.e. meeting cultural needs of the Members).

d. In-depth minutes are recorded at each meeting by a Provider Services Administrative Assistant, with review by the Credentialing Manager and IEHP Medical Director.

   1) Minutes include all activities addressed in Subcommittee meetings, including credentialing and recredentialing decisions, and other business related to credentialing and recredentialing of Practitioners including thoughtful discussion and consideration of all Practitioners being credentialed and recredentialed before a credentialing decision is determined.

   2) Minutes are dated, signed, and reflect the responsible person for follow-up actions.

   3) Credentialing minutes are stored in a confidential and secure location with access only to authorized staff.

e. Updates of activities including minutes and appropriate reports are submitted to Quality Management (QM) Committee on a quarterly basis, or more frequently as needed.

f. The Credentialing Subcommittee meets monthly with additional meetings as needed.

C. Ensures that files that meet established criteria are reviewed and approved by a medical director or designated Physician. IEHP implemented a process to designate a Medical Director or other designated Physician review and approval of clean files submits all Practitioner files, and then provides a list to the Credentialing Subcommittee for review as a repository.

1. IEHP's Medical Director is directly responsible for the credentialing process, credentialing policies and procedures and has overall responsibility and participation in the credentialing process.

2. Evidence of the medical director's or equally qualified Physician's review will be present on a list or file of the Practitioners who meet the established criteria.

3. IEHP's Medical Director reviews, analyzes, and recommends any changes to the IEHP Credentialing and Recredentialing Program policies and procedures on an annual basis, or as deemed necessary. [5]

[5] NCQA, 2024 HP Standards and Guidelines, CR 2, Element A, Factor 3

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
Revision Effective Date:		

2. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

3. Credentialing Verification

APPLIES TO:

A. This policy applies to all IEHP Covered Providers contracted under IEHPs Direct Network.

POLICY:

A. IEHP verifies that the following are within the prescribed time limits: license to practice, Drug Enforcement Administration (DEA), education and training, board certification, work history and malpractice history.[1]

B. IEHP verifies State sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions.[2]

C. IEHP ensures applications for credentialing and recredentialing include reasons for inability to perform the essential functions of the position, lack of present illegal drug use, history of loss of license and felony convictions, history of loss or limitation of privileges or disciplinary actions, current malpractice insurance coverage, and a current and signed attestation confirm the correctness and completeness of the application.[3]

D. IEHP verifies that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital.

E. IEHP verifies that Practitioners meet all screening and enrollment requirements to include, but not limited to: enrollment in the Medi-Cal Program; Federal and State Database Checks for Social Security Administration's Death Master File (SSADMF), National Plan and Provided Enumeration System (NPPES), List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS' Medicare Exclusion Database (MED), DHCS' Suspended and Ineligible List, Restricted Provider Database (RPD).

F. IEHP monitors its credentialing files to ensure that it only contracts with Practitioners who have not opted out.

G. IEHP includes information from the quality improvement activities and Member complaints in the recredentialing decision-making process.

H. IEHP ensures all Primary Care Provider's (PCP) and Urgent Care's (UC) are informed that they must pass an on-site site review conducted by IEHP.

I. IEHP monitors its Provider network and ensures their Providers are not included in the Centers Medicare & Medicaid Services (CMS) Preclusions List.

J. IEHP must obtain appropriate documentation to expand or limit their practice parameters for

[1] National Committee for Quality Assurance (NCQA), 2024 Health Plan Standards and Guidelines, CR 3, Element A, Factors 1-6
[2] NCQA, 2024 HP Standards and Guidelines, CR 3, Element B, Factors 1-2
[3] NCQA, 2024 HP Standards and Guidelines, CR 3, Element C, Factors 1-6

IEHP review and approval.

K. IEHP must ensure and obtain the appropriate documentation for all Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) between the Mid-Level and Supervising Physician, provide them to IEHP, and ensure these documents are readily available upon request.

PURPOSE:

A. IEHP conducts timely verification of information to ensure that Practitioners have the legal authority and relevant training and experience to provide quality care.

B. Pencils are not an acceptable writing instrument for credentialing documentation.

C. Each file contains evidence of verification from a listed source and review by organization staff, defined by NCQA as "Appropriate documentation." IEHP documents verification in the credentialing files using any of the following methods or a combination:

   1. Credentialing documents signed (or initialed) and dated by the verifier.

   2. A checklist that includes for each verification:

      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. A checklist with a single signature and a date for all the verifications that has a statement confirming that the signatory verified all the credentials on that date and that includes for each verification.

      a. The source used.

      b. The report date, if applicable.

      c. If the checklist does not include checklist requirements listed above appropriate credentialing information must be included.

D. Using the Internet for Primary Source Verification (PSV): PSV on documents that are printed/processed from an internet site (e.g. BreEZe, National Practitioner Data Bank (NPDB) etc.), the data source date (as of date, release date) must be queried within the timeframe. The date of the query must be verified prior to the Credentialing Decision. If there is no data source date, the verifier must document the review date on the verification or the checklist. Verification must be from an NCQA approved and appropriate state-licensing agency.

E. PSV Documentation Methodology. The organization may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification.

DEFINITION:

A. Attestation: A signed statement by a practitioner confirming the validity, correctness and completeness of a credentialing application.[4]

B. Automated Verification - Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.

C. Board certified: A practitioner has satisfied the requirements/standards of a nationally recognized specialty board and received the board's specialist certification.[5]

D. CMS Preclusions List – List of prescribers and individuals or entities who fall within any of the following categories: (1) Are currently revoked from Medicare, are under an active re-enrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.

E. Death Master File (DMF) contains information about persons who had Social Security numbers and whose deaths were reported to the Social Security Administration from 1962 to the present; or persons who died before 1962, but whose Social Security accounts were still active in 1962.

F. National Practitioner Data Bank (NPBD): A federally mandated agency that is the repository of information about settled malpractice suits and adverse acts, sanctions or restrictions against the practice privileges of a physician.[6]

G. NPPES – CMS National Plan and Provider Enumeration System.

H. Primary source: The entity that originally conferred or issued a credential.[7]

I. Primary source verification: Verification of credentialing information directly from the entity (e.g. state licensing board) that conferred or issues the original credential.[8]

J. Types of Signatures:

1. Wet signature - created when a person physically marks a document.

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[4] National Committee for Quality Assurance (NCQA), 2024 Health Plan Standards and Guidelines, Glossary
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Ibid.

2. Faxed signature – the “copy” or “duplication” of your signature (no matter the method, system or medium you choose) is referred to as a facsimile signature.
3. Digital signature - type of electronic signature that encrypts documents with digital codes that particularly difficult to duplicate. It includes a certificate of authority, such as a Windows certificate, to ensure the validity of the signatory (the signature’s author and owner).
4. Electronic signature - symbols or other data in digital form attached to an electronically transmitted document as verification of the sender’s intent to sign the document.
5. Scanned signature - a written signature that’s been scanned into an electronic format, like a PDF.
6. Photocopied signature - a signature reproduced provided that the copy must be of an original document containing an original handwritten signature.
7. Signature stamp - is an implement personalized with an individual’s name for a quick and easy authorization of documents. These stamps can come customized with just a signature or can include both a signature and printed name.

K. Verbal Verification - Requires a dated, signed document naming the person at the primary source who verified the information, his/her title, the date and time of verification and include what was verified verbally.

L. Verification Time Limit (VTL): National Committee for Quality Assurance (NCQA) counts back from the decision date to the verification date to assess timeliness of verification.

1. For web queries, the data source data – e.g. release date or as of date is used to assess timeliness of verification.

M. Written Verification - Requires a letter or documented review of cumulative reports. IEHP must use the latest cumulative report, as well as periodic updates released by the primary source. The date on which the report was queried, and the volume used must be noted.

PROCEDURES:

A. IEHP verifies that the following are within the prescribed time limits:

1. A current and valid license to practice in the state they practice. (Verification Time Limit (VTL): 180 calendar days prior to Credentialing decision date).[9]
   a. Must be valid, current, and unencumbered at the time of committee and remain valid and current throughout the Practitioner’s participation with IEHP.
      1) Failure to maintain a valid and current license at all times, will result in an

[9] NCQA, 2024 HP Standards and Guidelines, CR 3, Element A, Factor 1

administrative termination of the Practitioner.

2. A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). All Practitioners who are qualified to write prescriptions, except non-prescribing Practitioners, must have a valid and current DEA certificate. IEHP must verify that the practitioner's DEA or CDS certificate is valid and current in each state where the practitioner provides care to members. The DEA or CDS certificate:[10]

   a. Must be valid and current at the time of committee and remain valid and current throughout the Practitioner's participation with IEHP), and registered with an address in State of California.

   b. Verification may be in the form of:

      1) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision;

   c. Any Practitioner with a DEA with an "EXEMPT" fee or status, the DEA is only valid at the exempting institution and any affiliate Hospital or Clinic rotations within the scope of training.

      1) IEHP must confirm the Practitioner's practice and exempting institutions relationship and document their findings in the Provider file, if the address on the DEA does not match the Providers practice location.

         - If a Practitioner is practicing outside of the exempting institution and/or its affiliates, the Practitioner must obtain a "Paid" status DEA.

   d. IEHP may credential a Practitioner whose DEA certificate is pending or pending a DEA with a California address. IEHP must obtain written documentation from the Provider of their arrangements with another Practitioner who will write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate. The prescribing Practitioner's name, DEA number, and NPI number will be documented in the Practitioner's file. See "Attachment/Prescribing Arrangements for DEA and CDS Eligible Practitioners" found on the IEHP website.[11]

      1) If a Practitioner does not have a DEA or CDS certificate, IEHP must obtain an explanation to why the Practitioner does not prescribe medications and to provide arrangements for the Practitioner's patients who need prescriptions requiring DEA certification.

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[10] NCQA, 2024 HP Standards and Guidelines, CR 3, Element A, Factor 2
[11] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

- For credentialing files where verification of DEA or CDS is before June 1, 2020, and a practitioner who is DEA- or CDS- eligible does not have a DEA or CDS certificate, NCQA accepts either the verification process required in the 2020 standards or the applicable prior year's standards, which state "If a qualified practitioner does not have a valid DEA or CDS certificate, the organization notes this in the credentialing file and arranges for another practitioner to fill prescriptions."
  - o Practitioner's statement: "I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management," example provided by NCQA.

e. If a Practitioner is practicing in Arizona, IEHP may credential a Practitioner whose DEA certificate is pending or pending a DEA with an Arizona address, by obtaining written documentation that the Practitioner with a valid DEA certificate will write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate. The prescribing Practitioner's name, DEA Number, and NPI number will be documented within the Practitioner's file.

f. The Credentialing Specialist reviews the Practitioner's Attestation Question regarding the Practitioner's DEA registration in any jurisdiction, for correctness, completeness and to ensure any applicable written explanation(s) are present in the file, date stamped 180 calendar days prior to Credentialing decision. If the practitioner chooses not to provide a written explanation or correct his/her attestation, it will be documented the Practitioners file and included for Credentialing Subcommittee review, as needed.

1) If the Practitioner is new to the IEHP Network, Credentialing will prepare the file as a Level II, files that do not meet IEHP's established thresholds, for review and discussion at the next scheduled Credentialing Subcommittee meeting.

2) If the practitioner is an existing Practitioner, the Credentialing Specialist will confirm if the practitioner was reviewed by the IEHP Credentialing Subcommittee previously, for area not met.

- If so, the Credentialing Specialist will document in the Practitioner's file when the Practitioner's adverse action was reviewed and discussed by the IEHP Credentialing Subcommittee.
- If not, the Credentialing Specialist will prepare the Practitioner's file as a Level II, for the next scheduled IEHP Credentialing Subcommittee meeting, for review and decision.

g. Failure to maintain an active DEA, may result in an administrative termination of the Practitioner.

3. Education and training (VTL: Prior to the Credentialing Decision) All Practitioners must have completed appropriate education and training for practice in the U.S. or a residency program recognized by NCQA, in the designated specialty or subspecialty they request to be credentialed and contracted. IEHP verifies the highest of the following three (3) levels of education and training obtained by the Practitioner, as appropriate i.e., Board Certification, Residency or Graduation from medical or professional school. An expired board certification may be used for verification of education/training.

   If the Practitioner is not board certified in the specialty or sub-specialty in which he/she is applying, there must be evidence of verification of residency and training in the sub-specialty (e.g., Fellowships in Cardiology, Rheumatology, Pediatric Endocrinology etc.), as relevant to the credentialed specialty. IEHP may use any of the following to verify education and training:[12]

   a. The primary source from the Medical School.

   b. The state licensing agency or specialty board or registry if the state agency and specialty board, respectively, perform primary source verification.

      1) IEHP obtains written confirmation of primary source verification from the primary source at least annually; or

      2) Provides a printed, dated screenshot of the state licensing agencies or specialty boards or registry website displaying the statement that it performs primary source verification of Practitioner education and training information; or

      3) Provides evidence of a state statute requiring the licensing agency, specialty board or registry to obtain verification of education and training directly from the institution.

      4) National Student Clearinghouse may be considered an agent of the medical or professional school if the school has a contract with the Clearinghouse to provide verification services.

         - Delegates must provide documentation that the specific school has a contract with the Clearinghouse, to ensure compliance with NCQA.

   c. Sealed transcripts if the organization provides evidence that it inspected the contents of the envelope and confirmed that Practitioner completed (graduated from) the appropriate training program.

[12] NCQA, 2024 HP Standards and Guidelines, CR 3, Element A, Factor 3

d. Below are acceptable sources for physicians (M.D., D.O.) to verify graduation from Medical School:

1) AMA Physician Master File;
2) American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File; and
3) Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

Below are acceptable sources for physicians (M.D., D.O.) to verify completion of residency training:

- AMA Physician Master File;
- Primary source from the institution where the postgraduate medical training was completed;
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File; and
- FCVS for closed residency programs.
    - NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.

e. Below is the acceptable sources for Nurse Practitioners (NPs) with a Behavioral Health (BH) designation to verify training in Psych/Mental Health.

1) The qualification must be recognized and verified through the BreEZe Online services website or directly with the licensing board via phone or mail.

f. Below is the acceptable source for Registered Dietician (R.D.s):

1) Commission on Dietetic Registration

g. If the Practitioner does not meet education and training requirements, set forth in this policy, the Credentialing Specialist will notify the Practitioner that they do not meet the training requirements therefore is subject to Credentialing Subcommittee review, with the possibility of denial due to not meeting education requirements. The Credentialing Specialist will:

1) Confirm the verified training and the required education and training requirements with the Practitioner.

2) Request for any additional training or justification the Practitioner would like to include for consideration, for the Credentialing Subcommittee for discussion.

3) The Credentialing Specialist reviews the Practitioners Attestation Question regarding internship, residency, fellowship, preceptorship, or any other clinical education program, for correctness, completeness and to ensure any applicable written explanation(s) are present in the file, date stamped one hundred-eighty (180) calendar days prior to Credentialing decision.

If the practitioner chooses not to provide a written explanation or correct his/her attestation, it will be documented in the Practitioners file and included for Credentialing Subcommittee review, as needed.

- If the Practitioner is new to the IEHP Network, Credentialing will prepare the file as a Level II, files that do not meet IEHP's established thresholds, for review and discussion at the next scheduled Credentialing Subcommittee meeting.
- If the Practitioner is an existing Practitioner, the Credentialing Specialist will confirm if the Practitioner's education and training was reviewed by the IEHP Credentialing Subcommittee previously.
  - If so, the Credentialing Specialist will document in the Practitioner's file when the Practitioner's education and training was reviewed and discussed by the IEHP Credentialing Subcommittee.
  - If not, the Credentialing Specialist will prepare the Practitioner's file as a Level II, for the next scheduled IEHP Credentialing Subcommittee meeting, for review and decision.

4. Board certification status, if applicable (VTL: 180 calendar days prior to Credentialing decision date).[13]

a. IEHP verifies current certification status of Practitioners who state that they are board certified.

1) IEHP must document the expiration date of the board certification within the credential file.

- If a Practitioner has a "lifetime" certification status and there is no expiration date for certification, the organization verifies that the board certification is current and documents the date of verification.

2) If board certification has expired, it may be used as verification of education and training.

[13] NCQA, 2024 HP Standards and Guidelines, CR 3, Element A, Factor 4

3) Verification must be performed through a letter directly from the board or an online query of the appropriate board as long as the board states that they verify education and training with primary sources, is an acceptable source by NCQA, and indicate that this information is correct. Below are the acceptable sources to verify board certification:

- For all Practitioner types
  - The primary source (appropriate specialty board); or
  - The state licensing agency if the primary source verifies board certification.
- For Physicians (M.D., D.O.)
  - ABMS or its Member boards, or an official ABMS Display Agency, where a dated certificate of primary-source authenticity has been provided.
    - The ABMS "Is your Doctor Board Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.
  - AMA Physician Master File.
  - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
  - Boards in the United States that are not Members of the ABMS or AOA if the organization documents within its policies and procedures which specialties it accepts and obtains annual written confirmation from the boards that the boards performs primary source verification of completion of education and training.
- For other health care professionals
  - Registry that performs primary source verification of board that the registry performs primary source verification of board certification status.
- For Podiatrists (D.P.M.)
  - American Board of Foot and Ankle Surgery (formerly The American Board of Podiatric Surgery).
  - The American Board of Podiatric Medicine.
  - American Board of Multiple Specialties in Podiatry.
- For Nurse Practitioners (N.P.).

- American Association of Nurse Practitioners (AANP).
- American Nurses Credentialing Center (ANCC).
- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties (NCC).
- Pediatric Nursing Certification Board (PNCB).
- American Association of Critical-Care Nurses (AACN).

- For Physician Assistants (P.A.-C).
  - National Commission of Certification of P.A.'s (NCCPA).
- For Certified Nurse Midwives (C.N.M.).
  - American Midwifery Certification Board (AMCB).
- For Psychologists (Ph.D., Psy.D.).
  - American Board of Professional Psychology (ABPP).

4) Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification to members.

5) If IEHP is unable to verify the board certification, the Practitioner is notified and given the right to review and correct erroneous information. In addition, the Providers attestation may require further review and correction.

b. The Credentialing Specialist reviews the Practitioner's Attestation Question regarding any changes in their board certification (other than changing from eligible to certified, for correctness, completeness and to ensure any applicable written explanation(s) are present in the practitioner's file, date stamped 180 calendar days prior to Credentialing decision.

   If the practitioner chooses not to provide a response or correct his/her attestation, it will be documented in the practitioner's file and presented to the Credentialing Subcommittee for review, as needed.

5. Work history (VTL: 180 calendar days prior to Credentialing decision date) IEHP must obtain a minimum of the most recent five (5) years of work history as a health professional through the application, Curriculum Vitae (CV) or work history summary/attachment, providing it has adequate information.[14]

   a. IEHP must document review of work history on the application, CV, or checklist that includes the signature or initials of staff who reviewed work history and the date of review. Documentation of work history must meet the following:

[14] NCQA, 2024 HP Standards and Guidelines, CR 3, Element A, Factor 5

1) Must include the beginning and ending month and year for each work experience.

2) The month and year do not need to be provided if the Practitioner has had continuous employment at the same site for five (5) years or more. The year-to-year documentation at that site meets the intent.

3) If the Practitioner completed education and went to straight into practice, this will be counted as continuous work history.

4) If the Practitioner has practiced fewer than five (5) years from the date of credentialing. The work history starts at the time of initial licensure.

5) IEHP must review for any gaps in work history. If a work history gap of six (6) months to one (1) year is identified, IEHP must obtain an explanation from the Practitioner. Verification may be obtained verbally or in writing for gaps of six (6) months to one (1) year.

6) Any gap in work history that exceeds one (1) year must be clarified in writing from the Practitioner. The explanation of the gap needs to be sufficient to ascertain that the gap did not occur as a result of adverse and/or reportable situations, occurrences or activities. See "Attachment/Work History Form Past Five (5) years' request" found on the IEHP website.[15]

6. Malpractice History - A history of professional liability claims that resulted in settlement or judgment paid on behalf of the Practitioner.[16] (VTL: 180 calendar days prior to Credentialing decision date)

   a. IEHP will obtain confirmation of the past seven (7) years of malpractice settlements through one of the following sources:

      - Malpractice Insurance Carrier
      - National Practitioner Data Bank Query
      - Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within 180 calendar days of the credentialing decision. Evidence must be documented in the file or on checklist.

   b. The Credentialing Specialist will review the Practitioner's malpractice claim history by querying National Practitioner Data Bank or confirmation from their malpractice carrier. A minimum the seven (7) years claim history must be reviewed for initial credentialing and all claim history activities after the previous credentialing decision date, will be reviewed for recredentialing. The seven (7) year

[15] https://www.providerservices.iehp.org/en/resources/provider-resources/forms
[16] NCQA, 2024 HP Standards and Guidelines, CR 3, Element A, Factor 6

period may include residency and fellowship years. IEHP is not required to obtain confirmation from the carrier for Practitioners who had a hospital insurance policy during a residency and fellowship.

For Practitioners with a history of malpractice suits or decision, the following criteria warrants Credentialing Subcommittee Review of the history:

1) Number of claims – any claims within the prior seven (7) years
2) Results of cases – any settlements within the prior seven (7) years.
    - o Settlements with a minimum payout of $30,000.00 or more
    - o Settlements resulting in major permanent injury or death
3) Trends in cases – Practitioners with multiple malpractice claims in a similar area (e.g. missed diagnosis, negative surgical outcomes, etc.,)

c. The Credentialing Specialist reviews the practitioners Attestation Question regarding Malpractice history for correctness, completeness and to ensure any applicable written explanation(s) are present in the file, date stamped one hundred-eighty (180) calenda days prior to Credentialing decision.

   If the practitioner chooses not to provide a written explanation or correct his/her attestation, it will be documented in the practitioners file and included for Credentialing Subcommittee review, as needed.

   1) If the practitioner is new to the IEHP Network, Credentialing will prepare the file as a Level II, files that do not meet IEHP's established thresholds, for review and discussion at the next scheduled Credentialing Subcommittee meeting.
   2) If the practitioner is an existing Practitioner, the Credentialing Specialist will confirm if the adverse history was reviewed by the IEHP Credentialing Subcommittee previously.
       - If so, the Credentialing Specialist will document in the Practitioner's file when the Practitioner's adverse action was reviewed and discussed by the IEHP Credentialing Subcommittee.
       - If not, the Credentialing Specialist will prepare the Practitioner's file as a Level II, for the next scheduled IEHP Credentialing Subcommittee meeting, for review and decision.

B. Medicare and Medicaid sanctions. (VTL: 180 calendar days prior to Credentialing decision). IEHP uses the NPDB, to review for Medicare and Medicaid sanctions.[17]

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[17] NCQA, 2024 HP Standards and Guidelines, CR 3, Element B, Factor 2

1. If a Practitioner is not identified on any reports, the NPDB findings are included in the Provider file and date stamped by the reviewer, to ensure that findings were reviewed within the 180 calendar-day timeframe.

   - If a Practitioner is identified on any reports with an action, the Credentialing Specialist obtains and reviews the action(s) identified. Verification sources for Medicare and Medicaid Sanctions, may include, but are not limited to:

     1) State Medicaid Agency or intermediary
     2) Medicare intermediary
     3) List of Excluded Individuals and Entities (maintained by OIG and available over the internet).
     4) Medicare Exclusions Database.
     5) Federal Employees Health Benefit Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General
     6) AMA Physician Master File
     7) Federation of State Medical Boards (FSMB).
     8) NPDB

        - Continuous Query (formerly Proactive Disclosure Service (PDS)). Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within one hundred-eighty (180) calendar days of the credentialing decision and show evidence the practitioner was enrolled in the alert services at the time of the cited report. Evidence must be documented in the file or on checklist.

2. The Credentialing Specialist reviews the Practitioner's Attestation Question regarding the restriction on licensure or limitations on scope of practice, for correctness, completeness and to ensure any applicable written explanation(s) are present in the file, date stamped 180 calendar days prior to Credentialing decision.

   If the practitioner chooses not to provide a response or correct his/her attestation, it will be documented in the practitioner's file and included for Credentialing Subcommittee review, as needed.

   a. If the practitioner is new to the IEHP Network, Credentialing will prepare the file as a Level II, files that do not meet IEHP's established thresholds, for review and discussion at the next scheduled Credentialing Subcommittee meeting.

b. If the practitioner is an existing Practitioner, the Credentialing Specialist will confirm if the adverse history was reviewed by the IEHP Credentialing Subcommittee previously.

1) If the Practitioner is new to the IEHP network, Credentialing will notify the Practitioner that their credentialing is closed due to IEHP not allowing Practitioners identified on the HHS-OIG Exclusions List and/or Medi-Cal Suspended & Ineligible List to participate in the IEHP network.

2) If the Practitioner is an existing Provider, the Credentialing Specialist will send the Provider a notification to terminate due to IEHP not allowing Practitioners identified on the HHS-OIG Exclusions List and/or Medi-Cal Suspended & Ineligible List to participate in the IEHP network.

- The Credentialing Specialist will prepare these documents for the Peer Review Subcommittee review and discussion for Providers identified through IEHPs ongoing monitoring of sanctions process for the HHS-OIG Exclusions List and/or Medi-Cal Suspended & Ineligible List review.

C. IEHP applications for credentialing and recredentialing must include the following:[18]

1. Reasons for inability to perform the essential functions of the position.

2. Lack of present illegal drug use.

   a. IEHPs application may use alternative language or general language that may not be exclusive to present use or only illegal substances.

3. History of loss of license and felony convictions.

   a. At initial credentialing, the Practitioner must attest to any loss of license or felony convictions since their initial licensure.

   b. At recredentialing, the Practitioners may attest to any loss of licensure or felony convictions since their last credentialing cycle.

4. History of loss or limitation of privileges or disciplinary actions.

   a. At initial credentialing, the Practitioner must attest to any loss or limitation of privileges since their initial licensure.

   b. At recredentialing, the Practitioners may attest to any loss or limitation of privileges since their last credentialing cycle.

5. Current malpractice insurance coverage. IEHP requires that a copy of the insurance face sheet or Certificate of Insurance (COI) or written verification from the insurance carrier directly be obtained in conjunction of collecting information on the application.

[18] NCQA, 2024 HP Standards and Guidelines, CR 3, Element C, Factors 1-6

(VTL: Must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee date and remain valid and current throughout the Practitioner's participation with IEHP.) [19]

a. All Practitioners must have current and adequate malpractice insurance coverage that is current and:

1) Meets IEHP's standard of $1 million/$3 million, as well as IEHPs standards. Professional Liability Insurance coverage and amounts of coverage must be verified with the insurance carrier or through the Practitioner via a copy of the policy and the signed attestation completed by the Practitioner.

   - The copy of the Practitioner's certificate must be initialed, and date stamped to show receipt prior to the credentialing decision and to show it was effective at the time of the credentialing decision.

2) Must include coverage for the specialty the Practitioner is being credentialed for and for all locations the Practitioner will be treating IEHP patients.

   - If the specialty coverage and/or the locations are not identified on the malpractice insurance certificate, the coverage must be verified with the insurance carrier and documented in the Practitioner's file.

3) For Practitioners with federal tort coverage, (e.g. Health Resources & Services Administration (HRSA)), the Practitioner must submit:

   - A copy of the face sheet, federal tort letter, or employer professional liability policy as an addendum to the application. The face sheet or federal tort letter must include the:
     - o Insurance effective and expiration dates (future effective dates are acceptable)
   - A roster that lists all practitioners covered under the federal tort coverage.

4) There must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee approval date.

   - Failure to maintain current malpractice coverage for the specialty the Provider is being credentialed for and for all locations the Practitioner will be treating IEHP patients, will result in an administrative termination of the Practitioner.

6. Current and signed attestation confirm the correctness and completeness of the application. Attestation must be: [20]

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[19] NCQA, 2024 HP Standards and Guidelines, CR 3, Element C, Factor 5

[20] NCQA, 2024 HP Standards and Guidelines, CR 3, Element C, Factor 6

a. Signed and dated within the timeframe and must include all elements to be compliant.

 1) The 180 calendar day timeframe is based on the date the Practitioner signed the application.

 - If the signature or attestation exceeds 180 calendar days the Practitioner must only attest that the information on the application remains correct and complete, be re-signing and re-dating the attestation. Practitioner does not need to complete another application.

b. Signed with a full signature, if the attestation needs to be re-signed by the Practitioner; dating and initialing is not acceptable.

 1) Faxed, digital, electronic, scanned or photocopies signatures are accepted. Signature stamps are not acceptable. (See Definitions, "Types of Signatures")

 - If the full signature is not acceptable, the Credentialing Specialist will reach out to the practitioner to re-sign and date the attestation.

c. If the attestation is not signed and/or dated, within the appropriate time frame, all application elements are non-compliant (except current malpractice coverage since IEHP requires a face sheet is obtained).

 1) If a question is answered and does not correlate with the practitioner's file, IEHP is responsible for notifying the Practitioner of the discrepancy and to have them re-review the question.

 - If the Practitioner chooses to change their response, the Practitioner must initial and date next to the change.

 o If the Provider chooses not to change their response, the IEHP will document their attempt to have the Practitioner review their response and that the Provider chose not to change their response and include their documentation in the practitioner and for Credentialing Subcommittee review, as needed.

d. When reviewing the Council for Affordable Quality Healthcare (CAQH) application, NCQA accepts the last attestation date generated by the CAQH system as the date when the practitioner signed and dated the application to attest to its completeness and correctness.

D. IEHP must verify that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital. Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting

privileges, must be:[21]

1. Confirmed with the Hospital, in writing, via approved website or verbally, and must include:
    a. The date of appointment.
    b. Scope of privileges, restrictions (if any i.e., restricted, unrestricted) and recommendations.
    c. Confirmation Provider has admitting privileges in the specialty the Provider is credentialed and contracted for.
    d. If a published Hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the Practitioner is in "good standing."
    e. Practitioner must meet the requirements for Hospital Privileges as required by IEHP. See Policy 2B, "Hospital Privileges", i.e., if an admitter or hospitalist arrangement is used, a written agreement that meets IEHP admitter requirements, confirming coverage for all inpatient work covering the entire age range of the Practitioner must be included in the Practitioner's credentialing file.
        1) These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider application, admitter report or attachment.
        2) If the Provider utilizes an admitter or hospitalist arrangement, IEHP will document these arrangements in the Provider file, to include when the Provider was notified. Documentation must include:
            - The date the Practitioner was notified.
            - Name(s) of the admitter and/or hospitalist, admitting on behalf of the Provider.
            - Name(s) of the Hospital, affiliated with the inpatient coverage arrangements.
2. If the Practitioner does not have clinical privileges, the IEHP must have a written statement delineating the inpatient coverage arrangement documented in the Providers file. See Policy 2B, "Hospital Privileges". For Specialties that are required to have clinical privileges or admitting privileges at a Participating hospital, See

[21] Title 28, California Code of Regulations § 1300.51 (d)(H)(iii)

"Attachment/Hospital Admitting Privileges Reference by Specialty" found on the IEHP website.[22]

3. Allied Health Professionals (Non-physicians i.e. Chiropractors, Optometrists) will not have hospital privileges and documentation in the file is not required for these types of Practitioners. See "Attachment/Hospital Admitting Privileges Reference by Specialty" found on the IHEP website.

4. Advanced Practice Practitioners (Physician Assistants (PA), Nurse Practitioners (NP), Certified Nurse Midwives (CNM)) may not have hospital privileges. However, if the Advanced Practice Practitioners provides IEHP their hospital privileges, IEHP will be responsible for verifying if those privileges are active and ensure they are in good standing.

5. Specialists (MDs, DOs and DPMs) may not have hospital privileges, documentation must be noted in the file as to the reason for not having privileges. (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).

   a. These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider application, admitter report or attachment.

      1) These arrangements are subject to IEHP Subcommittee review and approval.

      2) IEHP may request for inpatient coverage arrangements for the Practitioner, if IEHP identified that specialty as a specialty that requires hospital admitting arrangements.

6. Certified Nurse Midwives (CNMs) may provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services only after they are fully credentialed and approved by the same Provider network. CNM Providers must meet the following criteria:

   a. In lieu of having full hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e., low-risk, cesarean section etc.), must be available for consultations, as needed.

      1) The Agreement must include back-up physician's full delivery privileges at IEHP network hospital, in the same network as the CNM Provider.

      2) The OB Provider must be credentialed and contracted within the same practice and network.

7. Family Practice including outpatient Obstetrics (OB) services (FP-1) Must provide a copy of a signed agreement that states:

[22] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

a. Member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.

1) The OB must be contracted and credentialed by the same network as the Family Practice Provider and must hold admitting privileges to the IEHP hospital linked to IEHPs Direct Network.

8. Family Practice including full Obstetrics services and delivery (FP-2). Providers that fulfill these requirements may be referred to and see OB/Gyn Members within IEHPs Direct Network, and must have:

a. Full delivery privileges at an IEHP network hospital; and

1) Provide a written agreement for an available OB back up Provider is required. The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP hospital linked with the Family Practice Provider; and

2) Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e., low-risk, cesarean section, etc.).

9. Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a PCP only, will provide outpatient well woman services only with no hospital or surgical privileges, must provide the following information for consideration:

a. In lieu of obtaining or maintaining full hospital delivery privileges, the Practitioners must provide a written agreement with OB that includes:

1) A protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e., low-risk, cesarean section etc.).

2) Must be available for consultations, as needed and that the OB will provide prenatal care after 28 weeks gestation including delivery.

3) The agreement must include back-up physician's full delivery privileges at IEHP network hospital, in the same network as the non-admitting OB Provider.

- The OB Provider must be credentialed and contracted within the same network.

10. Licensed Midwife (LM) practitioners are required to have a backup Licensed Physician, engaged in active clinical obstetrical practice and with whom the Licensed Midwife consults when there are significant deviations from the normal, in either mother or infant. Therefore, LMs must complete a Licensed Midwife Attestation: Plan for Consultation, Emergency Transfer, & Transport.See "Attachment/Licensed Midwife

Attestation" found on the IEHP website[23] required for all Licensed Midwife Practitioners.

a. IEHP requires the backup Licensed Physician is an active Obstetrics/Gynecology Practitioner within the IEHP network.

11. Urgent Care Providers are not required to maintain hospital privileges if they are exclusively practicing at an Urgent Care.[24]

E. IEHP verifies that Practitioners meet all screening and enrollment requirements to include, but not limited to: enrollment in the Medi-Cal Program, Federal and State Database Checks for Social Security Administration's Death Master File (SSADMF), National Plan and Provider Enumerated System (NPPES), List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS' Medicare Exclusion Database (MED), DHCS' Suspended and Ineligible List (S&I), Restricted Provider Database (RPD). (VTL: 180 calendar days prior to Credentialing decision).

1. IEHP must ensure all Practitioners submitted to IEHP for participation, for the Medi-Cal line of business, are enrolled in the Medi-Cal Program, to ensure compliance with Title 42, California Code of Regulations § 438.602(b) to extend Provider screening and enrollment requirements to all Managed Care Plan's contracted Providers. The intent of this requirement is to reduce the incidence of fraud and abuse by ensuring that all Providers are individually identified and screened for licensure and certification.

   a. All Practitioners requesting for participation in the IEHP network, IEHP's Contracts Department must confirm the Provider is enrolled or in-process of enrolling in the Medi-Cal program state level enrollment through DHCS, prior to the Provider beginning the credentialing process.

      1) Submissions without proof of Medi-Cal enrollment will be ceased and not processed by IEHP.

      2) IEHP uses the California Health & Human Services Agency's portal to confirm the Providers enrollment status with the Medi-Cal Program through DHCS.

         - The portal can be accessed via http://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx

         - The portal is maintained by the Provider Enrollment Division (PED) and is updated monthly.

   b. IEHPs Provider Network Department will monitor all Medi-Cal enrollment activities, thereafter.

[23] https://www.providerservices.iehp.org/en/resources/provider-resources/forms
[24] California Code of Regulations (CCR) § 1300.51(d)(H)(iii)

2. To verify Federal State Database checks, the during the credentialing or recredentialing process, the Credentialing Specialist or designee will submit the Provider to OIG Compliance Now for screening.
   a. If a practitioner is not identified on any reports, the OIG Compliance Now Screening Report will be included in the practitioner's file, date stamped by the reviewer, to ensure compliance of the 180 calendar day timeframe.
3. If a practitioner is identified on a report, the Credentialing Specialist obtain and review the action(s) identified from the verification sources listed below:
   a. Social Security Administration's Death Master File (SSADMF). IEHP must obtain and provide IEHP with Social Security Numbers for all new and existing Practitioners participating Providers, to ensure all Practitioners are included in IEHP's screening of the SSADMF.
      1) All Practitioner applications for participation in the IEHP network, must include the Providers full Social Security Number (SSN).
         - Submissions without SSN will be ceased and not processed by IEHP.
      2) Existing Practitioners without SSNs will be notified. Practitioners are required to provide all missing SSNs to IEHP.
         - Practitioners who do not provide the requested information will be placed on a Corrective Action Plan (CAP), until all missing SSNs are submitted.
      3) If a Practitioner confirms that his/her SSN is correctly stated on the SSADMF, but is clearly not deceased, IEHP must request for:
         - A copy of the Social Security Card;
         - A photo ID;
         - A signed attestation from the Practitioner confirming they are who they say they are; and
         - The Provider to contact the SSADMF to correct the issue.
      4) If a Practitioners' SSN is correctly stated but the name and Date of Birth (DOB) does not, the IEHP must request for:
         - A copy of the Social Security Card;
         - A photo ID;
         - A signed attestation from the Practitioner confirming they are who they say they are; and
         - The Provider to contact the SSADMF to correct the issue.

5) This list will be reviewed monthly through the Ongoing Monitoring of Sanctions review, outside of the credentialing and recredentialing cycle.

b. National Plan and Provider Enumerated System (NPPES). IEHP must ensure all Practitioners hold and maintain a valid and active National Provider Identifier (NPI) Practitioners individual NPI number, and the information provided must be:

1) Verified through the NPPES website.

2) Active while in the IEHP network.

3) Current at all times (i.e. Primary Practice Address must be registered to an address within California).

   - Telehealth Providers are not required to have an NPI registered to an address within California.

4) Practitioners that have a group NPI number may submit that information to IEHP, in addition to the required individual NPI number.

c. List of Excluded Individuals/Entities (LEIE) maintained by the Office of Inspector General must be the verification source for Medicare sanctions, to ensure compliance with CMS.

1) If the practitioner is new to the IEHP Network, the Credentialing Specialist will notify the practitioner they were identified on the LEIE list, therefore not eligible to participate in the IEHP Network.

2) If an existing practitioner is identified, the Practitioner must be administratively terminated for all lines of business without appeal rights due to IEHP prohibiting employment of contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation.[25]

   - Members will be reassigned to new Practitioners.
   - The Provider is presented to Peer Review Subcommittee for further review and discussion as an administrative termination. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance Department findings of any additional prior quality of care issues and Member complaints regarding the Provider.[26]

d. System for Award Management (SAM). The OIG LEIE includes all healthcare providers and suppliers that are excluded from participation in federal health care programs, including those health care providers and suppliers that might also be on

[25] Medicare Managed Care Manual, "Relationships with Providers", Chapter 6 § 60.2
[26] NCQA, 2024 Health Plan Standards and Guidelines, CR 5, Element A, Factor 5

the SAM (previously Excluded Parties List System (EPLS)). In addition to health care providers (that are also included on the OIG LEIE) the EPLS includes non-health care contracts[27] which are out of scope for the practitioners undergoing the Credentialing process.

e. CMS' Medicare Exclusion Database (MED) is the source that is used to populate the LEIE list. IEHP will use the LEIE to verify if practitioners are identified on the MED.

f. DHCS' Suspended and Ineligible List (S&I) the verification source for Medicaid sanctions, to ensure compliance with DHCS.[28]

1) If the practitioner is new to the IEHP Network, the Credentialing Specialist will notify the practitioner they were identified on the Medi-Cal Suspended and Ineligible List, therefore not eligible to participate in the IEHP Network.

2) If an existing practitioner is identified, the Practitioner must be administratively terminated for all lines of business without appeal rights.

- Members will be reassigned to new Practitioners.
- The Suspended Practitioner is presented for further review and discussion at the Peer Review Subcommittee as an administrative termination. Peer Review Subcommittee discussion includes Quality Management (QM) and Grievance and Appeals Department findings of any additional prior quality of care issues and Member complaints regarding the Provider.[29]

g. Restricted Provider Database (RPD). The Credentialing designee will obtain the Restricted Provider Database report on a monthly basis, outside of the credentialing and recredentialing process.

1) Providers identified on the RPD are presented to Peer Review Subcommittee for review and discussion. The following actions are required to ensure compliance with DHCS guidelines:

- Payment Suspension: Providers are placed under a payment suspension while under investigation based upon a credible allegation of fraud.
  - o IEHP may continue contractual relationship; however, reimbursements for Medi-Cal covered services are withheld; or
    - ▪ If IEHP chooses to continue the contractual relationship with providers who are placed on payment suspensions, IEHP must

[27] Medicare Managed Care Manual, Chapter 21 "Compliance Program Guidelines and Prescription Drugs Benefit Manual", Section 50.6.8

allow out-of-network access to members currently assigned to the provider by approving the request.

- IEHP may choose to terminate the contract by submitting appropriate documentation as outlined in APL 21-003.

2) Temporary Suspension: Providers placed on a temporary suspension while under investigation for fraud or abuse, or enrollment violations.

- IEHP must terminate the contract and submit appropriate documentation as outlined on APL 21-003.

4. The Credentialing Specialist will review the report finding along with the Practitioners Application and Attestation for correctness, completeness and ensure any applicable written explanations are present in the practitioners file and for Credentialing Subcommittee review, as needed.

F. IEHP monitors its credentialing files to ensure that it only contracts with Practitioners who have not opted out. IEHP uses OIG Compliance Now, a sanction screening service to monitor its Provider network to ensure their Providers have not opted out of Medicare.

1. During the credentialing or recredentialing process, the Credentialing Specialist or designee will submit the Provider to OIG Compliance Now for screening. The results are reviewed by the Credentialing Specialists and included in the Provider file.

a. The document will identify when the Provider was screened, and if the Provider was identified on any of the ongoing monitoring of sanctions review required by IEHP, to include but is not limited to the Medicare Opt-Out Report.

1) If a Practitioner is not identified on any reports, the OIG Compliance Now findings are included in the Provider file and date stamped by the reviewer, to ensure that findings were reviewed within the 180 calendar-day timeframe.

2) If a Practitioner is identified on the report for Medicare Opt-out, the Credentialing Specialist reviews and obtains the information via hard copies, electronic from https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollemtn/opt-out-affidavits. The OIG compliance Now findings are included in the Provider file and date stamped by the review, to ensure the findings were reviewed within 180 calendar-days of the IEHP Subcommittee decision.

- The Credentialing Specialist will include these findings in the Provider's file and prepare these documents for Credentialing Subcommittee review and discussion.
- Certain healthcare Provider categories cannot opt-out of Medicare. These include Chiropractors, physical therapists and occupational therapists in independent practice.

- Behavioral Health (BH) Practitioners identified on the Medicare Opt Out Report are not allowed to participate in the IEHP network for any lines of business due to contract limitations and system design, therefore, are administratively terminated for all lines of business.
  - o All Members will be reassigned to new Practitioners.
- The Credentialing designee includes these findings in the Provider's file and prepares these documents for further review and discussion in the Peer Review Subcommittee as an administrative termination. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance and Appeals Department findings of any additional prior quality of care issues and Member complaints regarding the Provider.
- Practitioners outside of BH identified on the Medicare Opt Out Report are not allowed to participate in the IEHP network for Medicare lines of business.[30]
  - o All Medicare Members are reassigned to new Practitioners.[31]

G. IEHP includes information from the quality improvement activities and Member complaints in the recredentialing decision-making process. (Verification Time Limit: Last recredentialing cycle to present).

1. Quality activities include, but are not limited to:
   a. Adverse events
   b. Medical record review
   c. Data from Quality Improvement Activities
   d. Performance Information, may include but is not limited to:
      1) Utilization Management Data
      2) Enrollee satisfaction surveys
      3) Other activities of the organization
   e. Not all quality activities need to be present
2. Grievance/complaints[32]

H. All PCP and UC are informed that they must pass an on-site site review conducted by IEHP. All PCPs and UCs must pass an IEHP facility on-site review at the time of initials

[30] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Section 60.3
[31] Medicare Managed Care Manual, "Relationships with Providers", Section 60.2
[32] Medicare Managed Care Manual, "Relationships with Providers", Section 60.3

credentialing and every three (3) years thereafter, for Medi-Cal Programs.[33]

I. IEHP uses OIG Compliance Now, a sanction screening service to monitor its Provider network and ensures their Providers are not included in the Centers Medicare & Medicaid Services (CMS) Preclusions List.

1. During the credentialing or recredentialing process, the Credentialing Specialist or designee will submit the Provider to OIG Compliance Now for screening. The results are reviewed by the Credentialing Specialists and included in the Provider file.

   a. The document will identify when the Provider was screened, and if the Provider was identified on any of the ongoing monitoring of sanctions review required by IEHP, to include but is not limited to the Centers of Medicare and Medicaid Services (CMS) Preclusions List.

      1) If a Practitioner is not identified on any reports, the OIG Compliance Now findings are included in the Provider file and date stamped by the reviewer, to ensure that findings were reviewed within the 180 calendar-day timeframe.

      2) If a Practitioner is identified on the report for the (CMS) Preclusions List, the Credentialing Specialist reviews the information the (CMS) Preclusions List provided by IEHPs Compliance Department. The OIG compliance Now findings are included in the Provider file and date stamped by the review, to ensure the findings were reviewed within 180 calendar-days of the IEHP Subcommittee decision.

         - If the Practitioner is new to the IEHP network, Credentialing will notify the Practitioner that their credentialing is closed due to IEHP not allowing Practitioners identified on the Centers of Medicaid and Medicaid Services (CMS) Preclusions List to participate in the IEHP network.
         - If the Practitioner is an existing Provider, the Credentialing Specialist will send the Provider a notification to terminate due to IEHP not allowing Practitioners identified on the CMS Preclusions List to participate in the IEHP network.
           - The Credentialing Specialist will include these findings in the Provider's file and prepare these documents for the Peer Review Subcommittee review and discussion for Providers identified through IEHPs ongoing monitoring of sanctions process for the CMS Preclusions List.[34]

J. IEHP must obtain appropriate documentation to expand or limit their practice parameters for IEHP review and approval. Practitioners may practice outside of scope with approval from

[33] Medicare Managed Care Manual, "Relationships with Providers", Section 60.3
[34] 2019 Medicare Program Final Rule, "Preclusions List Requirements"

IEHP, by undergoing the Provide Privilege Adjustment process in this policy.

1. Provider Privilege Adjustment. Practitioners who request a change in practice parameters (i.e. reduction of Member age range, additional specialty) must:
   a. Submit a detailed explanation or complete a Provider Privilege Adjustment Request Form (See Attached, "Provider Privilege Adjustment Request Form") that includes the following, for review and consideration:
      1) Practice site demographics;
      2) Practical experience relating to the request (years in clinical practice, direct care experience with the relevant membership, etc.);
      3) Practice capacity; and
      4) Relevant training in the specialty, if applicable (e.g. Continuing Medical Education (CME), Post-graduate training, etc.)
2. PCPs age range expansions, the Credentialing Specialist will confirm if the practitioner submitted and meets the following requirements.
   a. For PCP's who have Adult age ranges assigned and would like to expand their age range to reflect all ages, will be processed with a secondary specialty of General Practice, must provide the following information for review and consideration:
      1) Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. See "Attachment/IEHP Addendum E" found on the IEHP website[35];
      2) Provide evidence of 25 CME units in Pediatric Primary Care completed within the last three (3) years;
      3) PCPs that have Members assigned ages (0-14) must enroll in the Vaccines for Children (VFC) Program;
      4) Malpractice coverage for the age range Provider is requesting for that covers all locations the Provider will be treating IEHP Members; and
      5) Pass a Medical Record Chart Audit for Pediatric Members
   b. For PCP's who have Pediatric age ranges assigned and would like to expand their age range to reflect all ages, will be processed with a secondary specialty of General Practice, must provide the following information for review and consideration:

[35] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

1) Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. See "Attachment/IEHP Addendum E" found on the IEHP website[36];

2) Provide evidence of twenty-five (25) CME units in Adult Primary Care completed within the last three (3) years;

3) PCPs that have Members assigned ages (0-14) must enroll in the Vaccines for Children (VFC) Program;

4) Malpractice coverage for the age range Provider is requesting for that covers all locations the Provider will be treating IEHP Members; and

5) Pass a Medical Record Chart Audit for Adult Members

c. After Practitioner submits his/her written request, the Credentialing Specialist will confirm the practitioner is compliant with the criteria set forth in Section 2, "Credentialing Standards – Credentialing Policies" and then forward it to the IEHP Medical Director for review and approval.

K. Practitioner offices who employ Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) must ensure written arrangements are in place between the Advanced Practice Practitioner and the practice where they treat IEHP members. These documents must be readily available to IEHP upon request.

1. IEHP requires all Advanced Practice Practitioners to practice at the same site as their Supervising Physician. The following written arrangements must be provided to IEHP upon request for:

a. Physician Assistants must provide one (1) on the following:

1) Delegation of Services Agreement and Supervising Physician Form. See "Attachment/Delegation of Services Agreement and Supervising Physician Form" found on the IEHP website.[37,38] This agreement must:

- Define specific services identified in practice protocols or specifically authorized by the supervising Physician., and
- Both the Physician and PA must attest to, date and sign the document.
- An original or copy must be readily accessible at all practice sites in which the PA works;

[36] Ibid.
[37] California Code of Regulations (CCR) § 1399.540(b)
[38] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

2) Practice Agreement, effective January 1, 2020,[39] the writing, developed through collaboration among one or more physicians and surgeons and one or more physicians' assistants, that defines the medical services the physician assistant is authorized to perform pursuant to Section 3502[40] and that grants approval for physicians and surgeons on the staff of an organized health care system to supervise one or more physician assistants in the organized health care system. Any reference to a Delegation of Services Agreement relating to physician assistants in any other law shall have the same meaning as a practice agreement. The Practice Agreement must include provisions that address the following:

- A practice agreement shall include provisions that address the following:[41]
  - The types of medical services a physician assistant is authorized to perform.
  - Policies and procedures to ensure adequate supervision of the physician assistant, including, but not limited to, appropriate communication, availability, consultations, and referrals between a physician and surgeon and the physician assistant in the provision of medical services.
  - The methods for the continuing evaluation of the competency and qualifications of the physician assistant.
  - The furnishing or ordering of drugs or devices by a physician assistant pursuant to Section 3502.1.
  - Any additional provisions agreed to by the physician assistant and physician and surgeon.
- A practice agreement shall be signed by both of the following:
  - The physician assistant.
  - One or more physicians and surgeons or a physician and surgeon who is authorized to approve the practice agreement on behalf of the staff of the physicians and surgeons on the staff of an organized health care system.
- A delegation of services agreement in effect prior to January 1, 2020, shall be deemed to meet the requirements of this subdivision.

[39] Senate Bill 697
[40] Business & Professions Code (BPC) § 3502
[41] Business & Professions Code (BPC) § 3502.3

- A practice agreement may designate a PA as an agent of a supervising physician and surgeon.
- Nothing in this section shall be construed to require approval of a practice agreement by the board.
  - Notwithstanding any other law, in addition to any other practices that meet the general criteria set forth in this chapter or regulations adopted by the board or the Medical Board of California, a practice agreement may authorize a PA to do any of the following:
    - Order durable medical equipment, subject to any limitations set forth in Section 3502 or the practice agreement. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.
    - For individuals receiving home health services or personal care services, after consultation with a supervising physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.
    - After performance of a physical examination by the PA under the supervision of a physician and surgeon consistent with this chapter, certify disability pursuant to Section 2708 of the Unemployment Insurance Code. The Employment Development Department shall implement this paragraph on or before January 1, 2017.

b. Nurse Practitioners and Nurse Midwives are required to have Standardized Procedures. Standardized Procedures must be on-site site specific and:

1) Reference textbooks and other written sources to meet the requirements of Title 16, CCR § 1474 (3), must include:
   - Book (specify edition) or article title, page numbers and sections.
2) NP and/or NM must be practicing at a site assigned to their supervising Physician; and
3) Standardized Procedures must be signed by both the Practitioner and the supervising Physician, initially and annually; and provided to IEHP, upon request. At minimum, the documents must include:
   - Table of Contents of the Standardized Procedures used, between the NP and/or CNM and supervising Physician, that references the textbook or written sources to meet the requirements of the Board of Registered Nursing.

- Evidence that the Standards of Care established by the sources were reviewed and authorized by the nurse Practitioner, Physician and administrator in the practice setting (i.e., signature page that includes all parties involved).

2. Standardized Procedures written using the Physician Assistants Delegation of Services Agreement and Supervising Physician Form format and/or verbiage is not accepted by IEHP.[42,43]

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[42] Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3
[43] Title 16, California Code of Regulations (CCR) § 1474 (3)

	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
Revision Effective Date:		

2. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

4. Recredentialing Cycle Length

APPLIES TO:

A. This policy applies to all IEHP Covered Providers contracted under IEHPs Direct network.

POLICY:

A. IEHP is responsible for formally recredentialing its contracted Practitioners (i.e., Primary Care Providers (PCPs), Non-Physician Practitioners, Specialists, and Admitting Physicians) at least every 36 months from their last credentialing decision date.[1,2]

PURPOSE:

A. To describe the guidelines for IEHP recredentialing and ensures recredentialing is conducted in a timely manner.

PROCEDURES:[3]

A. The length of the recredentialing cycle is within the required 36 month time frame. The 36 month recredentialing cycle begins on the date of the previous credentialing decision. The 36 month cycle is counted to the month, not to the day.[4]

   All written and verbal communications regarding recredentialing applications are documented within Credentialing database, by the person who made the attempt (i.e. Credentialing Specialist, Provider Services Representative (PSR) etc.), to ensure all attempts are documented and readily available for those Practitioners terminated due to non-compliance to recredentialing.

   1. Six (6) months prior to the recredentialing due date, the Credentialing Department generates and sends out the recredentialing applications to the respective Practitioners via email or fax to the Practitioners credentialing contact or Practitioner directly, for review and signature.

      a. The Practitioner is provided a due date within 14 calendar days to return the completed recredentialing application to the Credentialing Department.

         1) If the Practitioner does not submit the application within the designated timeframe, the Credentialing Specialist will make at least three (3) separate attempts to follow-up with the Practitioner's office. During this time, the Credentialing Specialist must obtain the following information:

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[1] National Committee for Quality Assurance (NCQA), 2024 Health Plan Standards and Guidelines, CR 4, Element A
[2] Title 42 Code of Federal Regulations (CFR) § 422.204(b)(2)(ii)
[3] NCQA, 2024 HP Standards and Guidelines, CR 4, Element A
[4] 42 CFR § 422.204(b)(2)(ii)

- Confirm the best contact for the recredentialing application
- Best communication method (i.e. e-mail, fax, phone call etc.)
- Confirmation of receipt of recredentialing application
- Next follow-up date
- Anticipated date of completion and submission to IEHP

2. Three (3) months prior to the recredentialing due date, the Credentialing Department will notify the Provider Services and Contracts Department of the Practitioners who have not submitted their recredentialing applications.

   a. The PSRs are responsible for at least three (3) separate attempts, via phone, email, and office visit, to follow up on the recredentialing application with the practitioner. During this time, the PSRs are responsible for:

      1) Reminding the Practitioner:

         - Their recredentialing application is past due;
         - If their application is not submitted to credentialing@iehp.org, by the 15th of the month prior their recredentialing application is due, their file will be recommended for termination due to non-compliance to recredentialing; and provide the following disclaimer:

           o After termination and the Practitioner wants to continue participation in the IEHP Direct Network, the Practitioner must undergo the initial credentialing process, regardless if the termination date was less than 30 calendar days.

      2) Obtain the next follow-up date and/or anticipated date of completion and submission to IEHP.

      3) Collecting and forwarding the recredentialing application to credentialing@iehp.org.

3. Two (2) months prior to the recredentialing due date, the Credentialing Department will notify the Provider Services and Contacts Department of the Practitioners who have not submitted their recredentialing applications. During this time, the PSRs are responsible for:

   a. Notifying the Contracts Managers (CMs) and Credentialing Specialists of their attempts to obtain the Practitioner's recredentialing application.

   b. If the recredentialing application is not received by the 15th of the month prior to the Practitioner's recredentialing due date, the PSRs will coordinate with the CMs, to send a request to terminate the Practitioner due to non-compliance to recredentialing, with an effective date of the 1st of the following month, their recredentialing

application is due.

1) The CMs are responsible for sending a request to terminate the respective Practitioner(s) due to non-compliance to recredentialing, with an effective date of the 1st of the month, following their recredentialing due date, to allow members at least 30 days advance notice of their Practitioner termination and ensure the Practitioner does not see Members beyond their approved credentialing cycle.

2) The Credentialing Specialist will send the termination letter due to non-compliance to recredentialing, via FEDEX and include the respective CMs and PSRs.

4. If the recredentialing application is received after the termination letter is sent to the Practitioner, the Practitioner is notified by recipient that the Practitioner was terminated due to non-compliance to recredentialing and if the Practitioner would like to continue their participation with the IEHP network, the Practitioner must undergo the initial credentialing process and submit their application to contracts@iehp.org to initiate the process.

B. IEHP may extend a Practitioner's recredentialing cycle time frame (beyond the 36 months) if the Practitioner is on active military assignment, on maternity/medical leave or a sabbatical. If the Credentialing Department is made aware of any of the reasons above, Credentialing must:

1. Obtain written documentation from the Practitioner's office that includes the reason and anticipated date of return.

2. Recredential the Practitioner within 60 calendar days of the Practitioner's return to practice.

   a. Failure to meet the allocated time frame above, will result in the administrative termination of the Practitioner due to non-compliance to recredentialing.

C. Practitioners who have exceeded the 36 month timeframe. If IEHP does not have the necessary information for recredentialing, IEHP will:

1. Inform the Practitioner that this information is needed at least 30 calendar days before the recredentialing deadline and that without this information, the Practitioner will be administratively terminated.

   a. This notification will be included in the Practitioner's credentialing file.

   b. If the Practitioner is subsequently terminated for lack of information, the termination notice will be included in the practitioner's file.

2. Terminate the Practitioner for administrative reasons (e.g. the Practitioner failed to provide complete credentialing information). IEHP does not allow automatic

reinstatement within thirty 30 calendar days of termination to Practitioners terminated due to non-compliance to recredentialing. IEHP will review and consider requests to reinstate Practitioners terminated due to non-compliance to recredentialing, on a case-by-case basis.

a. IEHP will perform initial credentialing if the reinstatement is more than 30 calendar days after termination.

D. IEHP allows reinstatements to Practitioners terminated for administrative reasons and not quality reasons if the reinstatement is within 30 calendar days of the termination.

1. If IEHP terminates a Practitioner for administrative reasons and not for quality reasons, IEHP may reinstate the practitioner within thirty 30 calendar days of termination and is not required to perform initial credentialing. The practitioner will resume their previous credentialing cycle.

   a. IEHP must perform initial credentialing if the reinstatement is more than 30 calendar days after termination.

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Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
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2. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

5. Ongoing Monitoring and Interventions

APPLIES TO:

A. This policy applies to all IEHP Covered Providers contracted under IEHPs Direct Network.

POLICY:

A. IEHP conducts ongoing monitoring of Practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against Practitioners when it identifies occurrences of poor quality on a monthly basis.[1]

B. IEHP maintains a documented process for monitoring whether network Providers have opted out of participating in the Medicare Program.[2]

C. IEHP verifies that contracted Providers have not been terminated as Medi-Cal Providers or have not been placed on the Suspended and Ineligible Provider List.

D. IEHP maintains a documented process for monitoring whether its Practitioners are included in the Centers for Medicare & Medicaid Services (CMS) Preclusions List, to ensure compliance with the Medicare Program Final Rule.[3]

E. IEHP maintains a documented process for monitoring Practitioners identified on the Restricted Provider Database.

F. IEHP maintains a documented process that includes the System for Award Management (SAM) in their list of database checks.

G. IEHP notifies the respective delegates of any identified findings through the ongoing monitoring of sanctions process. Delegates are required to present these findings to their Credentialing/Peer Review Committee for review and discussion, followed by a written response to IEHP of the written plan of action for each Practitioner within 14 calendar days of IEHP's notification.

H. IEHP notifies the respective Delegates of any findings and actions of the Peer Review Subcommittee regarding the Practitioners identified through the ongoing monitoring of sanctions, complaints, and quality issues between recredentialing cycles.

I. IEHP verifies and ensures Practitioners maintain an active licensure status, Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate and remedies if the license or certification expires or status changes during the Practitioner's participation with IEHP regardless of occurrence outside of the recredentialing cycle.

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[1] National Committee for Quality Assurance (NCQA), 2024 Health Plan Standards and Guidelines, CR 5, Element A, Factors 1-5

[2] Medicare Managed Care Manual, Chapter 6, "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks," § 60.2

[3] Centers for Medicare & Medicaid Services (CMS), Policy CMS-4182 Final Rule

J. IEHP must collect Social Security Numbers for all new and existing Practitioners to IEHP to ensure all Practitioners are included in IEHP's screening of the Social Security Administration's Death Master File (SSADMF).

PURPOSE:

A. IEHP identifies and when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.[4]

DEFINITION:

A. Adverse event: An injury that occurs in the course of a Member receiving health care services from a Practitioner.[5]

B. Peer review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (e.g., evaluation of a physician's credentials and practice by another physician).[6]

C. Quality of care: The degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[7]

PROCEDURES:

A. IEHP utilizes OIG Compliance Now as a contracted vendor to conduct the Ongoing Monitoring of Sanctions screenings for IEHPs credentialed and contracted Practitioners. All reports are reviewed within 30 calendar days of its release. New findings are presented to the next scheduled Peer Review Subcommittee, for review and discussion.[8,9]

1. The Credentialing designee submits a file by the fifth (5th) of each month, prepared by Health Care Informatics (HCI). The file contains a list of credentialed Providers to submit to OIG Compliance Now for screening. The sanction screening service provides screening across various Federal and State agencies including those required by IEHP as noted in this policy.

2. All reviews for Ongoing Monitoring of Sanctions are tracked in a Sanctions Log maintained by the Credentialing Department. This log includes the following information:

    a. Name of Institution, Licensing Board, Organization or Agency issuing the Sanction

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[4] NCQA, 2024 HP Standards and Guidelines, CR 5, Element A, Factor 1-5
[5] NCQA, 2024 HP Standards and Guidelines, Glossary
[6] Ibid.
[7] Ibid.
[8] NCQA, 2024 HP Standards and Guidelines, CR 5, Element A, Factor 5
[9] NCQA, 2024 HP Standards and Guidelines, CR 5, Element A, Factor 1-2

b. Practitioner types

c. Report frequency

d. Date Publication was released

e. Date report was reviewed

f. Providers identified and active credentialed affiliations

g. Description of the Sanction or finding

h. Name of person reviewing the report

3. All findings are referred to the following Departments and people and are included in the next scheduled Peer Review Subcommittee meeting:

   a. IEHP Peer Review Chairperson/Medical Director

      1) Reviews the sanction in preparation for the upcoming Peer Review Subcommittee discussion.

      2) Notifies the following departments if additional information is needed for presentation at the Peer Review Subcommittee meeting:

         - Information may include but are not limited to:
           - Licensure status
           - Education and Training
           - Hospital Affiliations or arrangements
           - Practice Locations
           - Advanced Practice Practitioners under his/her supervision (if applicable)
           - Membership counts
           - National Practitioner Data Bank history
           - Malpractice Claim History
           - Delegated affiliations
           - Facility Site Review/Medical Record Audit Status (if applicable)
           - Quality Improvement activities
           - Grievance History
           - Narcotics Audits (if needed, will work with Pharmacy to coordinate)

   b. Chief Medical Officer (CMO)

c. Chief Operating Officer (COO)

d. Director of Provider Operations

e. Director of Quality Management

f. Director of Grievance and Appeals

g. Credentialing Manager

h. Credentialing Designee

1) Responsible for the Peer Review Subcommittee packet compilation and coordination with the Provider Services Administrative Assistant for distribution to the Peer Review Subcommittee.

i. Quality Assurance Nurse

1) Responsible for collecting Quality Improvement activities, grievance history and summarizing licensure and/or action findings for the Peer Review Subcommittee packet.

j. Additional Information from other Departments, upon request.

4. IEHP will provide evidence of ongoing monitoring and appropriate interventions by:

a. Ensuring OIG Compliance Now collects and reviews information from the following sources for Medicare and Medicaid sanctions:

1) List of Excluded Individuals and Entities (LEIE) (maintained by Office of Inspector General) as the verification source for Medicare Sanctions, and review the report on a monthly basis, within 30 days of its release.[10]

- CMS' Medicare Exclusion Database (MED) is the source that is used to populate the LEIE list. IEHP will use the LEIE to verify if Practitioners are identified on the MED.

2) If a Practitioner is identified, the Credentialing designee will review the OIG Exclusions Report and confirm the findings.[11]

- A Practitioner identified on the HHS-Office of Inspector General (OIG) Exclusions Report is administratively terminated for all lines of business without appeal rights due to IEHP prohibiting employment of contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation.[12]

[10] NCQA, 2024 HP Standards and Guidelines, CR 5, Element A, Factor 5
[11] NCQA, 2024 HP Standards and Guidelines, CR 5, Element A, Factor 5
[12] Medicare Managed Care Manual, Chapter 6, "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks," § 60.2

- Members will be reassigned to new Practitioners.
- The Practitioner is presented to Peer Review Subcommittee for further review and discussion as an administrative termination. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance Department findings of any additional prior quality of care issues and Member complaints regarding the Practitioner.

3) IEHP ensures OIG Compliance Now collects and reviews information from BreEZe Online Services or directly from the licensing Board via phone, email, or mail, for reviewing sanctions or limitations on licensure. If a Practitioner is identified, the Credentialing designee will review and confirm the findings. The verifications are verified through:[13]

- Physicians
  - Medical Board of California (M.D., L.M.)
    - Subscription for email notifications of accusations, licensure suspensions, restrictions, or surrenders distributed by the Medical Board of California. (http://www.mbc.ca.gov/Subscribers/)
    - A distributed list of Disciplinary Actions/License Alerts can be obtained at (https://www.mbc.ca.gov/Resources/Publications/Alerts.aspx)
  - Osteopathic Medical Board of California (D.O.)
    - Distribution list from J. Corey Sparks, Lead Enforcement Analyst, Corey.Sparks@dca.ca.gov
      Phone: (916) 928-8393 Fax: (916) 928-8392.
- Chiropractors.
  - California Board of Chiropractic Examiners (D.C.)
    - Disciplinary Action Reports are posted monthly by the licensing board. (http://www.chiro.ca.gov/enforcement/actions.shtml)
    - Subscription email list (https://www.chiro.ca.gov/webapplications/subscribe/index.shtml)
- Oral Surgeons.
  - Dental Board of California (D.D.S., D.M.D.)

[13] NCQA, 2024 HP Standards and Guidelines, CR 5, Element A, Factor 2

- Disciplinary Action Reports are posted monthly by the licensing board. (http://www.dbc.ca.gov/consumers/hotsheets.shtml)
- Subscription for list of Board actions (https://www.dbc.ca.gov/webapplications/apps/subscribe/index.shtml)

- Podiatrists
  - Board of Podiatric Medicine (D.P.M.)
    - Recent Disciplinary Actions are updated every three to four (3 to 4) months by the licensing board. (https://www.pmbc.ca.gov/consumers/dispsumm.shtml). An email to the board may be sent if medical board site does not get updated within the three to four (3-to-4) month timeframe to inquire on status. (PMBC@dca.ca.gov).

Non-physician healthcare Practitioners.

- Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C., L.P.C.C.)
  - Subscription for list of enforcement actions. (https://www.dca.ca.gov/webapps/bbs/subscribe.php)
  - Enforcement Actions are updated monthly by the licensing board. (Enforcement Actions - Board of Behavioral Sciences (ca.gov))
- Board of Psychology (Ph.D., Psy.D.)
  - Subscription for list of enforcement actions. (https://www.dca.ca.gov/webapps/psychboard/subscribe.php)
  - Quarterly Journals are issued by the licensing board with all the Disciplinary Actions for that quarter reported. (https://www.psychology.ca.gov/forms_pubs/updates.shtml)
- California Board of Occupational Therapy (O.T.)
  - Disciplinary Actions are updated as needed by the licensing board, contingent when there is an Occupational Therapist placed on probation or revoked. (http://www.bot.ca.gov/consumers/disciplinary_action.shtml)
  - Subscription for list of enforcement actions. (https://www.bot.ca.gov/webapplications/apps/subscribe/index.shtml)
- California State Board of Optometry (O.D.)

  - Disciplinary Actions are updated as actions are adopted. (http://www.optometry.ca.gov/consumers/disciplinary.shtml)
- Physical Therapy Board of California (P.T.)
  - Subscription for email notifications of accusations, licensure suspensions, restrictions, or surrenders distributed by the Physical Therapy Board of California send an email requesting to be added to the monthly disciplinary distribution list (CPS@dca.ca.gov) Consumer Protection Services Phone: (916) 561-8200 Fax: (916) 263-2560.
  - Quarterly Progress Notes are available by the licensing board indicating the quarterly Administrative Actions for Discipline and Citations (https://www.ptbc.ca.gov/publications/index.shtml)
- Physician Assistant Committee (P.A., P.A.-C)
  - Disciplinary Actions are posted monthly by the licensing board. (https://pab.ca.gov/forms_pubs/disciplinaryactions.shtml)
  - Subscription for disciplinary actions from the licensing board (https://www.pab.ca.gov/webapplications/apps/subscribe/index.shtml)
- California Board of Registered Nursing (C.N.M., N.P.)
  - This Licensing Board does not release sanction information reports; therefore, organizations are required to conduct individual queries every 12 to 18 months on credentialed Practitioner)
- Speech-Language Pathology & Audiology Board (S.P., AuD.)
  - Disciplinary Actions are updated quarterly by the licensing board. (http://www.speechandhearing.ca.gov/consumers/enforcement.shtml)
- Subscription for disciplinary actions from the licensing board (https://www.speechandhearing.ca.gov/webapplications/apps/subscribe/index.shtml)Acupuncture Board (L.Ac.)
  - Disciplinary Action Reports reported monthly by the Licensing board. (www.acupuncture.ca.gov/consumers/board_actions.shtml); or
  - Subscription for disciplinary actions from the licensing board (https://acupuncture.ca.gov/webapplications/subscribe/index.shtml) [14]

3. IEHPs Grievance and Appeals Department is responsible for collecting and reviewing

[14] NCQA, 2024 HP Standards and Guidelines, CR 5, Element A, Factor 2

complaints and:[15]

a. Investigates Practitioner-specific Member complaints upon their receipt and evaluates the Practitioner's history of complaints, if applicable.

b. Evaluates the history of complaints for all Practitioner's history of complaints at least every six (6) months.

c. Quality or collecting and reviewing complaints received by Delegates must be forwarded to IEHP, since they are not delegated for these activities.

d. Policy and evidence may be found in the Grievance and Appeals Department.

4. IEHPs Quality Management Department is responsible for collecting and reviewing information from identified adverse events and:[16]

   a. Monitors for adverse events every six (6) months.

   b. Quality/collecting and reviewing adverse events received by Delegates must be forwarded to IEHP, since they are not delegated for these activities.

   c. Policy and evidence may be found in the Quality Department

5. IEHP implements appropriate interventions when it identifies instances of poor quality related to Practitioners with Medicare/Medicaid Sanctions, Sanctions and/or limitations on licensure, member complaints, or adverse events may be found in the Quality Management, Grievance and Appeals, and/or Credentialing Department and documented in the Peer Review Subcommittee minutes. This process determines if there is evidence of poor quality that could affect the health and safety of its Members and implements the appropriate policy based on action/intervention.

   The Peer Review Subcommittee meets the 4th Wednesday of every other month and reviews all Practitioners identified through the Ongoing Monitoring of Sanctions Process, Practitioners escalated from the Medical Director(s) for Potential Quality Incidents (PQIs), Practitioners escalated from the Grievance and Appeals Department, and any new Practitioner (s) with adverse history requesting participation through one (1) or more of our networks. The Peer Review Subcommittee will review each of the Practitioners and give thoughtful consideration to the information collected [17]and presented for review. The Peer Review Subcommittee obtains advice from participating Practitioners during the decision process. All discussions and actions will be documented in the Peer Review Subcommittee meeting minutes and will be reviewed and approved at the following Peer Review Subcommittee.

   a. At minimum, Practitioners identified through ongoing monitoring for licensure

[15] NCQA, 2024 HP Standards and Guidelines, CR 5, Element A, Factor 3
[16] NCQA, 2024 HP Standards and Guidelines, CR 5, Element A, Factor 4
[17] NCQA, 2024 HP Standards and Guidelines, CR 2, Element A, Factor 2

actions, sanctions, adverse history, grievances and/or complaints, must be fully discussed and reviewed by the Peer Review Subcommittee. The reason for review must be considered and documented in the meeting minutes.[18]

1) Interventions can be identified in one of the following:

- Committee minutes
- Practitioner files
- Delegate file binders

D. IEHP monitors when network physicians have opted out of participating in the Medicare Program through the Ongoing Monitoring process with OIG Compliance Now and ensures the vendor is conducting screenings for Medicare Opt-Out using (https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits).

1. IEHP must review the Opt-Out Report most current list available within thirty (30) calendar days of its release

   a. Certain healthcare Practitioner's categories cannot opt-out of Medicare. These include Chiropractors, Physical Therapists and Occupational Therapists in independent practice.

   b. If a Practitioner is identified on the Medicare Opt-Out Report, the Credentialing designee reviews the information via hard copies, electronic or one (1) of the CMS.gov Opt-Out sites to confirm the finding.[19]

      1) Behavioral Health (BH) Practitioners identified on the Medicare Opt Out Report are not allowed to participate in the IEHP network for any lines of business due to contract limitations and system design, therefore, are administratively terminated for all lines of business.

         - All Members will be reassigned to new Practitioners.
         - The Credentialing designee includes these findings in the Practitioner's file and prepares these documents for further review and discussion in the Peer Review Subcommittee as an administrative termination. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance and Appeals Department findings of any additional prior quality of care issues and Member complaints regarding the Practitioner.

      2) Practitioners outside of BH identified on the Medicare Opt Out Report are not

[18] NCQA, 2024 HP Standards and Guidelines, CR 5, Element A, Factor 5
[19] Medicare Managed Care Manual, Chapter 6, "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks," § 60.2

allowed to participate in the IEHP network for Medicare lines of business.

- All Medicare Members are reassigned to new Practitioners.

C. IEHP ensures OIG Compliance Now collects and reviews the Medi-Cal Suspended and Ineligible List published monthly by the Department of Health Care Services (DHCS) (https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx) as the verification source for Medicaid Sanctions. IEHP must review the Suspended & Ineligible List on a monthly basis, within thirty (30) days of its release.

1. If a Practitioner is identified, the Credentialing designee reviews the Medi-Cal Suspended and Ineligible List and confirms the findings.

   a. Practitioner identified on the Medi-Cal Suspended and Ineligible List are automatically terminated for all lines of business without appeal rights.

      1) All Members assigned to the suspended Practitioner are reassigned to new Practitioners.

      2) The Suspended Practitioner is presented for further review and discussion at the Peer Review Subcommittee as an administrative termination. Peer Review Subcommittee discussion includes Quality Management (QM) and Grievance and Appeals Department findings of any additional prior quality of care issues and Member complaints regarding r the Provider.

D. IEHP ensures OIG Compliance Now screens the CMS Preclusions List to ensure compliance with the Medicare Program Final Rule. In order for Providers (including entities) to receive payment from Medicare Plan (Part C and D), they must not be included in the Centers for Medicare & Medicaid Services (CMS) Preclusions List.[20]

1. If a Practitioner is identified, the Credentialing designee will review the CMS Preclusions List and confirm the findings.

   a. Providers identified on the CMS Preclusions List are automatically terminated for all lines of business without appeal rights.

      1) All Members assigned to suspended Practitioners are reassigned to new Practitioners.

      2) The Practitioner is presented to the Peer Review Subcommittee for further review and discussion as an administrative termination. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance and Appeals Department findings of any additional prior quality of care issues and Member complaints regarding the Practitioner.

E. IEHP maintains a documented process for monitoring Practitioners identified on the

Restricted Provider Database (RPD). The Credentialing designee will obtain the Restricted Provider Database report monthly.

1. Practitioners identified on the RPD are presented to Peer Review Subcommittee for review and discussion. The following actions are required to ensure compliance with DHCS guidelines:
   a. Payment Suspension: Practitioners are placed under a payment suspension while under investigation based upon a credible allegation of fraud.
      1) IEHP may continue contractual relationship; however, reimbursements for Medi-Cal covered services are withheld; or
         - If IEHP chooses to continue the contractual relationship with Practitioners who are placed on payment suspensions, IEHP must allow out-of-network access to Members currently assigned to the Practitioner by approving the request.
      2) IEHP may choose to terminate the contract by submitting appropriate documentation.
   b. Temporary Suspension: Practitioners placed on a temporary suspension while under investigation for fraud or abuse, or enrollment violations.
      1) IEHP must terminate the contract and submit appropriate documentation.

F. IEHP maintains a documented process that includes the System for Award Management (SAM) in the list of database checks. IEHP uses OIG Compliance Now as the vendor to collect data and alert services, including but not limited to the System for Award Management (SAM) in the scope of review.

1. The OIG LEIE includes all healthcare Practitioners and suppliers that are excluded from participation in federal health care programs, including those health care Practitioners and suppliers that might also be on the SAM (previously Excluded Parties List System (EPLS)). In addition to health care Practitioners (that are also included on the OIG LEIE) the EPLS includes non-health care contracts[21] which are out of scope for the Practitioners undergoing the Credentialing process.

G. During the ongoing monitoring of sanctions review, the Credentialing designee notifies the respective delegates of any identified findings.

1. IEHP sends an email to the Delegate notifying them of the findings and the affiliation of the Practitioner to IEHP. The Delegate must provide a written plan of action for the Practitioner identified within 14 calendar days that includes:
   a. The date the Practitioner was presented to the Credentialing Committee for review

[21] Medicare Managed Care Manual, Chapter 9 & 21 "OIG/GSA Exclusion,"

and discussion.

1) If the Credentialing Committee has not discussed the Practitioner, the Delegate must provide the date the Practitioner is scheduled for review.
2) A summary of the Credentialing Committee's discussion and plan of action. Committee's Decision.

b. Delegates are responsible for notifying IEHP of any findings and the actions decided by the Credentialing Committee within 30 days of the decision, to include, but not limited to:

1) Date(s) of the Credentialing Committee the Practitioner was reviewed.
2) Date of the Credentialing Committee decision.
3) Delegate's Plan of action for the Practitioner.
4) Frequency of monitoring (if applicable); and
5) Any follow-ups scheduled.
6) Any of the following actions with a contracted Practitioner:
   - The surrendering, revocation or suspension of a license.
   - The surrendering, revocation or suspension of DEA registration.
   - A change in hospital staff status or hospital clinical privileges, including any restrictions or limitations.
   - A change in Hospital admitting arrangements for Practitioners without IEHP affiliated Hospital privileges.
   - Loss of malpractice insurance; and
   - The notification must include the Plan's proposed action and/or resolution.
7) Committee decision resulting in suspension or termination. The Delegate must confirm if suspension or termination was due to administrative reasons or Quality of Care. Delegates are required to notify IEHP in writing within thirty (30) days of the filing if any of the following occurs with one of their contracted Practitioners:
   - Any filing pursuant to Business and Professions Code Sections § 805, 805.01 or 809.
   - Any filing with the NPDB; and
   - The notification must include the Delegate's proposed action and/or resolution.

- Suspension or terminations for administrative reasons. The Delegate needs to provide the termination date and reason for termination.
  - This termination notification does not replace the standard termination notification sent to our Provider Relations Team. Delegates must submit terminations to providerupdates@iehp.org to ensure Practitioners are terminated timely.
- Suspensions or terminations for Quality of Care. Delegates must submit a copy of the 805 and/or 805.01 filing to IEHP for review, within 30 days of file submission to DGCredentialingSME's@iehp.org.

2. IEHP presents the Practitioner to the Peer Review Subcommittee for review and discussion and includes the plan of actions from the respective networks.
3. IEHP is responsible for notifying the Practitioner's respective delegated networks of any findings and the actions decided by the Peer Review Subcommittee within 30 days of the decision, including, but not limited to:
   a. Date of the Credentialing Committee Practitioner review;
   b. Date of the Credentialing Committee decision;
   c. IEHPs Plan of action for the Practitioner;
   d. Frequency of monitoring (if applicable);
   e. Any follow-ups scheduled; and
   f. IEHP reserves the right to approve, deny, terminate or otherwise limit Practitioner participation in the IEHP network for any reason including quality issues.
      1) If a Practitioner is denied participation due to quality of care, an 805 is filed with the appropriate licensing agency and the National Practitioner Data Bank (NPDB) is notified then the Practitioner is not eligible to reapply.
         - A Provider may reapply for participation in the IEHP network, after one (1) year if denied participation due to administrative terminations or denials.
      2) Practitioners can appeal adverse decisions by the IEHP Peer Review Subcommittee as delineated in IEHP's Peer Review Process and Level I Review and Level II Appeal. See "Attachments/IEHP Peer Review Level I and Credentialing Appeal" and "IEHP Peer Review Process and Level II Appeal" on the IEHP website.[22]

I. IEHP runs a monthly report of all licensures and DEA certifications that have or will expire within 30 days.

[22] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

1. For all licensures, IEHP will verify the Practitioner's licensure with the appropriate licensing agency and ensure that the Practitioners' licensure is valid and current.
   a. IEHP sends a notification of administrative termination for all lines of business to Practitioners whose licensures are not valid and current.
      1) The letter notification:
         - Is copied to the Practitioners' affiliated networks.
         - Includes the effective termination date, which is the day after the licensure is no longer valid.
         - Includes a current copy of the licensure verification as an enclosure.
      2) All Members assigned to the Practitioner are reassigned to other Practitioners.
2. For all Practitioners with expired DEA certificates, IEHP will verify the DEA certificate through the DEA Number website (https://apps.deadiversion.usdoj.gov/webforms2/spring/validationLogin?execution=e1s1), to ensure the Practitioners DEA certificate is valid and current.
   a. For all DEA certificates that are no longer valid, the Credentialing designee contacts the individual Practitioner's office to obtain the Practitioner's:
      1) New DEA Number.
      2) The Practitioner's prescribing arrangements until the Practitioner obtains a new DEA certification.
      3) Written explanation for the Practitioner not having a DEA certification, which is presented to the Peer Review Subcommittee for review and discussion.
         - If the Practitioner does not have an appropriate DEA arrangement on file, the Practitioner's respective network will be notified and IEHP will request a plan of action to include the option of an administrative termination due to not having appropriate DEA arrangements, as required by NCQA.[23]
3. Practitioners are responsible for notifying IEHP of any licensure and DEA changes within 30 days of the change. The notification must include:
   a. Date the Practitioner was aware
   b. Type of change
   c. Effective date of the change

J. IEHP must collect Social Security Numbers (SSN) for all new and existing Practitioners in the network, to ensure all Practitioners are included in IEHP's screening of the Social Security

[23] NCQA, 2024 HP Standards and Guidelines, CR 3, Element A, Factor 2

Administration's Death Master File (SSADMF).

1. All Delegates and/or practitioners must provide the Social Security Numbers for the respective practitioners under the following:
   a. Credentialing/Recredentialing Application(s)
   b. Practitioner Profile Submission
   c. Credentialing Activities Report
   d. Upon request by IEHP. Applicable to all existing Practitioners with missing SSN.
      1) Delegates and/or Practitioners who do not provide the requested information will be placed on a Corrective Action Plan (CAP) until all missing SSNs are submitted.
2. If a Practitioner is identified on the SSADMF, and the Practitioner:
   a. Is not deceased but confirms that his/her SSN is correctly stated on the SSADMF, IEHP will request the following information from the Practitioner:
      1) A copy of the Social Security Card.
      2) A Photo ID.
      3) A signed attestation, See "Attachment/Death Master File Identity Attestation" found on the IEHP website from the Practitioner; [24] and
      4) Request for the Practitioner to contact the SSADMF to correct the issue.
   b. Is not deceased, confirms their SSN is correctly stated but the name and/or Date of Birth (DOB) is not correct, IEHP will request for the following:
      1) A copy of the Social Security Card.
      2) A Photo ID.
      3) A signed attestation, See "Attachment/Death Master File Identity Attestation" found on the IEHP website from the Practitioner;[25] and
      4) Request for the Practitioner to contact the SSADMF to correct the issue.
3. Upon receipt of the required documents, the Credentialing designee will provide the attestation and supporting documentation to our Compliance Department for review and repository.

[24] https://www.providerservices.iehp.org/en/resources/provider-resources/forms
[25] Ibid.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
Revision Effective Date:		

2. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

APPLIES TO:

A. This policy applies to all IEHP Covered Providers.

POLICY:

A. IEHP must review participation of Practitioners whose conduct could adversely affect members' health or welfare, specify the range of actions that may be taken to improve practitioner performance before termination, IEHP report its actions to the appropriate authorities including State licensing agencies, the National Practitioner Data Bank (NPDB), and Inland Empire Health Plan (IEHP)[1] and inform Practitioners of the appeal process.[2]

B. A Practitioner's status or participation in the IEHP network may be denied, reduced, suspended, or terminated for any lawful reason, including but not limited to a lapse in basic qualifications such as licensure, insurance, or required medical staff privileges or admission coverage at an IEHP contracted Hospital or a determination by IEHP based on information obtained during the credentialing process that the Practitioner cannot be relied upon to deliver the quality or efficiency of Member care required by IEHP.

PURPOSE:

A. IEHP must use objective evidence and patient-care considerations when deciding on a course of action for dealing with a Practitioner who does not meet its quality standards.[3]

B. Notification applies to licensed Practitioners for suspensions and terminations for quality reasons.[4]

C. IEHP must provide evidence that it followed its appeal process if it altered the conditions of a Practitioner's participation based on quality of care or service reasons.[5]

D. Practitioners must appeal directly to their contracted Plan for adverse credentialing decisions rendered by the Plan.

E. Reporting to appropriate authorities is not applicable in the following circumstances:

   1. There are no instances of suspension, termination, restriction or revocation to report for

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[1] National Committee for Quality Assurance (NCQA), 2024 Health Plan Standards and Guidelines, CR 6, Element A, Factor 1

[2] NCQA, 2024 HP Standards and Guidelines, CR 6, Element A, Factor 2

[3] NCQA, 2024 HP Standards and Guidelines, CR 6, Element A, Factor 1-2

[4] Title 42 Code of Federal Regulations (CFR) § 422.202

[5] NCQA, 2024 HP Standards and Guidelines, CR 6, Element A, Factor 2

quality reasons.

2. Automatic administrative terminations based on the Practitioners not meeting specific contractual obligations for participation in the network.

F. All credentialing records and proceedings are confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law.[6]

G. Practitioners who do not meet the criterion set forth in this policy are subject for review by the Credentialing Subcommittee and/or Peer Review Subcommittee. This criterion is used to determine which Practitioners may participate in its network, which may include, but are not limited to:

1. Education and Training

   a. Medical Doctors (M.D.) and Doctor of Osteopathic (D.O.) must meet the education and training requirements set forth by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) and additional criterion set by IEHP and noted below, if applicable. All IEHP specific specialty requirements are subject for review by the IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

2. Verification of Credentials

   a. A current and valid, unencumbered license to practice medicine in the state they practice (i.e. California or Arizona), at the time of Credentialing decision.

      1) IEHP verifies that Practitioners have clinical privileges in good standing. Practitioners must indicate their current Hospital affiliation or admitting privileges at a participating Hospital. Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be confirmed with the Hospital, in writing, via approved website or verbally.

      2) IEHP identifies HIV/AIDS Specialists during the credentialing and recredentialing process, and annually thereafter. All credentialing and recredentialing applications include an HIV/AIDS form for all Practitioners to review and complete if they would like to be identified as an HIV/AIDS Specialist Provider.

         - IEHP identifies and verifies the appropriately qualified Physicians who meet the definition of an HIV/AIDS Specialist. An “HIV/AIDS Specialist” is a Physician

[6] California Evidence Code § 1157

who holds a valid, unrevoked and unsuspended certificate to practice medicine in the State of California, who meets any one of the four (4) criterion below:

- Is credentialed as an HIV Specialist by the American Academy of HIV Medicine (AAHIVM); a. IEHP will verify the Physician's credentials on the American Academy of HIV Medicine website https://aahivm.org/.
- Is board certified, or has earned Certificate of Added Qualifications, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualifications, in the field of HIV medicine; or a. IEHP will verify the Physicians board certification(s) using the sources in See Policy 2A1, "Credentialing Standards – Credentialing Policies"
  - Is board certified in the field of Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:
  - In the immediately preceding 12 months has clinical managed medical care to a minimum of 25 patients who are infected with HIV; and
  - In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuous medical education (CME) in the prevention of HIV infection, combined with diagnosis, treatment, or both, of the HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year.
- Meets the following qualifications: a. In the immediately preceding twenty-24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and
  - Has completed any of the following: 1) In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious disease from a member board of the American Board of Medical Specialties; or
  - In the immediately preceding12 months has successfully completed a minimum of30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment of both, of HIV-infected patients.
  - IEHP will verify the Physicians board certification(s) using the sources in Policy 2A1, "Credentialing Standards – Credentialing Policies";

- IEHP will request for copies of those Continuing Medical Education (CME) credits and verify: and
- The appropriate number of CMEs hours in the Prevention of HIV Infection, combined with diagnosis, treatment of both of HIV-infected patients, were completed.

- In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competence Examination administered by the American Academy of HIV Medicine.

3) Effective January 1, 2023, upon receipt of credentialing applications from Behavioral Health, Mental Health, and/or Substance Use Disorder Providers: 73

3. IEHP will notify the applicant within seven (7) business days of receiving the application to confirm receipt and inform the applicant whether the application is complete.

   a. If the application is incomplete or requested supporting documents were not provided, IEHP will notify the practitioner within seven (7) business days of receiving the Practitioner's application noting the application received date and that the application was deemed incomplete and withdrawn from the credentialing process due to the missing information.

      1) The practitioner must submit the incomplete or requested documentation along with a current application for reconsideration.

         Once the additional information is received, the application will be deemed complete.

   b. If the application is deemed complete, the practitioner will be notified that their application will be forwarded to the Initial Application process.

      1) The processing time for an initial application starts on the day the Practitioner is notified of their completed application.

4. Practitioner qualifications will be assessed and verified within 60 calendar days after receiving a completed credentialing application. The 60 day timeframe only applies to credentialing process for Behavioral Health, Mental Health, and/or Substance Use Disorder Providers and does not include contracting completion.

DEFINITION:[7]

A. "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates.

B. "Denial or termination of staff privileges, membership, or employment" includes failure or refusal to renew a contract or to renew, extend or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

C. "Licentiate" means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, or physician assistant. Licentiate also includes a person authorized to practice medicine.[8]

D. "Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to the patient's safety or to the delivery of patient care.

E. "Peer" is an appropriately trained and licensed Physician in a practice similar to that of the affected physician.

F. "Staff privileges" means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

[7] Business and Professions Code § 805
[8] Business and Professions Code § 2113 and 2168

PROCEDURES:

A. IEHP's Credentialing Subcommittee is appointed by its Quality Management Committee and is responsible for reviewing, approving, and denying Practitioners who directly contract with IEHP's Direct network.

B. IEHP's Peer Review Subcommittee is responsible for reviewing Member complaints, grievances, appeals, and sanctions regarding Practitioners and Practitioner-related quality of care and service issues including Facility Site and Medical Record Reviews. Other Peer Review matters such as Retrospective Practitioner Quality Reviews referred by the Grievance and Appeals Department are reviewed and discussed as directed by the IEHP Medical Director(s) and IEHP Chief Medical Officer (CMO). The Peer Review Subcommittee also performs oversight of contracted credentialing activities of Delegates.[9]

   1. IEHP utilizes vendor, OIG Compliance Now to collect and review information from BreEZe online services or directly from the Licensing Board via phone, email, or mail, for reviewing sanctions and/or limitations on licensure.

      a. If a practitioner is identified, the Credentialing Designee will review and confirm the findings and present the documentation to the Peer Review Subcommittee for review and decision.

   2. The range of actions that IEHP may take to improve Practitioner performance before termination include, but is not limited to: [10]

      a. Profiling

      b. Corrective actions(s)

      c. Monitoring

      d. Medical Record Audit

      e. Pharmacy Audit

      f. Focused Quality Management Audit

   3. Practitioners have the right to appeal any adverse credentialing decision that impact their participation status with IEHP in accordance with the appeals procedures provided herein. IEHP will:

[9] Bus. & Prof. Code § 805

[10] NCQA, 2024 HP Standards and Guidelines, CR 6, Element A, Factor 1

a. Provide written notification when a professional review action has been brought against a Practitioner, including reasons for the action. See "Attachments/ Credentialing Subcommittee Termination Letter" and "Peer Review Termination Letter" found on the IEHP website.[11]

b. Allow Practitioners 30 calendar days to request a hearing/appeal.

c. IEHP cannot have an attorney if the Practitioner does not have attorney representation to ensure compliance with CA Business & Professions Code 809.3(c).[12,13]

4. Practitioner Appeal Process. IEHP informs the affected Practitioner of its appeal process and includes the following information in the process and notification.[14]

a. IEHP provides written notification by FedEx delivery, return receipt requested, within 30 calendar days of the decision reached by the IEHP Subcommittee (Peer Review or Credentialing) to any Practitioner denied participation. The written notice will indicate the following:

1) A professional review action has been brought against the Practitioner

2) Reason(s) for the action. This may include a brief description of the factual basis for the proposed action that includes but is not limited to

- A lapse in basic qualifications such as licensure, insurance, or required medical staff privileges;
- A determination that the Practitioner cannot be relied upon to deliver the quality or efficiency of patient care desired by IEHP;
- A determination that the Practitioner cannot be relied upon to follow IEHP's clinical or business guidelines or directives;
- Falsification of information provided to IEHP;
- Adverse malpractice history;
- Adverse events that have potential for or have caused injury or negative impact to Members; and/or
- Felony convictions.

3) A summary of the appeal rights and process is provided in the provider manual and is included as an enclosure with the credentialing decision letter. See

[11] https://www.providerservices.iehp.org/en/resources/provider-resources/forms
[12] NCQA, 2024 HP Standards and Guidelines, CR 6, Element A, Factor 2
[13] Bus. and Prof. Code § 809.3(c)
[14] NCQA, 2024 HP Standards and Guidelines, CR 6, Element A, Factor 2

"Attachment/IEHP Peer Review Level I and Credentialing Appeal" found on the IEHP website.[15]

4) A statement that the Practitioner may request an IEHP Peer Review Level I Appeal or Credentialing Appeal conducted by the IEHP Subcommittee (Credentialing or Peer Review) who denied participation is included in the decision letter in accordance with this policy.

- The Practitioner is notified that a request for an IEHP Peer Review Level I Appeal or Credentialing Appeal must be requested by the Practitioner in writing, addressed to the IEHP Committee Chairperson or Medical Director designee.
- The Practitioner is notified that a request for an IEHP Peer Review Level I Appeal or Credentialing Appeal must be received within 30 days of the date of receipt of the notice. The Practitioner's written request must include:
  - A clearly written explanation of the reason for the request; and
  - A request to exercise the right to present the appeal orally

5) A summary of the Practitioner's Rights at the appeal includes the right to:

- Present additional written material for review by the IEHP Subcommittee (Peer Review or Credentialing);
- Present any information orally to the IEHP Subcommittee (Peer Review or Credentialing);
- Notification that the IEHP Peer Review Level I or Credentialing Appeal meeting takes place before the IEHP Peer Review or Credentialing Subcommittee.
  - The IEHP Peer Review Level I and Credentialing Appeal meetings are not hearings and procedural rights associated with the formal peer review hearings do not apply for adverse credentialing decisions.
    i. Practitioners may not be represented by a licensed attorney at the IEHP Peer Review Level I or Credentialing Appeal meeting. However, they have a right to be represented by a non-attorney representative of their choice.

b. Practitioners not requesting an appeal within the required timeframe and as specified above waive the right to further appeals and the decision of the IEHP Subcommittee is

[15] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

final.

1) The decision is adopted as the final action; and

2) IEHP reports the final decision to the IEHP Governing Board, appropriate state licensing agency, and National Practitioner Data Bank.[16,17]

c. If an appeal is submitted in a timely manner, IEHP arranges for a review of the appeal to be conducted at the next scheduled meeting of the IEHP Subcommittee (Peer Review or Credentialing) that made the decision to deny.

1) Prior to the meeting, IEHP sends a written notice via FedEx, to the Practitioner with the date, time and place of the meeting.

d. The IEHP Subcommittee (Peer Review or Credentialing) meets to complete its evaluation and renders a decision to uphold or overturn the denial. Within 30 calendar days of the decision, the Practitioner is provided written notification of the appeal decision which contains specific reasons for the decision. Written notification also includes:

1) If the appeal decision by the IEHP Subcommittee (Peer Review or Credentialing) is to overturn the original denial of the Practitioner's participation in the IEHP network, the Practitioner is notified in writing within 30 calendar days of the decision.

2) If the appeal decision by the IEHP Subcommittee (Peer Review or Credentialing) is to uphold the original denial of the Practitioner's participation in the IEHP network, the Practitioner is notified in writing within 30 calendar days of the decision. The written notice will include:

- The decision, including a brief description of the decision and the reasons for it;
- A statement that the Practitioner may request for an IEHP Peer Review Process and Level II Appeal, in accordance to this policy.
- A copy of the IEHP Peer Review Process and Level II Appeal. See "Attachment/IEHP Peer Review Process and Level II Appeal" found on the IEHP website;[18]
- A statement that the Practitioner may request an IEHP Peer Review Process and Level II Appeal in accordance with this policy. The request must be in writing, addressed to the IEHP Committee Chairperson or Medical Director designee, and must be received within 30 days of the date of receipt

[16] Bus. & Prof. Code § 805
[17] Title 45 CFR § 60
[18] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

of the notice.

- The Practitioner is notified that a request for an IEHP Peer Review Process and Level II Appeal, must be requested by the Practitioner in writing, addressed to the IEHP Committee Chairperson or Medical Director designee.
- The Practitioner is notified that the Practitioner's request for an IEHP Peer Review Process and Level II Appeal, must be received within 30 days of the date of receipt of the notice.
- At the hearing, the Practitioner can be represented by an attorney or another person of the Practitioner's choice at the hearing. IEHP cannot have an attorney if the Practitioner does not have attorney representation.

e. A Practitioner not requesting an appeal within the required timeframe and as specified above waives the right to further appeals, and the decision of the IEHP Subcommittee is final.

1) The decision will be adopted as the final action and

2) The action, if implemented, IEHP will report the final decision to the IEHP Governing Board, appropriate state licensing agency, and National Practitioner Data Bank.[19,20]

- IEHP complies with the reporting requirements of the Medical Board of California, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Podiatric Medicine, the California Board of Behavioral Sciences, the Board of Psychology, and the Physician Assistant Board, and other licensing agencies and National Practitioners Data Bank (NPDB) as required by law. IEHP also complies with the reporting requirements of the California Business and Professions Code and the Federal Health Care Quality Improvement Act regarding adverse credentialing actions. Practitioners are notified of the report and its contents in accordance with law.

f. The following types of Providers require 805 and 805.01 reporting: Medical Doctors (MD), Dentists (DDS), Osteopaths (DO), Podiatrists (DPM), Marriage Family

[19] Bus. and Prof. Code § 805
[20] Title 45 CFR § 60

Therapists (MFT), Licensed Clinical Social Workers (LCSW), Psychologists (Psy.D., Ph.D.) and Physician Assistants (PA).[21,22]

3) 805 Reports

IEHP is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a Physician and Surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

If the California Board of Podiatric Medicine or a licensing agency of another state revokes or suspends, without a stay, the license of a doctor of podiatric medicine, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension

- If an 805 is reported, it shall include the following information:
  - The name of the licentiate;
  - The license number of the licentiate
  - A description of the facts and circumstances of the medical disciplinary cause or reason;
  - Any other relevant information deemed appropriate by the reporter
- IEHP must file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body:
  - A licentiate's application for staff privileges or membership is denied or rejected for medical disciplinary cause or reason.
  - A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.
  - Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12 month period, for a medical disciplinary cause or reason.

[21] Bus. and Prof. Code § 805 and 805.01
[22] 45 CFR § 60

- If a licentiate takes any of the actions listed below after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that his or her application for membership or staff privileges is denied or will be denied for a medical disciplinary cause or reason, the Chief Medical Officer (CMO) or a medical or professional staff or other Chief Executive Officer (CEO), Medical Director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the renewal thereof, shall file an 805 report with the relevant agency within 15 days: after the licentiate takes the action.[23]
  - Resigns or takes a leave of absence from membership, staff privileges or employment.
  - Withdraws or abandons his or her application for staff privileges or membership.
  - Withdraws or abandons his or her request for renewal of staff privileges or membership.

4) 805.01 Reports

IEHP must file an 805.01 report within 15 days after a peer review body makes a final decision or recommendation of termination, suspension or restriction of staff privileges, membership or employment due to an investigation for at least one (1) of the following reasons:

- Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one (1) or more patients in such manner as to be dangerous or injurious to any person or the public.
- The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
- Repeated acts of clearly excessive prescribing, furnishing or administering o

[23] Bus. & Prof. Code § 805

controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.

- Sexual misconduct with one (1) or more patients during a course of treatment or an examination.

5) National Practitioner Data Bank (NPDB)

- Reports must be submitted to the NPDB within 30 days of the action.

6) Health Plan Reporting

- Delegate Reports must be submitted to IEHPs Credentialing Manager within 30 days of the action.

C. IEHPs policies and procedures regarding suspension or termination of a participating Physician require IEHP to ensure that the majority of the hearing panel members are peers of the affected Physician.[24,25]

1. A peer is an appropriately trained and licensed Physician in a practice similar to that of the affected Physician.
2. Panel members do not have to possess identical specialty training.
3. Policies and procedures do not always have to state the word “majority”, but at least 51% of the members must be peers.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
Revision Effective Date:		

[24] Medicare Managed Care Manual, Chapter 6, “Suspension, Termination, or Nonrenewal of Physician Contract,”, Section 60.4

[25] 42 CFR § 422.202

2. CREDENTIALING AND RECREDENTIALING

B. Hospital Privileges

APPLIES TO:

A. This policy applies to all IEHP Covered Providers.

POLICY:

A. IEHP must ensure that all of their contracted and subcontracted PCPs have Hospital admitting arrangements at a designated IEHP contracted Hospital[1], within a 15 mile radius or 30 minute travel time from their assigned Member's residence. In rural areas, or in specific situations, IEHP may approve Primary Care Provider (PCP) links to Hospitals outside of these standards. See Policy 12F, "Hospital Affiliations".[2]

B. IEHP are required to contract with a dedicated Hospitalist at the Hospitals they are linked to and where such Hospitalist exists. IEHP requires that the Plan contract with the Hospitalist contracted with IEHP Direct if IEHP Direct holds a contract with the Hospitalist at the Hospital in question. The Plan may request to contract with another dedicated Hospitalist present at the Hospital, subject to IEHP approval. Hospitalist can only provide coverage for other Primary Care Providers (PCPs) with the same age range.

C. If a dedicated Hospitalist does not exist at the hospital, the PCP may use their own privileges to admit patients.

D. If a dedicated Hospitalist does not exist at the hospital and the physician does not have their own hospital admitting privileges, the physician may use an Admitting physician within their same Plan, and cover the same age range, to admit patients on their behalf contingent that they are credentialed and contracted with hospital admitting privileges.

E. If there is a Hospital where a dedicated Hospitalist does not exist and the physician does not hold their own admitting privileges, the Plan can contract with an Admitter, who may be a person or group, to admit their assigned Members. Admitting Practitioners must be contracted and credentialed within the same network, and cover the same age range, as the non-admitting Provider, in accordance with regulatory standards and IEHP requirements.

F. IEHP and its Delegates must ensure that all contracted and subcontracted Specialist Practitioners (in the appropriate specialties). See, "Attachment/Hospital Admitting Privileges Reference by Specialty" found on the IEHP website,[3] must have a formal inpatient coverage arrangement at an IEHP contracted Hospital, with a specialist within the same practice and specialty. If the Practitioner does not have clinical admitting privileges, a written statement delineating the inpatient coverage arrangement, which must be documented in the Provider's file.

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[1] Title 28, California Code of Regulations (CCR) § 1300.51 (d)(H)(iii)
[2] Knox-Keene Health Care Service Plan Act of 1975, § 1300.67.2.2
[3] https://www.iehp.org/en/providers/provider-resources?target=forms

G. Practitioners who provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services (i.e. Certified Nurse Midwives, Obstetrics/Gynecology [OB/GYN], Family Practice 1, Family Practice 2 Providers, Licensed Midwives) must have appropriate Hospital arrangements in place.

PURPOSE:

A. No enrollment is given to any PCP until appropriate and complete arrangements for Hospital admissions are in place and verified by IEHP.

B. In the event it is discovered that a PCP with assigned enrollment does not have privileges at the designated IEHP contracted Hospital, and the Plan has not made arrangements with other Practitioners to provide admitting and inpatient care services for that Practitioner, IEHP may freeze the membership of the PCP and/or transfer these Members immediately. The Plan may request to unfreeze or open the Provider's panel once they provide appropriate arrangements with other Practitioners to provide admitting inpatient care services for that Practitioner.

C. IEHP must have established processes for outpatient and inpatient Utilization Management.

D. IEHP must have established processes for outpatient and inpatient Utilization Management and are responsible for reviewing, maintaining and notifying IEHP of any changes to their hospital admitting arrangements for each of their affiliated links.

DEFINITION:

A. Hospitalist: A doctor who primarily takes care of patients when they are in the Hospital. This doctor will oversee a Member's care when the Member is inpatient, keeping the Member's primary doctor informed about the Member's progress, and will return the Member to the care of your Primary Care Provider when the Member is discharged from the Hospital.[4]

B. Hospitalists do not need to be credentialed. They are Practitioners who practice exclusively in an inpatient setting and provide care for organization Members only because Members are directed to the Hospital or another inpatient setting. The facility will be responsible for Credentialing each practitioner.

C. Admitting Physician(s): The doctor(s) responsible for admitting a patient to a Hospital or other inpatient health facility.[5]

PROCEDURES:

A. IEHP must ensure that all of their contracted and subcontracted PCPs have Hospital admitting arrangements at a designated IEHP contracted Hospital, within a 15 mile radius or 30 minute

[4] CMS.gov (Glossary)
[5] CMS.gov (Glossary)

travel time from their assigned Member's residence.[6] In rural areas, or in specific situation IEHP may approve PCP links to Hospitals outside of these standards (See Policy 12F, "Hospital Affiliations").

1. Upon receipt of a Provider application for IEHP or Provider profile for Plans, IEHP will confirm:

    a. PCPs meet the time and distance requirements specified and above and ensure the physician has appropriate hospital arrangements documented on the Provider Application or profile. IEHP is required to:

        1) Use a Hospitalist if a dedicated Hospitalist exists at the Hospital;

        2) If a dedicated Hospitalist does not exist, the physician may use their own privileges to admit patients;

        3) If the PCP Practitioner does not have clinical admitting privileges, IEHP and its Delegates must obtain a written statement delineating the inpatient coverage arrangement which must be documented in the Provider's file. IEHP may then use:

            - Admitting Physician who covers the same age range, who is credentialed and contracted within the same network; or

            - Admitter who is contracted by the same network, to admit patients on behalf of the Plan, contingent that they are contracted and credentialed by the same network.

    b. Specialists must have their current affiliations listed on their application for IEHP or Provider Profile for Plan. IEHP will verify the Specialist:

        1) Has privileges in good standing and must indicate their current hospital affiliations or admitting privileges at a participating hospital.[7]

            - Privileges must be in the specialty they are credentialed and contracted

            - Specialists will be linked to all Hospitals where they have appropriate Hospital arrangements;

                o IEHP are not required to have an existing link at the hospitals for the Specialists to be added.

        2) If the Practitioner does not have clinical admitting privileges, IEHP and its Delegates must obtain a written statement delineating the inpatient coverage arrangement which must be documented in the Provider's file.

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[6] KKA § 1300.67.2.2

[7] Title 28 California Code of Regulations (CCR) § 1300.51(d)(H)(iii)

2. For those physicians who meet IEHPs established criteria, will be added to the network. Those practitioners who have Hospitalist or Admitter arrangements noted, will be added to the Hospitalist and Admitter List for review and maintenance, thereafter.
3. During the Joint Operations Meetings (JOM) with our network hospitals they are provided a Hospitalist Admitter list for review. It includes Hospitalist/Admitters name, phone number and fax number for each Provider who has an alternate hospital arrangement.
   a. If Hospitals find discrepancies, they are communicated to the Provider Contracting Service Manager, for action.

B. Hospitalists are used to provide coverage for PCPs affiliated with the same Provider network and age range. IEHPs Direct Hospitalist List is maintained by the Contracts Department and is made available to Plan via Provider Portal as a reference.

1. IEHP is required to contract with a dedicated Hospitalist at the Hospitals they are linked (receiving membership assignment) and where such Hospitalists exist.
   a. IEHP requires contract with the Hospitalist Group contracted with IEHP Direct.
      1) Hospitalist arrangement that do not align with IEHP Direct, will require review and approval from the IEHP Medical Director.
   b. IEHP does accept utilization of a rotating on-call Hospitalist arrangement, however these arrangements are subject for review and approval. The following arrangements have been reviewed and accepted by IEHP:
      1) Arrowhead Regional Medical Center
      2) Loma Linda University Medical Center
      3) Riverside County Regional Medical Center

      If the Plan is receiving membership assignments for these hospitals, they will automatically be assigned to the rotating on-call Hospitalist arrangement, therefore will not be required to submit Hospital arrangements.
2. For all Hospitalist arrangements, Plans are required to complete a Hospitalist Admitting Arrangement Attestation – Hospitalist. See "Attachment/Hospital Admitting Arrangement Attestation – Hospitalist" found on the IEHP website,[8] or submit a written agreement between the Plan and Hospitalist Group that includes the following:
   a. Name of the Plan and Hospitalist;
   b. Hospitalist \ covered age range;

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[8] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

c. Hospitals where the Hospitalist will admit;

d. Hospitalist Phone;

e. Hospitalist Fax Number;

f. Hospitalist National Provider Identifier (NPI);

g. Hospitalist W-9 and TIN;

h. The agreement must stipulate a minimum of 30 days advance notice of intent to terminate by either party. Notice of termination must be submitted to IEHP within five (5) days of the Plans knowledge of pending termination; and

i. The agreement must also specify that bills for services rendered are submitted to and paid by the Plan.

3. Upon receipt of the written arrangement from the Plan, IEHP verifies:

   a. The Hospitalist arrangements can collectively cover admissions for all ages for the Plan and respective Hospital.

   b. The Plan and Hospital have an existing and/or upcoming link/affiliation arrangement; and

      1) Plans do not have to obtain Hospitalist arrangements to Hospitals where they do not receive membership assignment.

   c. The Hospitalist aligns with IEHP Direct Hospitalist List

      1) If the Hospitalists' do not align, the written documentation will be forwarded to the IEHP Medical Director for review and approval.

4. Upon approval, IEHP will update the Hospitalist Admitter list for the Plan to reflect the Plans Hospitalist arrangements.

   a. The Plans existing PCPs receiving membership at that hospital, will be reassigned to the Plans Hospitalist arrangement for the respective hospital.

   b. The Plans PCP additions to that hospital, will be assigned with the Plans designated Hospitalist and will appear on the Plans Admitter Reports thereafter, for review and maintenance.

C. If there is a Hospital where a dedicated Hospitalist does not exist, the practitioner may use their own privileges to admit patients. IEHP and the Plan must confirm the physician:

   1. Has admitting privileges at the respective hospital

   2. Is credentialed and contracted with a network hospital where there is membership assignment

D. If a dedicated Hospitalist does not exist at the hospital and the physician does not have their own hospital admitting privileges, the physician may use a physician within their same

practice, same Plan, and same specialty to admit patients on their behalf contingent that they are credentialed and contracted with hospital admitting privileges.

1. If a Delegate PCP physician is using a physician within their same practice, the Plan must verify the following:
   a. Physicians are within the same practice
   b. Physicians are within the same specialty of coverage and same age range
   c. Both practitioners are credentialed and contracted within the same network
   d. The Admitting Physician has admitting privileges to the respective hospital
   e. The Plan has a link at the respective hospital
   f. These arrangements are documented in the physicians credentialing file.
2. Upon submission to IEHP confirms the PCP meets the time and distance requirements as required by IEHP. See Policy 12F, "Hospital Affiliations." and include the physicians hospital arrangements on their provider profile during the submission process to avoid delays and/or rejection.
   a. Hospital arrangements must be documented in the physicians credentialing file.
   b. All rejected submissions must be resubmitted to IEHP via SFTP portal to its entirety.
3. Upon approval, IEHP will update the Hospitalist Admitter List for the Plan to reflect the physicians' admitter arrangements. The Plan will then be responsible for:
   a. Reviewing the Plans Hospitalist Admitter Reports and monthly, thereafter
   b. Ensuring the Admitting Physicians holds current and active admitting privileges at the respective hospitals while listed as an Admitting Physician
   c. Screening the Admitting Physician during the ongoing monitoring of sanctions, on a monthly basis.

E. If there is a Hospital where a dedicated Hospitalist group does not exist, the Plan can contract with an Admitter, who may be a person or group, to admit on behalf of the Plans assigned Members. Admitters must be contracted and credentialed within the same network, and cover the same age range, as the non-admitting Physician, in accordance with regulatory standards and IEHP requirements.

1. If the Plan chooses to contract with an Admitter, the must credential and contract each Admitter affiliated with the contract, to ensure the Admitter:
   a. Provides appropriate coverage for the age range
   b. Is included in the screening of the ongoing monitoring of sanctions,
   c. Holds Admitting privileges to the respective Hospital while listed as an Admitter

2. For all Admitter arrangements, Plans are required to complete a Hospital Admitting Arrangement Attestation. See "Attachment/Hospital Admitting Arrangement Attestation – Admitter" found on the IEHP website,[9] or submit a written agreement between the Plan and Admitter, that includes the following:
   a. Name of the Plan and Admitter;
   b. Admitter's covered age range;
   c. Hospitals where the Admitter will admit;
   d. Admitter's Phone Number;
   e. Admitter's Fax Number;
   f. Admitter's NPI;
   g. Admitter's W-9 and TIN
   h. Name(s), Specialties and NPIs of the Physicians affiliated with the Admitter Agreement
   i. The agreement must stipulate a minimum of t30 days advance notice of intent to terminate by either party. Notice of termination must be submitted to IEHP within five (5) days of the Plans knowledge of pending termination; and
   j. The agreement must also specify that bills for services rendered are submitted to and paid by the Plan.
4. Upon receipt of the written admitting arrangements, IEHP verifies:
   a. The Admitter can collectively cover admissions for all ages for the Plan and respective Hospital;
   b. The Plan and Hospital have an existing and/or upcoming link/affiliation arrangement; and
   c. All physicians affiliated with the Admitter Arrangement is credentialed, contracted and has admitting privileges to Hospitals they are admitting to that are in good standing.
5. Upon approval, IEHP will update the Hospitalist Admitter List for the Plan to reflect the Plans Admitter arrangements.
6. As Plans submit Provider Profile submissions, the Plan confirms the PCP meets the time and distance requirements as required by IEHP. See Policy 12F, "Hospital Affiliations," and include the physicians hospital arrangements on their provider profile during the submission process to avoid delays and/or rejection.

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[9] https://www.iehp.org/en/providers/provider-resources?target=forms

a. Hospital arrangements must be documented in the physicians credentialing file.

b. All rejected submissions must be resubmitted to IEHP via SFTP portal to its entirety.

7. All PCPs that meet IEHPs established criteria, will be added with the Plans current hospital arrangements.

   a. As Hospitalist and Admitters changes are made for each Plan, these changes will be reflected in the Hospitalist Admitters List for review and maintenance.

F. Specialist Practitioners (in the appropriate specialties). See "Attachment/Hospital Admitting Privileges Reference by Specialty" found on the IEHP website,[10] must have admitting staff privileges with at least one (1) contracted Hospital or a formal inpatient arrangement at an IEHP contracted Hospital.[11] IEHP must have these arrangements documented in the Practitioner's file. Plans are required to include these arrangements during the IEHP submission process. Upon receipt of a Provider Application for IEHP or Provider Profile for Plans, IEHP will verify the Specialist:

1. Has admitting staff privileges at the respective hospital listed on the application or provider profile.

   a. If the Practitioner does not have clinical admitting privileges, IEHP and its Delegates must obtain a written statement delineating the inpatient coverage arrangement which must be documented in the Provider's file.

      1) Specialists may use another physician to admit on his/her behalf, the Admitting Physician must be:

         - Within the same specialty
         - Within the same covered age range
         - Within the same practice as the respective physician, to avoid delay in care.
         - The Hospital admitting arrangement will be added to the Hospitalist Admitter Report for review and maintenance by the Plans on a monthly basis.[12]

G. Practitioners who provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services (i.e. Nurse Midwives, Obstetrics/Gynecology, Family Practice 1, Family Practice 2 Providers, Licensed Midwives) must have the following arrangements in place:

1. Nurse Midwives (NM) Providers must meet the following criteria:

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[10] https://www.iehp.org/en/providers/provider-resources?target=forms
[11] 28 CCR 1300.51(d)(H)(iii)
[12] Ibid.

a. In lieu of having full Hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed.

1) The Agreement must include back-up physician's full delivery privileges at IEHP network Hospital, in the same network as the CNM Provider.

a. The OB Provider must be credentialed and contracted within the same practice and network.

2. Family Practice 1: Family Practice that includes Outpatient OB services must:

a. Provide a copy of a signed agreement that states member transfers will take place within the first 28 weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.

1) The OB must be within the same network as the Family Practice Provider and hold admitting privileges to the IEHP contracted Hospital linked with that network.

3. Family Practice 2: Family Practice that includes full OB services and delivery must:

a. Have and maintain full delivery privileges at an IEHP contracted Hospital.

b. Provide a written agreement for an available OB back up Provider is required.

1) The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP Hospital linked with the Family Practice Provider; and

2) Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc.).

4. OB/GYN Providers who would like to participate as a PCP only, will provide outpatient well woman services only with no Hospital or surgical privileges, must provide the following information for consideration:

a. In lieu of having full Hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed and that the OB will provide prenatal care after 28 weeks gestation including delivery. See "Attachment/Patient Transfer Agreement" found on the IEHP website.[13]

1) The Agreement must include back-up Physician's full delivery privileges at IEHP network Hospital, in the same network as the non-admitting OB Provider.

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[13] https://www.iehp.org/en/providers/provider-resources?target=forms

2) The OB Provider must be credentialed and contracted within the same network.

b. These OB/GYNs provide outpatient well woman services only with no Hospital or surgical privileges.

1) This exception must be reviewed and approved by IEHP Medical Director or Chief Medical Officer.

- Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

5. OB/GYN Specialists must have full delivery privileges at an IEHP network Hospital or have an arrangement with an Obstetrics/Gynecology Specialist practicing within their same practice, credentialed and contracted with IEHP, who will admit patients on their behalf. This arrangement must be documented in the Provider's credentialing application.

6. Licensed Midwives (LM) Providers who are authorized to attend cases of normal pregnancy and childbirth, and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn. To assist a woman in childbirth as long as progress meets criteria accepted as normal. LMs must meet the following criteria:

a. In lieu of having full hospital delivery privileges, provide a completed Licensed Midwife Attestation. See "Attachment/Licensed Midwife Attestation", found on the IEHP website.[14]

H. Plans must have established processes for outpatient and inpatient Utilization Management and are responsible for reviewing, maintaining and notifying IEHP of any changes to their hospital admitting arrangements for each of their affiliated links.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
Revision Effective Date:		

[14] https://www.iehp.org/en/providers/provider-resources?target=forms