

HEALTH PLAN OF SAN JOAQUIN		
Subject: Recredentialing of Providers		
Department: Medical Management		Policy #: QA24
Applies to: Medi-Cal; Healthy Families		Scope: QI, UM
Effective Date: 2/96	Revised Date: 6/08	Approved by: Medical Director

POLICY

- A.** Health Plan of San Joaquin (HPSJ) formally recredentials its practitioners at least every 36 months through information verified from primary sources to identify any changes that may have occurred since the last credentialing process that may affect the care provided to its members.
- B. The following types of licensed independent providers shall be recredentialled:**
1. Medical Doctor (M.D.)
 2. Doctor of Osteopathy (D.O.)
 3. Doctor of Podiatric Medicine (D.P.M.)
 4. Doctor of Chiropractic (D.C.)
 5. Doctor of Dental Surgery (D.D.S)
- C. The following types of non-physician medical providers shall be recredentialled:**
1. Family Nurse Practitioner (F.N.P.)
 2. Certified Nurse Mid-wife (C.N.M)
 3. Physician Assistant (P.A.)
 4. Optometrists
 5. Physical therapists
 6. Occupational therapists
 7. Speech and language therapists
- D. Right of Practitioners to Review Recredentialing Application Information**
1. A practitioner has the right to review the information in their recredentialing file, which is used by the Committee to determine participation or contract continuation.
 2. HPSJ staff will notify practitioners of this right in a number of ways:
 - a) recredentialing application and/or
 - b) provider contract and/or
 - c) provider Services Manual and/or
 - d) other publications.

E. Notification to Practitioners of Information Discrepancies

1. In the event that recredentialing information obtained by HPSJ varies substantially from that provided by the Practitioner, the Credentialing Specialist would notify the Practitioner by letter, telephone, or fax. If the notification is conducted by telephone, it will be documented and retained in the credentialing file.
2. HPSJ staff is not required to reveal to practitioners the source of information if that information is not obtained to meet HPSJ credentialing verification requirements or if law prohibits disclosure.

F. Right of Practitioners to Correct Erroneous Information.

1. Practitioners have the right to correct erroneous information submitted by another party in the course of the recredentialing process.
2. HPSJ staff will notify practitioners of this right in a number of ways:
 - a) recredentialing application and/or
 - b) provider contract and/or
 - c) Provider Services Manual and/or
 - d) other Publications

G. Confidentiality of Information

1. Credential files and all relevant credentialing and recredentialing information are maintained as high-level secured documents. Confidentiality is maintained via file storage in locked cabinets, in secure offices. File access is limited to the Medical Director, Director of Medical Management, and the QI Manager. Provider information stored in an electronic database is confidential and secure, accessible only by personnel with a unique password.
2. Committee members and HPSJ staff are required to sign confidentiality statements annually.

PROCEDURE

A. Licensure Verification

1. The Credentialing Specialist verifies that a current, valid license to practice in the state of California is in effect at the time of the Peer Review/Credentialing Committee's decision. Verification must come directly from the state-licensing agency. The verification time limit is 180 days.

B. Recredentialing Verification

1. The Credentialing Specialist verifies the following factors within 180 days:
 - a) A valid DEA or CDS certificate, as applicable

- b) Board certification, if the practitioner states that he/she is board certified.
 - Board certification must be verified at recredentialing if a practitioner has acquired an additional board certification or the practitioner's board certification expired since the last credentialing. Further verification of education and training for a previously board-certified practitioner is not required, even upon expiration of the board certification (i.e., residency training or graduation from medical school).
- c) History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

C. Application Correctness/Completeness

- 1. The practitioner completes an application for membership that includes a current and signed attestation with the following factors:
 - a) reasons for any inability to perform the essential functions of the position, with or without accommodation
 - b) lack of present illegal drug use
 - c) history of loss or limitation of privileges or disciplinary activity
 - d) current malpractice insurance coverage
 - e) correctness and completeness of the application

D. Practice History and Current Malpractice Coverage

- 1. An application must contain:
 - a) A history of loss of license and felony convictions
 - b) A history of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges.
- 2. An application should include the dates and amount of the current malpractice insurance coverage. The practitioner must attest to the correctness and completeness of the application. If the application form does not include specific questions regarding the dates and amount of a practitioner's current malpractice insurance, HPSJ will use a signed addendum or obtain a copy of the insurance face sheet.

E. HIV/AIDS Specialist Designation

- 1. Included in the application packet for completion is the HIV/AIDS Specialist Designation Request form – Attachment A. This form details the educational or clinical requirements for designation as a HIV/AIDS specialist for internal Medicine Physicians..

F. Recredentialing Process

1. The credential specialist for correctness and completeness reviews each provider's credentialing file. Any file identified as having potential issues is referred to the QI Manager to review and make recommendations in consultation with the Medical Director. Potential issues needing review by the QI Manager and Medical Director include:
 - a) Any YES response on the Practitioner Application Attestation Questionnaire, 1-14
 - b) Any denial, limitation, restriction, suspension, revocation, forfeiture of, or subject to probationary condition, disciplinary action, or voluntarily or involuntarily relinquishment, or such pending action, of providers:
 - State License
 - DEA Registration
 - Hospital Clinical Privileges
 - Professional Organization Membership
 - Medicare/Medicaid Participation
 - c) Any malpractice cases within the past three years
 - d) Any malpractice case settled over \$30,000 within the past three years
 - e) Any cases found through inquiry of the NPDB not reviewed during a previous credentialing cycle
 - f) Refusal to comply with a corrective action plan based on a facility site or medical chart audit, or non-compliance with Committee recommendations
 - g) Provider appears on the Medi-Cal Sanction Report, lists of parties Excluded from Federal Procurement and Non Procurement Program, Medi-Cal Participation Exclusion Report, or the Medical Board Hot Sheet Report
 - h) Member complaints exceed threshold

G. Committee Review

1. The Committee shall review the provider profile and supporting documentation to determine if the provider meets criteria for recredentialing
2. If the Committee does not approve a provider for recredentialing, the provider will be notified of the decision via certified letter. The provider may appeal the decision using the process as identified in the Fair Hearing Process for Adverse Decisions policy, QA 37.
3. The Committee shall present recommendations for provider re-credential in a summary report to the Commission for final approval.
4. If the Committee, as a result of its review of data and performance, recommends termination or suspension of privileges of any participating provider, the provider will be notified of the recommendation before the issue is brought to the Commission.

5. The Committee shall, give the provider the opportunity to respond. If after such response, the Committee continues to recommend provider sanctioning, the recommendation and all the supporting documents including the provider's response shall be presented to the Commission by the HPSJ Medical Director in executive session. The Commission shall take final action. Certified letter from the HPSJ Medical Director will immediately notify the provider.
6. In the event of sanction, suspension or termination of privileges by the Commission, the Medical Director or designee shall notify the State Department of Health Services, the State Medical Board of California, and any participating hospital where the provider has privileges.
7. The provider's current patients will be notified by HPSJ. If the provider is a primary care physician, assigned members will be offered the choice of, or auto-assigned to another primary care physician.

H. Repeated Requests for Recredentialing Materials From the Provider

1. Recredentialing packets are sent to the provider. The provider has 15 days to send the recredentialing materials to HPSJ. If materials are not received within that timeframe, the credentialing specialist sends a second request on the 16th day.
2. If the recredentialing materials are not received 15 days after the second notice, on the 16th day, a THIRD AND FINAL notice is sent to the provider via certified mail by the Contract Manager. This letter notifies the provider that he/she has an additional 15 days to forward recredentialing materials to HPSJ. The letter further explains that if the completed forms are not received by the date stated in the letter and the provider's credentialing lapses, HPSJ will have no other alternative but to send a Notice of Termination to the provider. (see attached template)
3. If the recredentialing materials are not received within 15 days of the final notice, on the 16th day, the credentialing specialist notifies the Contract Manager. The Contract Manager terminates the provider and sends the provider a termination letter. The contract Manager attempts to obtain materials. If unable to do so, contract manager begins termination process after recredentialing appointment date expires.

REFERENCE

- A. DHS contract, Exhibit A, Attachment 4, Credentialing and Recredentialing
- B. DHS MMCD Policy Letter 02-03
- C. NCQA MCO Surveyor Guidelines

Created by/Date	Revised by/Date	Revised by/Date	Revised by/Date	Revised by/Date	Revised by/Date
2/96	D. Lesko 3/05/01	S. Steely 2/28/02	S. Steely 9/15/03	S. Steely 3/22/05	

**Practitioner 2168 Fax Back Form
HIV/AIDS Specialist Designation Request**

Fax To: _____

Fax Number: _____

Return By Date: _____

- No, I do not wish to be designated as an HIV/AIDS specialist.
- Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:
 - I am credentialed as an “HIV Specialist” by the American Academy of HIV Medicine.
OR
 - I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV medicine by a member board of the American Board of Medical Specialties;
OR
 - I am board certified in Infectious Disease and in the past 12 months have clinically managed at least 25 HIV patients and completed 15 hours of category 1 CME in HIV medicine, five hours of which was related to antiretroviral therapy;
OR
 - In the past 24 months I have provided clinical management to 20 HIV patients and in the past 12 months have completed board certification in Infectious Disease;
OR
 - In the past 24 months I have provided clinical management to 20 HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV medicine;
OR
 - In the past 24 months I have clinically managed at least 20 HIV patients and in the past 12 months have completed 15 hours of category 1 CME in HIV medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

I attest that, to the best of my knowledge, the information can be supported by documentation (if required).

Physician’s Name (Print) _____ Date _____

Signature _____ License # _____

Telephone #

Name and Title of Person Submitting Form _____