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SECTION 3: PROVIDER CREDENTIALING

CREDENTIALING

Credentialing is an important function of the Quality Management and Improvement (QMI) Department. The HPSJ credentialing program has been developed in accordance with the standards of the National Committee for Quality Assurance (NCQA), the California Department of Health and Human Services (DHCS), California Department of Managed Health Care (DMHC), and all other State and federal requirements. HPSJ initially credentials most health care providers seeking to participate in the network and recredentials them at least every three (3) years. Credentialing information submitted to HPSJ is reviewed and verified using many resources including Primary Source Verification as applicable. To verify information, HPSJ uses the same sources and processes for initial credentialing and recredentialing.

In order to assure the highest quality health care delivery system and to maintain compliance with all regulatory agencies, HPSJ credentials or oversees the credentialing of the following types of providers:

- Physicians (MD)
- Osteopathic Practitioners (DO)
- Podiatrists (DPM)
- Nurse Practitioners (NP)
- Chiropractors (DC)
- Oral Surgeons (DMD)
- Physician Assistants (PA)
- Nurse Midwives (NMW)

In addition, HPSJ also credentials the following allied health professionals and ancillary providers:

- Psychologists
- Optometrists
- Physical Therapists
- Speech/Hearing Therapists
- Occupational Therapists
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage Family Therapists (LMFT)
- Other allied or ancillary providers as deemed necessary

The credentialing process typically takes between sixty (60) and ninety (90) days. The information gathered during this process is confidential and disclosure is limited to parties who are legally permitted under State and federal law to have access to this information.

In order to maintain health care quality standards, no Members will be assigned or referred to providers who have not completed the credentialing process and signed an Agreement with HPSJ to participate in the network.

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OBTAINING A CREDENTIALING APPLICATION

For New Contract Opportunities, please contact the Contracting Department:

San Joaquin County: Alexis Villanueva avillanueva@hpsj.com or Mayra Portillo mportillo@hpsj.com

Stanislaus County: Juanita Vauss jvauss@hpsj.com or Angela Hernandez ahernandez@hpsj.com

Contracting Coordinator or Network Manager will screen provider for Medi-Cal Fee for Service Enrollment or submission prior to contacting the Credentialing Department to send out the Electronic Credentialing application.

For Existing Contracted Providers, please contact the Credentialing Department:

Initial Applications are processed by Provider last name:

A through L: Mae Cayetano mcayetano@hpsj.com

M through Q: Tami O'Reilly toreilly@hpsj.com

R through Z: Alejandra (Alex) Chavez achavez@hpsj.com

REQUIREMENTS FOR NETWORK PARTICIPATION

Requirements for Physicians

HPSJ will ensure that at a minimum, physicians considered for network participation and continued participation are in good standing (through Primary Source Verification, as applicable) and meet the following criteria before being accepted in the network:

- Valid, unrestricted, and current California State license
- Clinical privileges at a Hospital or coverage arrangements with another physician for Members who require hospitalization (if applicable)
- Current and valid federal Drug Enforcement Agency (DEA) registration for the State
- Current and valid Controlled Dangerous Substance (CDS) certificate for the State
- Graduation from an approved medical school and completion of an appropriate residency or specialty program
- Board certification (if required)
- Work history of the preceding five (5) years acceptable to HPSJ
- Current professional liability (malpractice) insurance in amounts acceptable to HPSJ

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- Professional liability claims history acceptable to HPSJ
- Absence of Office of Inspector General (OIG) exclusions
- Absence of State sanctions against licensure
- National Practitioner Data Bank (NPDB) query results acceptable to HPSJ
- Absence of Quality of Care and service issues
- Facility Site Review (FSR) findings acceptable to HPSJ, if an office site visit is conducted

For recredentialing, acceptable findings from quality reporting is required. This may include but is not limited to a review of:

- Member and Provider complaints
- Results of access and satisfaction surveys
- Grievance reports
- Potential Quality Incident (PQI) reporting

Requirements for Non-Physician Providers & Non-Physician Medical Practitioners

HPSJ shall ensure, at a minimum, that non-physician providers and Non-Physician Medical Practitioners are considered for network participation and continued participation are in good standing (through Primary Source Verification, as applicable) and meet the following criteria before being accepted in the network:

- Valid, unrestricted, and current State license
- For prescribing practitioners, current, valid federal Drug Enforcement Agency (DEA) registration for the State
- For prescribing practitioners, current, valid Controlled Dangerous Substance (CDS) certificate, for the State
- Work history of the preceding five (5) years acceptable to HPSJ
- Current professional liability (malpractice) insurance in amounts acceptable to HPSJ
- Graduation from an approved professional school
- Board certification, if applicable
- Hospital clinical privileges, if applicable
- Professional liability claims history acceptable to HPSJ
- Absence of Office of Inspector General (OIG) exclusions

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- Absence of State sanctions against licensure
- National Practitioner Data Bank (NPDB) query results acceptable to HPSJ
- Absence of Quality of Care and service issues

THE CREDENTIALING PROCESS

During the credentialing process, the information on the provider's electronic credentialing application is reviewed and verified for correctness, and then reviewed through government verification sources which will include, but not be limited to:

- National Practitioner Data Bank (NPDB)
- Office of Inspector General (OIG)
- State licensing boards for California and other states if applicable

In addition to providing documentation, a Facility Site Review (FSR) may be required for Primary Care Physicians (PCP). Providers will be contacted by HPSJ FSR Team to schedule and coordinate the FSR.

Completed electronic credentialing applications will then be presented to the Peer Review & Credentialing Committee (PR&CC) which currently meets every other month. The PR&CC reviews each credentialing application to determine if the provider meets the initial credentialing or recredentialing criteria, and then makes the decision to either accept or reject a provider's application.

All credentialing applications approved by the PR&CC are submitted to the San Joaquin County Health Commission for review and final approval. The Commission meets monthly and once the Commission grants approval, HPSJ can offer or complete an Agreement with the provider.

INITIAL CREDENTIALING

The provider data that is examined during the credentialing and recredentialing process includes:

- California State licensure
- Current professional liability insurance or self-insurance
- Provider's primary admitting hospital, if appropriate
- Exclusions, suspensions, or ineligibility to participate in any State or federal health care program
- National Provider Identification (NPI) number
- Valid California Drug Enforcement Agency (DEA) or Controlled Dangerous Substance

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(CDS) certificate, if applicable

- Education and training, including board certification (if the provider states on the application that he or she is board certified)
- American Medical Association (AMA) screening for Education Commission for Foreign Medical Graduates (ECFMG)
- Work history
- History of professional liability claims
- National Practitioner Data Bank
- Licenses of any mid-level providers employed under the provider, as well as verification of liability insurance coverage for the mid-level provider.

RECREREDENTIALING

HPSJ re-credentials all Providers at least every three (3) years but may re-credential Providers more often if it is deemed necessary. The same information that is reviewed during the initial credentialing process is usually reviewed during the recredentialing process with the exception of the Provider's educational credentials and work history. In addition, HPSJ will review Provider contact logs to assess any Quality of Care issues.

The recredentialing process requires a timely response from all Providers. Providers will receive an electronic recredentialing link five (5) months in advance of the three (3) year anniversary of the last credentialing date. Providers are required to complete identified areas of the application and verify that the information provided on the application is current. Electronic Recredentialing packets are sent to practitioners at least every thirty-six (36) months or sooner.

The practitioner has 15 business 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. If the recredentialing materials are not received 15 business days after the second notice, on the 16th day, a THIRD AND FINAL notice is sent to the practitioner via email by the Contracting Department.

If the recredentialing materials are not received within 15 business days of the final notice, on the 16th day, the Credentialing Specialist notifies the Contracting Department. The Contracting Department attempts to obtain the materials. If unable to do so, the Contracting Department notifies the practitioner that he or she will receive an Administrative Termination via Certified Mail as the recredentialing appointment date has expired.

A practitioner may reapply for participation however the full initial credentialing process will be required.

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PROVIDER'S RIGHTS DURING THE CREDENTIALING PROCESS

Review of Credentialing Files

Providers have the right to review the information in their credentialing files that have been obtained in order to evaluate their credentialing application. This includes the application, attestation, and Curriculum Vitae (CV), and information from outside sources. Files that are not available for review would include references, recommendations, or other peer-review protected information which are used by the Chief Medical Officer and/or PR&CC to determine initial network participation and/or contract continuance.

Requests to review this file must be made in writing to the Chief Medical Officer and the Chief Medical Officer will be present at the time of review.

HPSJ notifies providers of this right to review credentialing files through a number of sources which include notifications in the credentialing application or reapplication cover letter, the HPSJ website, the provider contract, this Provider Manual, and other publications distributed to providers.

Notification of Errors in Credentialing Submissions

In the event that credentialing information obtained by HPSJ varies substantially from that provided by the provider on the application materials, HPSJ Credentialing Specialists will notify the provider by letter, telephone, or fax. If the notification is conducted by telephone, the date, time, and the person initiating the call and obtaining the information along with the response will be documented and the documentation retained in the credentialing file.

The notification to the provider will include the following:

- A description of the discrepancy
- A request for a written explanation and/or correction of the discrepancy
- The name and telephone number of the Credentialing Specialist to whom the response should be submitted
- Notification that a written response is due no later than sixty (60) calendar days from the date of the letter
- Notification that failure to respond within the sixty (60) calendar days will result in, for initial application, closure of the file for lack of response
- For recredentialing Providers, notification that the file will be presented to the Peer Review and Credentialing Committee without benefit of explanation or correction of the discrepancy

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The Credentialing Specialist will review the response, sign and date the response, and then notify the provider that the response has been received. The Credentialing Specialist will also document the receipt and notification to the provider of the receipt of the information in the credentialing file. HPSJ staff members are not required to reveal to a provider the source of the information if the information is not obtained to meet HPSJ's credentialing verification requirements, or if law prohibits disclosure.

Correction of Erroneous Information

Providers have the right to correct erroneous information they may have provided or which has been submitted by another party in the course of the credentialing process. If information provided on the application is inconsistent with information obtained via Primary Source Verification in the credentialing or recredentialing process, the Credentialing Specialist will send the provider a written notification of the discrepancy and request formal written clarification.

This letter will include a summary of the information in question and a request to have the provider's response to the information returned within fourteen (14) business days. This letter will be sent electronically or via certified mail marked as "Confidential" with return receipt requested.

Providers do not have the right to correct an application already submitted and attested to be correct and complete. However, they may submit an addendum to correct erroneous information they may have provided, or which is submitted by another party. If preferred, the provider may add an explanation for the erroneous information on their application, include a signed and dated statement attesting to the accuracy of the information provided, and then return the information to the Credentialing Specialist who initiated the query.

Application Status and Notification on Decision

Providers have the right to receive information about the status of their application or reapplication and may contact the Credentialing Department at any time to request this information.

HPSJ will notify providers in writing of their approval no later than sixty (60) calendar days from the Peer Review and Credentialing Committee's (PR&CC) approval date. Any provider who is denied participation, approved with conditions, pended or terminated, will be notified in writing within sixty (60) days of the PR&CC's action and given the reasons for the decision.

CREDENTIALING A NEW GROUP PROVIDER

To ensure that there is no disruption in obtaining services requiring prior Authorization and to avoid claims being denied, it is imperative that any new provider who joins a Group which is in the HPSJ Provider network is approved by the PR&CC prior to providing Covered Services to Members.

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Before a provider can be added to a Group contract the new provider must receive notification from the Credentialing Department that all credentialing requirements have been met. In addition, providers must receive official notice from the Contracting Department as to the effective date upon which they can provide Covered Services to Members. The Provider Services Department should be contacted as soon as possible when new providers are joining a Group.

DELEGATED CREDENTIALING

When appropriate and at our sole discretion, HPSJ may elect to delegate credentialing functions to another entity. However, responsibility for final acceptance of a provider and the continuation of a Provider rests with the PR&CC and the San Joaquin County Health Commission.

Each delegated credentialing entity must sign the *Delegated Credentialing Agreement* which outlines the responsibilities of both HPSJ and the delegated entity, as well as the evaluation process of the delegated entity's performance. Delegated entities must also meet all other criteria as outlined in HPSJ's delegation policies.

Delegation is renewed annually, contingent upon an ongoing evaluation of the delegate's performance and successful completion of delegation audits. Either party may terminate the *Delegated Credentialing Agreement* without cause with thirty (30) days prior written notice. Delegated entities must provide practitioner rosters at least quarterly to the Compliance Department. These rosters can be submitted to: ComplianceDepartment@hpsj.com

Any Provider additions or terminations that occur in between the quarterly submittals must be submitted to the Compliance Department as soon as possible and as often as they occur. Failure to provide timely updates to the practitioner rosters may result in Provider Authorizations and claims being denied.

FACILITY SITE REVIEW (FSR)

HPSJ conducts site reviews for all primary care sites contracted to provide care to Medi-Cal Members as required by California statute (Title 22, section 56230). This review is done at the time of initial credentialing and every three (3) years at a minimum as part of the recredentialing process. Providers must notify HPSJ at least thirty (30) days prior to the relocation of their practice or clinic so that a review may be conducted at the new site. The site review process includes the following:

- **Facility Site Review (FSR):** a formal review of primary care sites that occurs prior to the practice accepting Medi-Cal Managed Care Members, and then every three (3) years thereafter
- **Medical Record Review (MRR):** A review of selected medical records to determine compliance in the documentation of clinical care

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- **Physical Accessibility Review Survey (PARS):** A review to determine physical accessibility for seniors and people with disabilities

All new primary care sites must undergo an initial full scope site review and attain a minimum passing score of eighty percent (80%) on both the FSR and on MRR surveys. Initial full scope site reviews will be performed at sites that have not previously had a FSR, PCP sites that have not had a FSR within the past three (3) years, and PCP sites that are returning to Medi-Cal Managed Care and have a passing score but were previously terminated for cause and non-compliance with their Corrective Action Plans (CAP).

The FSR can be waived by HPSJ for a pre-contracted provider site if the provider has documented proof that a current FSR with a passing score was completed by another health plan within the past three (3) years. HPSJ may review sites more frequently if it is determined necessary.

Non-Compliance or Failure on FSR

Pre-contractual providers

Prior to being contracted with HPSJ, a provider must pass the FSR at a score of eighty percent (80%) or higher. HPSJ reserves the right not to contract with any provider who does not pass the pre-contractual FSR.

Contracted Providers

Contracted Providers must also pass the FSR at a score of eighty (80%) or higher. HPSJ reserves the right to remove from the provider network any Provider with a non-passing score. However, if a Provider with a non-passing score is permitted to remain in the Provider network, survey deficiencies must be corrected and verified by HPSJ.

Non-Compliant Provider

New Members will not be assigned to Providers that score below eighty (80%) on a subsequent FSR, until corrections are verified, and the CAP is closed. Any Provider who does not come into compliance with survey criteria within the established timelines will be removed from the network and their Members will be re-assigned to other Providers. HPSJ will provide these Members with thirty (30) days' notice that the non-compliant Provider is being removed from the network.

In addition, provider sites that score below eighty percent (80%) in either the FSR or MRR for two (2) consecutive reviews must score a minimum of eighty percent (80%) in the next site review in both the FSR and MRR (including sites with open CAPs in place). Sites that do not score a minimum of eighty percent (80%) in both the FSR and MRR must be removed from the network and Members must be appropriately reassigned to other Providers.

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Corrective Action Plans for Deficiencies

All sites that receive a Conditional Pass, which is defined as eighty to eighty nine percent (80–89%), or ninety percent (90%) and above with deficiencies in critical elements, pharmaceutical services, or infection control, will be required to establish a CAP that addresses each of the noted deficiencies. CAP documentation must identify:

- Specific deficiency
- Corrective action(s) needed
- Re-evaluation timelines/dates
- Responsible person(s)
- Problems in completing corrective actions
- Education and/or technical assistance provided by HPSJ
- Evidence of the correction(s)
- Completion/closure dates
- Name/title of reviewer

Timelines for CAP

Providers will be informed of non-passing survey scores, critical element deficiencies, other deficiencies that require immediate corrective action, and the CAP requirements for these deficiencies.

Below is the timeline for correction and reporting:

CAP Timeline	CAP Action(s)
FSR and/or MRR Completion Day	The MCP must provide the PCP site a report containing: <ul style="list-style-type: none">• The FSR and/or MRR scores;• Any critical element findings, if applicable; and• A formal written request for CAPs for all critical elements, if applicable.
Within 10 calendar days of the FSR and/or MRR	<ul style="list-style-type: none">• The PCP site must submit a CAP and evidence of corrections to the MCP for all deficient critical elements, if applicable.• The MCP must provide a report to the PCP site containing FSR and/or MRR findings, along with a formal

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	<p>written request for CAPs for all non-critical element deficiencies.</p> <ul style="list-style-type: none"> • The MCP must provide educational support and technical assistance to PCP sites as needed.
Within 30 calendar days from the date of the FSR and/or MRR report	<p>The MCP must conduct a focused review to verify that CAPs for critical elements are completed.</p> <ul style="list-style-type: none"> • The PCP site must submit a CAP for all non-critical element deficiencies to the MCP. • The MCP must provide educational support and technical assistance to PCP sites as needed.
Within 60 calendar days from the date of the FSR and/or MRR report	<ul style="list-style-type: none"> • The MCP must review, approve, or request additional information on the submitted CAP(s) for non-critical findings. • The MCP must continue to provide educational support and technical assistance to PCP sites as needed.
Within 90 calendar days from the date of the FSR and/or MRR report	<p>All CAPs must be closed.</p> <ul style="list-style-type: none"> • Providers can request a definitive, time-specific extension period to complete the CAP(s), not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.
Beyond 120 days from the date of the FSR and/or MRR report	<ul style="list-style-type: none"> • The MCP must request approval from DHCS to complete a CAP review for any extenuating circumstances that prevented completion of a CAP within the established timeline. • The MCP must conduct another FSR and/or MRR, as applicable, within 12 months of the applicable FSR and/or MRR date(s).

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FACILITY AND ANCILLARY CREDENTIALING

Facilities and ancillary providers seeking to contract with HPSJ must fill out an application and meet the following criteria before they are accepted in the network. This information will be reviewed by the HPSJ Contracting Department who will make a decision as to whether or not to pursue contracting. The criteria for participation and continued participation may vary depending upon the types of Covered Services provided. The minimum criteria are as follows:

Facility Providers

- Valid California state license
- Current general and professional liability (malpractice) insurance in amounts acceptable to HPSJ
- Medicare/Medi-Cal Certification
- Accreditation by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or another accreditation body acceptable to HPSJ, if applicable
- Absence of Office of Inspector General (OIG) exclusions

Ancillary Providers

- Valid business license
- Current general and professional liability (malpractice) insurance in amounts acceptable to HPSJ
- Medicare/Medi-Cal certified and/or participating, as appropriate
- Clinical Laboratory Improvement Amendment (CLIA) certificate if applicable
- Accreditation for Radiology/Imaging, if applicable
- Absence of Office of Inspector General (OIG) exclusions

For more information regarding specific requirements for participation, please contact the Provider Contracting Department at (209) 942-6320.