
5. CREDENTIALING AND RECREDENTIALING

A. IEHP Practitioner Guidelines

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Providers.

POLICY:

- A. IEHP will follow these guidelines for recommended education and/or training for PCPs and specialists, patient age ranges for practitioners, and recommendations for review of malpractice or other adverse history when making credentialing and recredentialing decisions.
- 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.

PROCEDURE:

- A. IEHP must use the following guidelines when credentialing or recredentialing practitioners for participation in IEHP's network.
1. Education and Training Guidelines
 - a. PCPs – physicians being reviewed for credentialing as a PCP must meet the following criteria as indicated:
 - 1) Pediatrics - either board certified, three years pediatrics residency training, or rotating internship plus two years residency [Post Graduate Years (PGY-2, 3)] in pediatrics.
 - 2) Family Practice - either board certified, three years family practice residency training, or rotating internship plus two years residency (PGY-2, 3) in family practice.
 - 3) Family Practice 1 (Family Practice including outpatient OB services) – either board certified, three years family practice residency training or rotating internship plus two years residency (PGY-2,3) in family practice. Must include signed agreement with delivering OB which states that member transfers will take place within the first 28 weeks of gestation and a protocol for identifying and transferring high risk members.
 - 4) Family Practice 2 (Family Practice including full OB services and delivery) - either board certified, three years family practice residency training or rotating internship plus two years residency (PGY-2,3) in family practice. Must have full delivery privileges at an IEHP network hospital, a protocol for identifying and

5. CREDENTIALING AND RECREDENTIALING

A. IEHP Practitioner Guidelines

transferring high risk members and stated types of deliveries performed (i.e.: low-risk, cesarean section, etc). A written agreement for OB back up provider must be available. Providers that fulfill these requirements may be referred to and see OB/GYN Members within the same IPA.

- 5) Internal Medicine - either board certified, three years internal medicine residency training, or rotating internship plus two years residency (PGY-2, 3) in internal medicine.
- 6) OB/GYN - board certification, or completion of a four year OB/GYN residency, documentation of primary care practice in the United States and 50 Continuing Medical Education (CME) units for prior three year period, half of which must be in primary care related areas. Must have full delivery privileges at an IEHP network hospital.
- 7) General Practice - at a minimum, completion of a 1 year rotating internship or PGY-1 Family Practice, documentation of primary care practice in the United States which includes a mix of pediatric and adult patients, and evidence of 50 Continuing Medical Education (CME) units in primary care related areas for prior three year period.
- 8) General Practice 1 (General Practice including outpatient OB services) – at a minimum, completion of a 1 year rotating internship or PGY-1 Family Practice, documentation of primary care practice in the United States which includes a mix of pediatric and adult patients, and evidence of 50 CME units in primary care subjects for prior three year period, half of which must be in OB/GYN related areas. Must include signed agreement with delivering OB which states that member transfers will take place within the first 28 weeks of gestation and a protocol for identifying and transferring high risk members.
- 9) Practitioners outside of scope - Practitioners must have evidence of half of all CME in the specialty outside of their normal scope of practice (i.e. Internal Medicine with expanded age range to all ages or General Practice board certified in Pediatrics only).
 - a) Practitioners who do not meet the internship or residency requirements can be considered for General Practice if they demonstrate significant primary care practice experience and evidence of significant recent CME in primary care related areas.

5. CREDENTIALING AND RECREDENTIALING

A. IEHP Practitioner Guidelines

Practitioners must provide a letter of recommendation from a physician he/she has worked with for at least 24 months in the requested specialty and include 25 CME in area of requested scope, continuing to do so for duration of participation in the IEHP network.

OR

Evidence of taking and passing board certified prep class and include 25 CME in area of requested scope, continuing to do so for duration of participation in the IEHP network.

b. Physicians being reviewed for credentialing as a specialist practitioner should meet one of the following criteria:

- 1) Board Certification in the specialty and subspecialty, if applicable, or
- 2) Proof of education and/or residency training and/or fellowships as appropriate for the particular specialty and additional training required for subspecialties as applicable.
- 3) Physicians must maintain current license, malpractice and DEA. Optometry providers must maintain TPA or DPA certification.
- 4) All OB/GYN providers must provide OB as well as GYN care to Members. All OB/GYN providers must have full delivery privileges at an IEHP network hospital.
- 5) All 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 IPA or IEHP directly. CNM must have a physician back-up agreement with an IPA or IEHP credentialed network OB physician. Agreement must include back-up physician's full delivery privileges at an IEHP network hospital, a protocol for identifying and transferring high risk members, stated types of deliveries performed (i.e.: low-risk, cesarean section, etc), and must be available for consultations, as needed.

2. Patient Age Ranges

- a. Patient age ranges for PCPs and non-physician practitioners must be specifically delineated as part of the IPA credentialing process.
- b. Guidelines for age ranges for PCPs are:

5. CREDENTIALING AND RECREDENTIALING

A. IEHP Practitioner Guidelines

- 1) Pediatrics - ages 0-18 or 0-21
 - 2) Family Practice - all ages, or 14 and above only
 - 3) Internal Medicine - age 14 and above, 18 and above, or 21 and above
 - 4) OB/GYN - age 14 and above, restricted to females
 - 5) General Practice – age 14 and above or all age ranges if evidence of pediatric training, experience and/or CME is present.
- c. Guidelines for age ranges for non-physician practitioners which include Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Dieticians and Nutritionists are as applicable to the training and certification of the non-physician practitioner.
 - d. Patient age ranges for specialty physicians are specific to the specialty involved, training, and education of the physician.
3. Provider Privilege Adjustments
 - a. Providers are required to submit a detailed explanation when requesting a change in practice parameters such as an expansion or education in Member age range or specialty care privileges.
 - b. IEHP will consider all relevant information including practice site demographics, provider training, experience and practice capacity issues before granting any such change.
 - c. At a minimum, provider submissions must include:
 - 1) A written explanation specifically outlining the material basis for the requested change;
 - 2) Documentation of any relevant training (e.g., Continuing Medical Education, post graduate/residency training, etc.);
 - 3) Practical experience relating to the request (e.g., years in clinical practice, direct care experience with the relevant membership, etc.); and
 - 4) Supplemental CHDP certification, if applicable
 4. Adverse History Guidelines
 - a. IEHP must carefully review all practitioners with evidence of adverse history, including malpractice history, adverse licensing, privileges, sanctions or other negative actions.

5. CREDENTIALING AND RECREDENTIALING

A. IEHP Practitioner Guidelines

- b. For practitioners with a history of malpractice suits or decisions, the following criteria warrants full discussion and review of the history and should be applied in making credentialing and recredentialing decisions:
 - 1) Number of claims - three claims in any five-year period.
 - 2) Results of cases - multiple settled or negative verdicts in excess of \$100,000.
 - 3) Trends in cases - practitioners with multiple malpractice claims in a similar area (e.g., missed diagnosis, negative surgical outcomes, etc.).
 - c. Practitioners with any history of negative license actions, sanctions by Medicare or Medicaid, negative privilege actions or other negative actions against them (felony convictions, etc.) must be fully discussed and reviewed by IEHP's Credentialing Subcommittee prior to a committee recommendation.
 - d. Practitioners who are currently on probation with the Medical Board of California (MBOC) must be fully discussed and reviewed by IEHP's Credentialing Subcommittee. The reason for the probation, conditions of the probation and compliance with probation conditions by the practitioner must be considered during the credentialing decision making process.
- B. If review by IEHP's Credentialing Subcommittee does not meet the above requirements, IEHP can submit the practitioner to the Peer Review Subcommittee for review as stated in Policy 5C, "IEHP Quality Oversight of Participating Practitioners." IEHP reserves the right to approve, disapprove, terminate or otherwise limit practitioner participation in the IEHP network for quality issues.
- C. 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 5-1 and 5-2 in Section 5, "Attachments").

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	January 1, 2007
Chief Title: Chief Executive Officer	Revised date:	January 1, 2012

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Providers.

POLICY:

- A. IEHP provides all credentialing (including recredentialing) functions for participating practitioners as delineated below. .
- B. 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 a minimum, this includes all Physicians (MDs), Osteopaths (DOs), Podiatrists (DPMs), Chiropractors (DCs), Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Dieticians and Nutritionists who are contracted to treat Members and who fall within IEHP's scope of authority and action. IEHP is required to credential all psychiatrists, psychologists, master level clinical nurses, Licensed Clinical Social Workers (LCSW), and Marriage, Family Therapist (MFTs), and other behavioral health professionals licensed to provide behavioral health services in the state of California IEHP contracts and credentials Dentists (DDSs) who provide medical services only (if applicable). IEHP does **not** contract with Dentists where services rendered by these practitioners are not covered by IEHP. IEHP does not require covering practitioners and locum tenens that do not have an independent relationship with IEHP or an IPA to be credentialed. IEHP does not credential practitioners that are hospital based and do not see Members on a referral basis.
- C. IEHP is required to verify the accreditation status, license, certification and standing with regulatory bodies of all subcontracted organizational providers (as applicable), in compliance with the most current NCQA standards. Subcontracted organizational providers include but are not limited to hospitals, home health agencies, skilled nursing facilities, and freestanding surgical centers, including family planning facilities and alternative birth centers. Subcontracted mental health and substance abuse providers include inpatient, residential, and ambulatory settings.
- D. IEHP must obtain approval of practitioners seeking participation with IEHP from IEHP's Credentialing Subcommittee and IEHP's Medical Director before assignment of Members. IEHP credentialed and approved practitioners must meet IEHP practitioner guidelines for education, age limits and other criteria as specified in Policy 5A, "IEHP Practitioner Guidelines."
- E. Delegated IPA and IEHP must maintain a full credentialing file and perform all necessary credentialing activities per the most current NCQA guidelines requirements.
- F. IEHP may designate to their Medical Director the authority to determine and sign off on a

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

credentialing and recredentialing file that meets the IEHP's standards as complete, clean, and approved. IEHP may assign an associate medical director or other qualified medical staff member as the designated medical director if the individual has equal qualifications as the medical director and is responsible for credentialing, as applicable. IEHP's Credentialing Subcommittee has the opportunity to review the credentials of all practitioners being credentialed or recredentialed who do not meet the established criteria, and to offer advice as necessary.

- G. All PCPs must undergo a facility review by IEHP as part of the credentialing process.
- H. All PCPs must pass a required initial facility review performed by IEHP prior to receiving IEHP enrollment and treating Members. IEHP has 90 days from the submission of all required credentialing information to complete the facility site review.
- I. IEHP is responsible for recredentialing their contracted PCPs, non-physician practitioners, and specialists as defined above every three years and submit specific updates to IEHP. Practitioners must be recredentialed within 36 months of the last Committee approval date.
- J. IEHP is required to adhere to all procedural and reporting requirements under state and federal laws and regulations regarding the credentialing process, including the confidentiality of practitioner information obtained during the credentialing process.
- K. IEHP oversees by monitoring, reviewing, and auditing the IPA's credentialing and recredentialing processes prior to contracting and on an ongoing basis. Audits include on-site reviews, evaluation, and examination of the IPA's existing credentialing and recredentialing processes, written policies and procedures, source data verification and file review using the Delegation Oversight audit tool that conforms to NCQA standards.
- L. IEHP reserves the right to rescind delegation of credentialing activities based on the outcome of monitoring activities or business need.

PROCEDURE:

Criteria

- A. IEHP and IPA's are required to meet the following criteria prior to being delegated to perform credentialing activities, and in order to remain delegated on an on-going basis:
 - 1. Program description for credentialing that includes the following:
 - a. Policies and procedures that:
 - 1) Document the scope of practitioners covered and explicitly identify all MDs, DOs, DPMs, DCs, NPs, PAs, CNMs, PT, OT, S/LT, MFTs, as applicable, who are contracted and treat Members and who fall within the IEHP and IPA's scope of authority and action.

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

- 2) Describe in detail the credentialing procedures for recommendation of a practitioner's participation based on satisfactory responses and appropriate primary source documentation with evidence that documentation was received and reviewed prior to the credentialing decision. Procedures must include the following:
 - a) Completed application signed by the practitioner that includes:
 - i. Education and training; and
 - ii. Work history.
 - b) Current attestation completed, dated and signed by the practitioner regarding:
 - i. Reasons for any inability to perform essential functions of the position with or without accommodation;
 - ii. Physical and mental status;
 - iii. Lack of present illegal drug use;
 - iv. Lack of impairment due to chemical dependency/substance abuse;
 - v. History of loss of license and felony convictions;
 - vi. History of loss or limitation of privileges or disciplinary action or other negative license or privilege actions;
 - vii. Judgments entered against or settlements pending, filed and served regarding liability lawsuits or arbitration;
 - viii. Correctness and completeness of above attestations and information on application; and
 - ix. Certification that the practitioners will keep the information up-to-date.
 - x. The health status attestations conform to the legal requirements of the Americans with Disabilities Act (ADA).
 - c) Timeframes and basic requirements for processing the application, including procedures for:
 - i. Requesting additional information;

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

- ii. Returning the application to practitioner if questions are left blank;
 - iii. Practitioner to resubmit corrected information; and
 - iv. Notification of practitioners if application is denied.
- d) Primary Source verification of:
- i. Current valid license - All practitioners must be licensed by the state of California for the specialty in which they practice. Current California state medical license must be obtained by direct confirmation from the Medical Board of California (MBOC), via the Internet, mail or phone. Verification of license must be within the 180- days immediately preceding the credentialing decision by the committee. The license must be current at the time of credentialing and must remain current throughout the practitioner’s participation with IEHP;
 - ii. Clinical privileges - All practitioners must have admitting privileges or appropriate admitter arrangements at a contracted IEHP Hospital, as necessary. Verification that all clinical privileges are in good standing to perform functions for which the practitioner is contracted must be confirmed with the Hospital, in writing or verbally, and must include the date of appointment, scope of privileges, restrictions and recommendations. 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.” If an admitter arrangement is used, a written agreement that meets IEHP admitter requirements (see Policy 5E, “Hospital Privileges”) confirming coverage for all inpatient work must be included in the practitioner’s credentialing file. Verification of clinical privileges must be within the 180- day immediately preceding the credentialing decision by the committee;
 - iii. Valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate, as applicable - All practitioners, except non-

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

prescribing practitioners, must have a valid DEA certificate. Verification may be in the form of a photocopy of the current DEA certificate or a query of the National Technical Information Service (NTIS) database. The copy of the practitioner's certificate or query must be initialed and date stamped to show receipt prior to the credentialing decision, be effective at the time of the credentialing decision and remain effective throughout the practitioner's participation with IEHP;

- iv. Education and training - All practitioners must have completed appropriate education and training for practice in the designated specialty or subspecialty. Because Medical boards verify education and training, verification of board certification fully meets this requirement. Only the highest level of credentials must be verified:
 - (1) Residency Training - Confirmation is required for non-board certified MDs, DOs, or DPMs. Verification of completion of residency must be obtained from the institution where the postgraduate medical training was completed, the American Medical Association (AMA) Physician Master File, or the American Osteopathic Association (AOA) Physician Master File; and
 - (2) Medical School - If no residency has been completed, verification of medical school completion must be confirmed from the medical school or clearinghouse, AMA Physician Master File, AOA Physician Master File, or confirmation from the Education Commission for Foreign Medical Graduate (ECFMG), or unbroken, sealed transcripts from the institute in which the practitioner completed the appropriate training program. Evidence that IEHP inspected the contents of the envelope and confirmation that transcript shows that the practitioner completed the appropriate

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

training program must be include in file if verified via sealed transcripts.

- v. Board certification, as applicable - Verification of board status must be performed through the American Board of Medical Specialties (ABMS), AOA Physician Master File, American Board of Podiatric Specialties (ABPS) or AMA Physician Master File. Verification must be performed through a query of the appropriate board, or a letter directly from the board, Verification is valid for up to one year.
- vi. Malpractice insurance - All practitioners must have appropriate malpractice insurance coverage that is current and meets IEHP's standard of \$1 million/\$3 million. 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, be effective at the time of the credentialing decision and remain effective throughout the practitioner's participation with IEHP;
- vii. Malpractice history - Verification of claims history must be obtained from the current and/or previous carriers and public record as necessary. A minimum of five years of claims history must be reviewed for initial credentialing and three years for recredentialing. The National Practitioner Data Bank (NPDB) may be queried in lieu of verification of history from carriers. Verification must be within the 180- days immediately preceding the credentialing decision by the committee; and
- viii. Failure to keep current and active license, DEA and malpractice insurance can result in administrative termination of the practitioner.
- ix. No exclusions, suspensions, or ineligibility in any state or federal health care program at the time of the credentialing subcommittee's decision.

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

- x. Eligible for payment under Medicare.
- xi. No exclusion from participation at any time in federal or stated health care programs based on conduct within the last five (5) years that supports a mandatory exclusion under the Medicare program as set forth in Title 42, United States Code, Sections 1320.7(a) as follows:
 - (1) A conviction of a criminal offense related to the delivery of an item or service under federal or state health care programs;
 - (2) A felony conviction related to neglect or abuse of patients in connection with the delivery of a health care item or service;
 - (3) A felony conviction related to health care fraud; or
 - (4) A felony conviction related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.
- e) Work history - All practitioners must supply a minimum of five years of work history for initial credentialing and three years for recredentialing. . This may be in the form of a written curriculum vitae (CV), practitioner’s application, or work history summary, providing it has adequate information. IEHP is required to review gaps in work history for a time period of six months or more. Any work history gap that exceeds one year must be clarified in writing. Verification of work history must be within the 365days immediately preceding the credentialing decision by the committee.
- f) NPI – Practitioners are required to maintain an individual NPI number which must be verified through CMS. Providers that have group NPI numbers may submit that information in addition to the individual number. Verification of NPI must be completed within the 180 day time limit.
- g) Process to document receipt and review of all documentation via date stamp and initials on the following:
 - i. Application;

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

- ii. Attestation;
 - iii. Queries;
 - iv. Copies of certificates or licensure; and
 - v. Any document containing practitioner signature.
 - h) Information with regard to disciplinary actions, restrictions, limitations and Medicare/Medicaid sanctions must be obtained from the following and be no more than 180 days old at the time of the credentialing decision by the committee:
 - i. NPDB query;
 - ii. Health Integrity Protection Data Bank (HIPDB) query
 - iii. MBOC query; and
 - iv. Medicare/Medicaid sanctions reports including:
 - a. Medi-Cal Suspension and Ineligible List
 - b. Medicare Opt-Out List
 - c. Office of Inspector General (OIG) Sanction – Exclusions and Reinstatements
 - i) Process in place for the ongoing monitoring of practitioner sanctions, complaints, and appropriate interventions taken when it identifies occurrences of poor quality between recredentialing cycles through the use of the following:
 - i. Medicare/Medicaid sanctions (same as above);
 - ii. Sanctions or limitations on licensure; and
 - iii. Complaints.
- 3) Processes to verify and maintain practitioner licensing status, DEA or CDS Certificate, etc., and remedies if the license or certification expires or status changes during the practitioner’s participation with IEHP regardless of whether or not the practitioner is due for recredentialing.
 - 4) Process to verify W9 with the IRS.
 - 5) Process to verify individual practitioner NPI number with CMS.
 - 6) Verification of information submitted through one of the following means:

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

- a) Verbal Verification - Requires a dated, signed note in the credentialing file naming the person, at the primary source who verified the information, his/her title, the date and time of verification and that it was verified verbally.
 - b) Automated Verification - Requires there be a mechanism to identify the name and title of the individual verifying the information, the date of the verification, the source, and the report date, if applicable. The information must be noted in the file.
 - c) 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 in the file.
 - d) Internet Web Site Verification - Requires a printed copy of the information from the web site with date noted or a note in the credentialing file that is dated and either signed or initialed by the individual who verified each credential. Verification must be from an NCQA approved and appropriate state-licensing agency.
- 6) Practitioner Rights
- a. Right of practitioners to review information submitted to support their credentialing application:
 - 1) Policies and procedures must state that practitioners are notified of their right to review information obtained by the organization to evaluate their credentialing application.
 - 2) The evaluation includes information obtained from any outside source (e.g. malpractice insurance carrier, state licensing boards) with the exception of references, recommendations or other peer-review protected information.
 - b. Right of practitioner to correct erroneous information:
 - 1) Policies and procedures must state that practitioners are notified in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

- and must clearly identify time frame, methods, documentation and responsibility for notification.
- 2) IEHP is not required to reveal the source of information if the information is not obtained to meet credentialing verification requirements or if discloser is prohibited by law.
 - 3) Policies and procedures must also state the practitioners right to correct erroneous information submitted by another source and must clearly state:
 - a. Time frame for changes.
 - b. Format for submitting corrections.
 - c. Person to whom corrections must be submitted.
 - d. Documentation of the receipt of the corrections.
 - e. How practitioners are notified of their right to correct erroneous information.
 - c. The right of practitioner to be informed of the status of their credentialing or recredentialing application upon request.
 - 1) Policies and procedures must state that practitioners have a right to be informed of the status of their application upon request, and must describe the process for responding to such requests, including information that the organization may share with practitioners.
 - d. Notification of these rights
 - 1) Policies and procedures must state how practitioners are notified of these rights. Some appropriate avenues may be through the application, contracts, provider manuals, other information distributed to practitioners, or web site.
 - 7) Specifically document the Medical Director or physician designee's direct responsibilities and participation in the Credentialing Program, including but not limited to:
 - a) Possession of a current license to practice in the state of California;

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

- b) His/her role in implementation, development, and coordination in the functions of the Credentialing Program;
 - c) Oversight of the credentialing program and policies and procedures;
 - d) Membership, attendance and/or chairmanship at all Credentialing Committee meetings; and
 - e) Description of reporting structure and responsibilities for Medical Director/physician designee, Committee and Board of Directors for final recommendation for participation, as applicable.
- 8) Describe in detail the process used in making confidential credentialing and recredentialing decisions and the mechanisms in place to maintain confidentiality. Procedures must include, but are not limited to, requiring that:
- a) Practitioner files are maintained in locked file cabinets and are only accessible by appropriate personnel;
 - b) Confidentiality statements are signed by Committee members and staff; and
 - c) Security for database systems is maintained through passwords or other means to limit access to practitioner information to authorized staff only.
- 9) A mutually agreed upon document with IEHP or an outside vendor such as an NCQA accredited Credentialing Verification Organization (CVO) who have access to the protected health information (PHI) on Members or practitioners in the course of their work, must ensure that the information remains protected under the following provisions:
- a) A list of the allowed uses of PHI;
 - b) A description of safeguards to protect PHI from inappropriate use or further disclosure;
 - c) A stipulation that IEHP have similar safeguards;
 - d) A stipulation that IEHP will provide individuals with access to their PHI;
 - e) A stipulation that IEHP will report to the IEHP Quality Management Committee if inappropriate use of information occurs; and

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

- f) A stipulation that IEHP will ensure PHI is returned, destroyed or protected if the delegation agreement ends.
- 10) An outside vendor such as an NCQA accredited Credentialing Verification Organization (CVO) may perform portions of the verification process, however, IEHP, must provide oversight and document the process in approved policies and procedures that include:
- a) A mutually agreed upon document that describes the responsibilities of the delegated agency;
 - b) Document the process of reporting at least semi-annually;
 - c) Process by which IEHP evaluates the delegated agency's performance;
 - d) Remedies, including the revocation of the delegation by IEHP if the delegated agency does not fulfill its obligation;
 - e) IEHP retains the right and responsibility to review and approve practitioner's participation; and
 - f) For delegation arrangements in effect for 12 months or longer, IEHP must have reports on audited files for each year that the delegation is in effect.
2. Credentialing Committee
- a. IEHP must have a Credentialing Committee that reviews practitioner's information and either approves or denies practitioner participation.
 - b. Policies and procedures must document the structure of the Credentialing Committee that makes recommendations regarding credentialing decisions. At a minimum, the policy and procedure must include:
 - 1) Committee membership that includes participating practitioners.
 - 2) Composition of Committee that includes multidisciplinary representation with the ability to seek the advice of participating practitioners outside of the Committee, at the Committee's discretion, when applicable.
 - 3) Quorum requirements of Committee (minimum of three).
 - 4) Identity of voting members.
 - 5) Identity of who has authority to make final credentialing decisions and the relationship to the Governing Board (if applicable).
 - 6) Frequency of Committee meetings.

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

- 7) Process to document, review and approve credentialing policies and procedures by the Committee on an annual basis.
 - 8) Committee's opportunity to review documentation, criteria and credentials of all practitioners being credentialed or recredentialed prior to rendering a recommendation.
 - 9) Information obtained and reviewed in the credentialing or recredentialing process must be no more than 180 days old at the time of the Committee decision.
- c. Policies and procedures must document the process to ensure that the organization does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g., abortions) or patients (e.g., Medicaid) in which the practitioner specializes. This does not preclude the organization from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members.
 - d. Committee minutes must reflect thoughtful discussion and consideration of all practitioners being credentialed or recredentialed before a credentialing decision is determined.
 - e. Policies and procedures must document a process to ensure that practitioners are notified of the credentialing and recredentialing decision within 60 days of the Committee's decision.
 - f. IEHP may adopt a "clean file" process for credentialing and recredentialing and the policies and procedures must describe the process used to determine clean files (i.e. files that meet IEHP's criteria) and must include the following:
 - 1) Identify the medical director as the individual with the authority to determine that the file is "clean" and to sign off on it as complete, clean, and approved.
 - 2) IEHP may assign an associate medical director or other qualified medical staff member as the designated medical director if this individual has equal qualifications as the medical director and is responsible for credentialing.
 - 3) At a minimum, the designated medical director must review and sign off on all files of practitioners who meet the established criteria. IEHP uses this sign off date as the "committee review date."

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

- 4) The designated medical director may use a handwritten signature, handwritten initials, or unique electronic identifier as documentation of sign off.
 - 5) The medical director's sign off date is used as the "credentialing decision date." The organization may choose to continue submitting all practitioner names to the credentialing committee.
3. Facility Site Reviews
- a. Prior to credentialing, or when a practitioner relocates, IEHP must perform an on-site facility review for all contracted PCPs. Policy and procedure must meet IEHP's facility site review requirements for the Medicare Programs, as stated in Policy 6A, "Site Review and Medical Record Review Requirements and Monitoring." Documentation of site review must include:
 - 1) Standards and thresholds for acceptable performance;
 - 2) Evaluation of initial site, new site or relocation against standards;
 - 3) Evidence of corrective action actions for improvement of sites that do not meet established thresholds; and
 - 4) Follow-up for sites with significant deficiencies to ensure compliance.
4. Recredentialing
- a. IEHP must formally recredential its practitioners at least every three years. This three-year period must be within 36 months of the last Committee approval date.
 - 1) Failure to meet the 36 month time frame will result in termination of the practitioner. Practitioners who wish to continue participation with IEHP must complete Initial Credentialing procedures as listed above.
 - b. Recredentialing must include primary source verification of the following (as defined for credentialing primary source verification):
 - 1) Current State License;
 - 2) Current and Valid DEA;
 - 3) Clinical Privileges;
 - 4) Board Certification;
 - 5) Current Malpractice Insurance;

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

- 6) Malpractice History-a minimum of three years;
- 7) Individual Practitioner NPI number;
- 8) Completed W9; and
- 9) Current, signed attestation statement by the practitioner which conforms to the legal requirements of the Americans with Disabilities Act (ADA) regarding:
 - a) Reasons for any inability to perform the essential functions of the position, with or without accommodation;
 - b) Physical and mental status;
 - c) Lack of present use of illegal drugs;
 - d) Lack of impairment due to chemical dependency/substance abuse;
 - e) History of loss or limitation of privileges or disciplinary action or negative license or privilege actions;
 - f) History of loss of license and/or felony convictions;
 - g) Malpractice insurance coverage, as applicable;
 - h) Judgments entered against or settlements pending, filed and served regarding liability lawsuits or arbitration;
 - i) Certification that the practitioner will keep the information up-to-date; and
 - j) The correctness and completeness of information.
- c. A re-query must be made during the recredentialing process regarding disciplinary actions, restrictions, limitations, and Medicare/Medicaid sanctions as defined above and include:
 - 1) Medi-Cal Suspension and Ineligible List
 - 2) Medicare Opt-Out List
 - 3) OIG Sanction – Exclusions and Reinstatements
- d. Medicare Opt-out Providers
 - 1) Credentialing staff shall verify Providers who are excluded from participation in Medicare and Providers who have opted out of Medicare utilizing the OIG/Medicare website during primary source verification, initial Credentialing, and Recredentialing.

5. Performance Monitoring

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

- a. When recredentialing a practitioner, IEHP must include review of data from Member grievances, results of quality reviews, and any information obtained from IEHP specific to the practitioner in any of the above areas. Documentation of the review must be sufficient to determine that the information was received and reviewed prior to the recredentialing decision.
6. Notification to Authorities and Practitioner Appeal Rights
 - a. IEHP must have policies and procedures for, and evidence of implementation of the conditions that alter a practitioner's participation with IEHP based on issues of quality of care and service defining:
 - 1) Methods used to identify deficiencies both during the credentialing and recredentialing process on an ongoing basis.
 - 2) Process for follow-up of any identified deficiencies.
 - 3) Range of actions that IEHP takes prior to termination.
 - 4) Appeals process for the practitioner and mechanism for notification of the right to appeal by practitioner.
 - 5) Procedures for reporting to authorities of any adverse action.
 - 6) Description of how, when, and what serious quality deficiencies are reported to appropriate authorities.
7. Assessment of Subcontracted Organizational Providers
 - a. IEHP must have policies and procedures for the initial and ongoing assessment of subcontracted organizational providers. Policies and procedures must include how they perform the following:
 - 1) Confirms that the subcontracted organizational provider is accredited by an approved accrediting body, as delineated in policy 5E "Subcontracted Organizational Providers."
 - 2) Conducts an onsite quality assessment, if there is no accreditation status.
 - 3) Verifies the subcontracted organization provider's license is current and that the facility has met all state and federal licensing and regulatory requirements.
 - 4) Confirms that the subcontracted organizational provider is in good standing with federal and regulatory bodies, including Medicare/Medicaid sanctions.
 - 5) Reassesses the subcontracted organizational provider at least every contract period, but no less than every three years.

5. CREDENTIALING AND RECREDENTIALING

B. Practitioner Credentialing Requirements

8. PCPs must also pass an IEHP facility review at the time of initial credentialing and every three years thereafter for Medicare Programs as stated in Policy 6A, “Site Review and Medical Record Survey Requirements and Monitoring.”
- B. IPAs not meeting delegation requirements as determined through oversight activities are subject to rescission of delegated credentialing activities.
- C. IEHP and any regulatory oversight agency, has the right, within two working days advance notice, to examine credentialing/recredentialing files or sites as needed to perform oversight of all practitioners or to respond to a complaint or grievance.
- D. All information obtained by IEHP during the credentialing/recredentialing process is confidential to the extent required by law.
- E. Once the information is received for PCPs, IEHP schedules a facility site review for Medicare Programs, as per Policy 6A, “Site Review and Medical Record Survey Requirements and Monitoring.”
- F. IEHP completes a practitioner quality review in accordance with Policy 5C, “IEHP Quality Oversight of Participating Practitioners.”

NLANDEMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	January 1, 2007
Chief Title: Chief Executive Officer	Revised date:	January 1, 2012

5. CREDENTIALING AND RECREDENTIALING

C. IEHP Quality Oversight of Participating Practitioners

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Providers.

POLICY:

- A. All IPAs are required to monitor the credentialing and recredentialing status and performance of their contracted practitioners on a continuous basis in compliance with IEHP requirements and current NCQA guidelines.
- B. All IPAs are required to notify IEHP of any adverse actions against any of their contracted practitioners. IPAs must provide IEHP 60-days advance notice of any significant change in their network, including the termination of a practitioner.
- C. IPAs must provide IEHP with a status report of their specialty network on a quarterly basis.
- D. IEHP notifies the IPA of any adverse actions it becomes aware of through sources other than the IPA. In addition, IEHP shares with all IPAs the results of performance monitoring through quality improvement studies, Member complaints and Member satisfaction surveys, as applicable. IEHP reviews the history of each delegated IPA's credentialed and approved practitioners, including PCP's, specialists, non-physician practitioners and other as defined in Policies 5A, "IEHP Practitioner Guidelines," and 5B, "Provider Credentialing Requirements for Delegated IPAs."
- E. Delegated IPA credentialed and approved PCPs must successfully pass an initial IEHP and State mandated facility site review prior to Members being assigned to the practitioner and every three years thereafter in order to retain assigned Members.
- F. All practitioners have the right to appeal any adverse credentialing/recredentialing actions.

PROCEDURE:

Delegated IPAs

- A. IEHP performs oversight of delegated IPAs' ability to perform delegated credentialing activities as follows:
1. All delegated IPA credentialed and approved PCPs must successfully pass an IEHP State mandated facility site review during credentialing and every three years thereafter per Policy 6A, "Site Review and Medical Record Survey Requirements and Monitoring."
 2. Within six months of adding an IPA credentialed and approved practitioner to the IEHP network, IEHP performs a quality review of each delegated IPA's

5. CREDENTIALING AND RECREDENTIALING

C. IEHP Quality Oversight of Participating Practitioners

credentialed and approved practitioner, consisting of the following:

- a. Review of credentialed practitioner specialty type against IEHP guidelines for education, training, practice experience as stated in Policy 5A, “IEHP Practitioner Guidelines.”
 - b. Review of requested age range for credentialed practitioners against IEHP guidelines as stated in Policy 5A, “IEHP Practitioner Guidelines.”
 - c. Review of IPA submitted credentialing and/ or recredentialing packet and supporting documentation as stated in Policy 5B, “Provider Credentialing Requirements for Delegated IPAs” for:
 - 1) Malpractice history;
 - 2) History of negative license action;
 - 3) History of negative privileges action;
 - 4) History of Medicare or Medicaid sanctions; and
 - 5) Other adverse history (felony convictions, etc.).
3. In cases where the delegated IPA submitted credentialing information is consistent with IEHP guidelines, no adverse history is present, and the practitioner has successfully passed IEHP’s site review (if applicable), the practitioner is forwarded to the IEHP Chief Medical Officer or to an IEHP Medical Director for retrospective review and sign off.
 4. In cases where either the delegated IPA submitted credentialing information is inconsistent with IEHP guidelines, or there is evidence of significant adverse history, the practitioner is forwarded to the IEHP Chief Medical Officer or to an IEHP Medical Director for further review.
 - a. The IEHP Chief Medical Officer or an IEHP Medical Director reviews the practitioner’s credentialing file and any other necessary supporting documentation from the IPA, practitioners, or IEHP to determine if potential quality of care issues for Members exists.
 - 1) If the IEHP Chief Medical Officer or an IEHP Medical Director determines that no potential quality of care concern exists, no further action or review is undertaken.
 - 2) If the IEHP Chief Medical Officer or an IEHP Medical Director determines that a potential quality of care concern or adverse event does exist, the file is referred to the IEHP Peer Review Subcommittee for review at the next available meeting. The Peer Review Subcommittee may make recommendations to improve the performance of a practitioner.

5. CREDENTIALING AND RECREDENTIALING

C. IEHP Quality Oversight of Participating Practitioners

- a) The IEHP Peer Review Subcommittee reviews all pertinent information necessary, and takes any of the following actions:
 - i. No action, quality review complete, practitioner continues to be a part of the IEHP network;
 - ii. Request for additional information from IPA with review at next meeting;
 - iii. Individual counseling by the IPA or IEHP Chief Medical Officer or Medical Director;
 - iv. Focused audits of practitioner's practice by IEHP staff;
 - v. Continuing medical education or training;
 - vi. Restriction of privileges, including age range restrictions or other limitations;
 - vii. Termination of the practitioner from the IEHP network; and
 - viii. Any other action appropriate for the circumstances.
- 5. Actions by the IEHP Peer Review Subcommittee that differ from the IPA Credentialing Committee decisions, including changes in privileges and termination are tracked by IEHP.
 - a. If the tracking process reveals that an IPA has reached a total of five practitioners that the Peer Review Subcommittee has taken an action that differs from that taken by the IPA Credentialing Committee, the matter is referred to the IEHP Chief Medical Officer or Medical Director for review.
 - b. The IEHP Chief Medical Officer or Medical Director reviews the tracking report, the credentialing files and any other supporting information as necessary.
 - c. After review, IEHP takes any of the following action(s) against the delegated IPA:
 - 1) No action;
 - 2) Verbal or written request for additional information from the IPA Medical Director;
 - 3) Request an interim focused credentialing audit of the IPA by IEHP staff; or

5. CREDENTIALING AND RECREDENTIALING

C. IEHP Quality Oversight of Participating Practitioners

- 4) Any other action as appropriate, including revocation of delegated credentialing responsibilities.
 6. IEHP also monitors delegated IPAs' ability to perform delegated credentialing activities through annual or focused Medical Management Audits as delineated in Policy 13E, "IPA Delegation Oversight Audit."
- B. In addition to IEHP's quality oversight, delegated IPAs are expected to monitor the performance of their credentialed practitioners on a continuous basis and to review any performance issues as may be applicable during the recredentialing process obtained by the IPA, from other sources or IEHP.

All IPAs

- A. On a quarterly basis, IEHP provides IPAs with an electronic copy of a spreadsheet that contains the Specialty Roster information, including admitters and ancillary providers submitted previously by the IPA to IEHP that identifies the IPA's current provider network that includes: practitioner name, address, phone number, license number, specialty type, Hospital affiliations, IPA credentialing committee dates and, for obstetricians only the hospitals where they deliver.
- B. IPAs are required to verify and update the following information:
1. IPA Credentialing Committee Date must be completed for all practitioners with the most recent Committee Date.
 2. Mark the appropriate column of the spreadsheet for each specialist listed, as applicable, for the following:
 - a. "New Hospital Privileges" – provided to indicate the practitioner is adding new privileges with an IEHP network hospital. Indicate privileges (active, courtesy, etc.).
 - b. "New Hospital Link" – provided to indicate which network hospital will be added to practitioner.
 - c. "Information is correct" - provided to specify information is correct and no changes are required.
 - d. "Provider Term Date" – provided to indicate the practitioner is no longer part of the IPA's specialty network. Provide effective date of termination.
 - e. "Term This Site Only" – provided to indicate the practitioner is no longer at this location only. Provide effective date of location closure.
 - f. "Updated information" - provided to specify new addresses, a typo, or any other changes to the information provided in the excel spreadsheet.
 3. IEHP makes the indicated changes that will be reflected on the next quarter's roster.

5. CREDENTIALING AND RECREDENTIALING

C. IEHP Quality Oversight of Participating Practitioners

- a. IPAs are required to update all information located in the spreadsheet and return the information to their Provider Service Representative within 30 days of receipt of the spreadsheet.
- C. IEHP expects all IPAs to continuously monitor practitioner status and performance and to share the following information with IEHP:
1. IPAs are required to notify IEHP in writing immediately, upon its knowledge, if any of the following occurs with one of their contracted practitioners:
 - a. The surrendering, revocation or suspension of a license;
 - b. The surrendering, revocation or suspension of DEA registration;
 - c. A change in hospital staff status or hospital clinical privileges, including any restrictions or limitations;
 - d. A change in hospital admitting arrangements for practitioners without IEHP affiliated hospital privileges;
 - e. If a provider has opted-out of the Medicare program;
 - f. Loss of malpractice insurance; and
 - g. The notification must include the IPA's proposed action and/or resolution.
 2. IPAs are required to notify IEHP in writing within 15 days of its knowledge, if any of the following occurs with one of their contracted practitioners:
 - a. Any filing pursuant to Business and Professions Code Sections 805 or 809;
 - b. Any filing with the NPDB;
 - c. The filing of any malpractice claim of more than \$10,000; and
 - d. The notification must include the IPA's proposed action and/or resolution.
 3. IPAs are required to provide 60 days advance written notice to IEHP of any significant changes in the IPA's network, including relocation, change in affiliation or termination of practitioners. Refer to Section 18, "Provider Network" for more information.
 4. IPAs have 60 days from the effective date of a PCPs IPA affiliation change to submit the initial credentialing packet to IEHP. Failure to do so will result in freezing the PCP to new membership assignment or possible termination.
- D. IEHP also monitors practitioner credentialing status and performance directly, as follows:
1. Review of the following sources of information:
 - a. MBOC Monthly Hot Sheet, Quarterly Action Report, Daily Administrative

5. CREDENTIALING AND RECREDENTIALING

C. IEHP Quality Oversight of Participating Practitioners

- Outcomes, Quarterly OMBC Reports, and OIG Sanctions Report for IEHP practitioners with adverse action;
 - b. Medi-Cal Suspension and Ineligible List, Medicare Opt-Out List;
 - c. Local newspapers for practitioners with adverse action;
 - d. Any other source of information, e.g., phone calls from Members, other practitioners, etc.;
 - e. Quality improvement studies;
 - f. Member complaints.
2. If any information of adverse action regarding an IEHP practitioner is obtained from any source, IEHP attempts to confirm the information through the following mechanisms:
 - a. Direct contact with pertinent licensing entity, in the event of a license action;
 - b. Direct contact with the hospital or other pertinent entity if it is privileges restriction or revocation; and
 - c. Direct contact with the IPA and practitioner, if necessary.
 3. Confirmed information is forwarded to the IPA for review and decision. IPAs are requested to inform IEHP in writing of their decision within 30 days of the decision.
 4. If IEHP believes that a Member's health or safety may be at risk due to adverse events or quality concerns, IEHP may take one of the following actions:
 - a. Refer the practitioner to the next IEHP Peer Review Subcommittee meeting for direction;
 - b. Immediately suspend the practitioner from participation with IEHP with referral to the next IEHP Peer Review Subcommittee meeting; or
 - c. Any other actions appropriate, given the circumstances and severity of the situation.
 5. If IEHP has taken action against the practitioner, IEHP informs the practitioner of the proposed action in writing, and includes the following information:
 - a. The action that has been proposed or taken against the practitioner;
 - b. A brief description of the factual basis for the action;
 - c. A statement that the practitioner may request that a Level I Review be conducted by the IEHP Peer Review Subcommittee in accordance with Attachment 5-1, "Peer Review Process and Level I Review;"

5. CREDENTIALING AND RECREDENTIALING

C. IEHP Quality Oversight of Participating Practitioners

- d. A statement that a Level I Review must be requested by the practitioner in writing, addressed to the IEHP Chief Medical Officer, within 30 days of the date of receipt of the notice by the practitioner;
 - e. A brief summary of the practitioner’s rights at the Level I Review meeting and that the meeting takes place before the IEHP Peer Review Subcommittee; and
 - f. A notice that the action, if implemented, must be reported to the MBOC under California Business and Professions Code, Section 805, as applicable, and/or under any other applicable federal or state law.
6. IEHP also provides the IPA with copies of any practitioner specific information such as Member complaints or studies received directly or conducted by IEHP.
- E. Any practitioner that has an adverse decision by IEHP that limits, restricts, suspends or terminates his/her status as a participating practitioner with IEHP has the right to appeal the decision, as delineated in “Peer Review Process and Level 1 Review” (see Attachment 5-1 in Section 5, “Attachments”) and “Peer Review Process and Level II Appeal” (see Attachment 5-2 in Section 5, “Attachments”).
- F. If a practitioner does not appeal an adverse decision within specified timeframes, the IEHP Chief Medical Officer presents a final action to the IEHP Governing Board.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	January 1, 2007
Chief Title: Chief Executive Officer	Revised date:	January 1, 2012

5. CREDENTIALING AND RECREDENTIALING

D. Hospital Privileges

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Providers.

POLICY:

- A. IEHP requires its IPAs to ensure that all of their contracted and subcontracted practitioners have privileges at a designated IEHP contracted Hospital. The contracted Hospital must be within a 15-mile radius or 30-minute drive via private or public transportation, of the Member's residence, when applicable.
- B. If the Primary Care Physician (PCP) does not or cannot obtain hospital privileges directly, the IPA must arrange for a practitioner or panel of practitioners to be responsible for admissions and providing inpatient care on behalf of the contracted practitioner.
- C. Admitting practitioners must be contracted and credentialed (unless practitioners are hospital based only) by the IPA in accordance with regulatory standards and IEHP requirements. The IPA must forward copies of hospital privileges documentation along with the credentialing information to IEHP.
- D. Utilizing on-call hospital practitioners without a contract is not an acceptable arrangement.
- E. All specialty practitioners must obtain hospital privileges directly with an IEHP contracted Hospital.

PROCEDURE:

- A. During the credentialing process, IPAs that identify PCPs who do not have privileges at the designated IEHP contracted Hospital must arrange for a practitioner or panel of practitioners to be responsible for admissions and providing inpatient care on behalf of the non-admitting practitioner.
- B. A written verification in the form of a signed agreement or letter from the admitting practitioner that such arrangements are in place is required. This agreement must include the following information:
 - 1. Non-admitting practitioner name
 - 2. Non-admitting practitioner specialties
 - 3. Non-admitting practitioner address and phone number
 - 4. Admitting practitioner name(s)
 - 5. Admitting practitioner specialties
 - 6. Admitting practitioner address and phone number
 - 7. IEHP contracted Hospital(s)

5. CREDENTIALING AND RECREDENTIALING

D. Hospital Privileges

8. Terms of arrangement
 - a. 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 days of the IPA's knowledge of pending termination.
- C. The Agreement must be signed and dated by the non-admitting practitioner, admitting practitioner, and the IPA.
- D. The Agreement must also specify that bills for services rendered are submitted to and paid by the IPA.
- E. The IPA must provide IEHP with a copy of the written verification of arrangements. Copies of arrangements must also be sent to the Hospital and involved practitioner.
- F. Upon receipt of written admitting arrangements, IEHP verifies:
 1. The non-admitting practitioner's specialty is completely covered by the admitting practitioner's specialty. (For example, a Family or General Practitioner may admit all patients for another Family or General Practitioner, an Internist and a Pediatrician may collectively cover admissions for a Family or General Practitioner.)
 2. Hospital privileges of the admitting practitioner(s) are in place and in good standing.
- G. No enrollment is given to any PCP until appropriate and complete arrangements for Hospital admissions are in place and verified by IEHP.
- H. In the event it is discovered that a PCP with assigned enrollment does not have privileges at the designated IEHP contracted Hospital, and the IPA 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.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	January 1, 2007
Chief Title: Chief Executive Officer	Revised date:	January 1, 2011

5. CREDENTIALING AND RECREDENTIALING

E. Credentialing Appeals Process for Practitioners Denied Participation with IEHP

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Providers.

POLICY:

- A. 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; 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 desired by IEHP; or a change in IEHP's operational requirements.
- B. Practitioners have the right to appeal any adverse credentialing decision that impacts their participation status with IEHP, including denial, reduction, suspension or termination of their participation status with IEHP, in accordance with the appeals procedures provided herein.
- C. IEHP complies with the reporting requirements of the Medical Board of California (MBOC), the Osteopathic Medical Board of California (OMBC), the California Board of Optometry (CBO), and the 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 and peer review actions. Practitioners are notified of the report and its contents in accordance with law.
- D. Practitioners must appeal directly to their contracted IPA for adverse credentialing decisions rendered by the IPA.

PROCEDURE:

- A. The IEHP Peer Review Subcommittee, upon referral from an IEHP Medical Director, can review practitioners that do not meet IEHP's credentialing criteria and may change a practitioner's participation status based upon their findings.
- B. Additionally, the IEHP Peer Review Subcommittee performs oversight of credentialing activities of IPAs who have been delegated credentialing responsibilities, including retrospective practitioner quality reviews referred by an IEHP Medical Director, through practitioner or Provider appeals for adverse credentialing decisions.

5. CREDENTIALING AND RECREDENTIALING

E. Credentialing Appeals Process for Practitioners Denied Participation with IEHP

- C. All credentialing decisions for practitioners credentialed by IEHP are made by the IEHP Credentialing Subcommittee, based on information obtained during the credentialing process are reviewed and presented to the IEHP Credentialing Subcommittee.
- D. If the IEHP Peer Review or Credentialing Subcommittee denies or restricts a practitioner's participation in the IEHP network for reasons related to credentialing requirements or quality issues, the practitioner is entitled to a Level I Review.
- E. IEHP sends written notification, by certified mail, to any practitioner denied or restricted participation within ten working days of the decision reached by the IEHP Peer Review or Credentialing Subcommittee. The written notice includes the following:
1. The action that has been proposed or taken against the practitioner that includes but is not limited to:
 - a) No action;
 - b) Reduction of participation status;
 - c) Suspension of participation status;
 - d) Denial of participation status; and
 - e) Termination of participation status.
 2. A brief description of the factual basis for the proposed action that includes but is not limited to:
 - a) A lapse in basic qualifications such as licensure, insurance, or required medical staff privileges;
 - b) A determination that the practitioner cannot be relied upon to deliver the quality or efficiency of patient care desired by IEHP;
 - c) A determination that the practitioner cannot be relied upon to follow IEHP's clinical or business guidelines or directives;
 - d) Falsification of information provided to IEHP;
 - e) Medicare/Medicaid sanctions;
 - f) Adverse malpractice history;
 - g) Adverse events that have potential for or have caused injury or negative impact to Members; and/or
 - h) Felony convictions.
 3. A statement that the practitioner may request a Level I Review be conducted by the IEHP Peer Review Subcommittee in accordance with this policy.

5. CREDENTIALING AND RECREDENTIALING

E. Credentialing Appeals Process for Practitioners Denied Participation with IEHP

4. A statement for a Level I Review must be requested by the practitioner in writing, addressed to the IEHP Chief Medical Officer, within 30 days of the date of receipt of the notice by the practitioner. The practitioner's written request must include:
 - a. A clearly written explanation of the reason for the request; and
 - b. A request to exercise the right to present the appeal orally at the Level I Review meeting, if so desired per below.
 5. A brief summary of the practitioner's rights at the Level I Review meeting and that the meeting takes place before the IEHP Peer Review Subcommittee. The summary states:
 - a. The practitioner has the right to present additional written material for review by the IEHP Peer Review Subcommittee;
 - b. The practitioner has the right to present any information orally to the IEHP Peer Review Subcommittee, in person, at the time of the meeting for the Level I Review;
 - c. That the Level I Review meeting is not a hearing, and procedural rights associated with formal peer review hearings do not apply in Level I Review for adverse credentialing decisions.
 6. A notice that the action, if implemented, must be reported to the MBOC, OMBC, or CBO and NPDB, as applicable under California Business and Professions Code, Section 805, as applicable, and/or under any other applicable federal or state law.
- F. If a Level I Review 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 Peer Review Subcommittee. Prior to the meeting, IEHP sends a written notice to the practitioner via certified mail informing the practitioner of the date, time and place of the Level I Review meeting.
- G. When the IEHP Peer Review Subcommittee completes its evaluation and renders a decision to uphold or overturn the denial made by the IEHP Credentialing Subcommittee or Peer Review Subcommittee as applicable, the practitioner is notified, in writing, within 10 business days of the decision.
- H. If the Level I Review decision by the Peer Review Subcommittee upholds the original denial of the practitioner's participation in the IEHP network by the IEHP Credentialing Subcommittee or Peer Review Subcommittee as applicable, the written notice includes the following:
1. The Level I Review decision, including a brief description of the decision and the reasons for it;

5. CREDENTIALING AND RECREDENTIALING

E. Credentialing Appeals Process for Practitioners Denied Participation with IEHP

2. The action, if implemented, must be reported to the MBOC, OMBC, CBO or NPDB, as applicable under Business and Professions Code, Section 805, as applicable, or under any other applicable federal or state law;
 3. That the practitioner may request a Level II Appeal;
 4. That the Level II Appeal must be requested, in writing, within 30 days of receipt of the notice by the practitioner, and that the request must include a statement of the grounds for requesting a Level II Appeal;
 5. A brief summary of the practitioner's rights with respect to the Level II Appeal;
 6. That the Level II Appeal process takes place before the IEHP Governing Board, and the decision of the Governing Board is final.
- I. Practitioners not requesting a Level I Review within the required timeframe and as specified above, waives his or her right to further appeals, and the decision of the IEHP Credentialing Subcommittee or Peer Review Subcommittee as applicable, is presented to the IEHP Governing Board as a final recommendation.
- J. The practitioner has 30 days following the date of receipt of a notice of an adverse credentialing decision resulting from a Level I Review to request a Level II Appeal. The request must be submitted, in writing, to an IEHP Medical Director and received by IEHP within the prescribed 30-day period.
- K. If the practitioner does not request a Level II Appeal within the required timeframe and as specified above, the decision of the IEHP Peer Review Subcommittee is presented to the IEHP Governing Board as a final recommendation.
- L. If a Level II Appeal is submitted in a timely manner, proceedings are in accordance with the formal Hearings process, as delineated in Attachment 5-2, "Peer Review Process and Level II Appeal."
- M. The decision of the IEHP Governing Board is final. Therefore, a practitioner may not reapply to be in the IEHP network until six months after termination.
- N. IEHP complies with all reporting requirements of the MBOC, OMBC, CBO or NPDB, as applicable 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 decisions. IEHP notifies the practitioner of such reporting and its contents in writing.
1. Actions that are reported to the MBOC, OMBC, CBO, or NPDB, as applicable, include a decision to deny or reject a practitioner's application for staff privileges or membership for a medical disciplinary cause or reason; a decision to terminate or revoke a practitioner's membership, staff privileges or employment for a medical disciplinary cause or reason; restrictions are imposed or voluntarily

5. CREDENTIALING AND RECREDENTIALING

E. Credentialing Appeals Process for Practitioners Denied Participation with IEHP

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 reasons; and or a practitioner's resignation or leave of absence from membership, staff, or employment following notice of impending investigation based on information indicating medical disciplinary cause or reason.

- O. All credentialing records and proceeds are confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law.
- P. Further details may be found in Attachments 5-1 and 5-2 (See Section 5, "Attachments"), "Peer Review Process and Level I Review" and "Peer Review Process and Level II Appeal," respectively.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	January 1, 2007
Chief Title: Chief Executive Officer	Revised date:	January 1, 2011

5. CREDENTIALING AND RECREDENTIALING

Attachments

<u>ATTACHMENT</u>	<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
5-1	IEHP Peer Review Process and Level I Review	5A, 5B, 5C, 5D
5-2	IEHP Peer Review Process and Level II Appeal	5A, 5B, 5C, 5D
5-3	IEHP Credentialing Verification Form	5B
5-4	Incomplete Credentialing Verification Form	5B
5-5a	Delegation of Services Agreement Between Supervising Physician and Physician Assistant	5B
5-5b	Approved Supervising Physician's Responsibility for Supervision of Physician Assistant	5B

INLAND EMPIRE HEALTH PLAN

PEER REVIEW PROCESS AND LEVEL I REVIEW

Denial, Reduction, Suspension or Termination of Practitioner Status

(Adopted April 14, 1997)

(Amended July 2010)

INLAND EMPIRE HEALTH PLAN

PEER REVIEW PROCESS AND LEVEL I REVIEW

Denial, Reduction, Suspension or Termination of Practitioner Status

Purpose:

To provide 1) a mechanism for peer review of IEHP providers of service (practitioners), 2) a process for practitioner to request review of negative peer review recommendations, decisions, and actions, for any reason related to quality of care issues and/or credentialing requirements, including, but not limited to, denial, reduction, suspension or termination of practitioner status, as requested by the Inland Empire Health Plan (IEHP) Peer Review Subcommittee, the IEHP Quality Management (QM) Committee, the IEHP Medical Director, or the IEHP Governing Board, and 3) a mechanism for appropriate action.

Scope:

The following policies and procedures apply to all health care professionals (practitioners) participating or requesting participation as a provider for IEHP, including, but not limited to, the following licentiates: Physicians (MD), Osteopathic Physician (DO), Podiatrists (DPM), Pharmacists (Pharm D or RPh), Dentists (DDS or DMD), Optometrists (OD), Chiropractors (DC), Clinical Psychologists, (PhD), Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Physical Therapists (PT), Occupational Therapists (OT), and Speech/Language Therapists (S/LT), psychiatrists, psychologists, master level clinical nurses, Licensed Clinical Social Workers (LCSW), Marriage, Family and Child Counselors (MFCC) and other behavioral health professionals licensed to provide behavioral health services in the state of California.

Policy:

1. A provider's status or participation 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; a determination by IEHP that the practitioner cannot be relied upon to deliver the quality or efficiency of patient care desired by IEHP; a determination by IEHP that the practitioner cannot be relied upon to follow IEHP's clinical or business guidelines or directives; or a change in IEHP's business needs.
2. A practitioner may request review of any initial adverse recommendation, decision or action by IEHP that is based on quality of care issues and/or credentialing requirements, and impacts his or her participation status with IEHP, including denial, reduction, suspension, or termination of his or her participation status with IEHP, in accordance with the Level I Review procedures, as provided herein. A practitioner may not request review of a recommendation, decision or action that is based on reasons unrelated to quality of care issues or credentialing requirements.

Procedure:

1. Issues raised about either an applicant or a participating practitioner's credentialing packet or performance as a practitioner shall be considered initially by the IEHP Medical Director, who shall have the discretion to investigate and to determine the necessary and appropriate response and intervention as delegated to the IEHP Medical Director as a member of the IEHP Peer Review Subcommittee. His/her options shall include, but not be limited to, maintaining a record of the matter without further investigation or action; investigating the matter personally and making a report and recommendation to the IEHP Peer Review Subcommittee, as warranted; or referring the matter to the IEHP Peer Review Subcommittee for investigation and the preparation of a report and recommendation to the IEHP Medical Director.
2. In instances where there may be an imminent danger to the health of any individual, the IEHP Medical Director and/or the IEHP Peer Review Subcommittee may summarily restrict or suspend the participating practitioner's privilege to provide patient care services, effective immediately upon written notice to the practitioner. The notice shall be in the same format as described in Section 3 herein, pending consideration and action by the IEHP Peer Review Subcommittee. The IEHP Peer Review Subcommittee may continue to enforce the reduction or suspension pending further action.
3. If an unfavorable recommendation, decision or action is made or taken by the IEHP Peer Review Subcommittee for a reason relating to quality of care issues or credentialing requirements, the practitioner shall be entitled to a Level I Review. The practitioner shall be sent a written notice, by certified mail, of the recommendation or decision and shall be afforded thirty (30) days in which to respond in writing to request a Level I Review, or to request a meeting with the IEHP Medical Director. A copy of the "Peer Review Process and Level I Review" document shall be provided with the notice. The notice will state:
 - a. The action which has been proposed against the practitioner;
 - b. A brief description of the factual basis for the proposed action;
 - c. That the practitioner may request that a Level I Review be conducted by the IEHP Peer Review Subcommittee;
 - d. That a Level I Review must be requested by the practitioner in writing, addressed to the Medical Director within thirty (30) days of the date of receipt of the notice by the practitioner. The practitioner's written request for a Level I Review must state the reasons for the request clearly, and if the practitioner wishes to exercise the right to present information orally at the Level I Review meeting as provided in Section 4b below, the practitioner shall so indicate in the written request for Level I Review;

- e. A brief summary of the practitioner's rights at the Level I Review, as set forth in Section 4 below;
 - f. That the Level I Review shall take place before the IEHP Peer Review Subcommittee; and
 - g. That the action, if implemented, must be reported to the Medical Board of California under California Business and Professions Code Section 805 as applicable, National Practitioner Data Bank (NPDB), and/or under any other applicable federal or state law.
4. A practitioner's rights at the Level I Review include:
- a. Right to present any additional written material for review by the IEHP Peer Review Subcommittee.
 - b. Right to present any information orally to the IEHP Peer Review Subcommittee in person at the time of the meeting for the Level I Review.
5. If the Level I Review is not requested by the practitioner within the time and in the manner specified, all administrative Level I Review rights of the practitioner shall be deemed waived, and the IEHP Peer Review Subcommittee shall propose such action as it deems appropriate, consistent with the notice previously given to the practitioner, in a written report to the IEHP Governing Board for adoption as the final action of IEHP, and shall provide a copy of the report describing the proposed action to the practitioner via certified mail.
- The decision of the IEHP Governing Board in cases where the practitioner has not requested a Level I Review shall be the final decision of IEHP. The practitioner shall receive a written notice of the decision of the IEHP Governing Board, including a statement of the basis for the decision, which shall be mailed via certified mail by the Secretary of the IEHP Governing Board. The notice shall contain a statement that there is no right of appeal to the IEHP Governing Board, following the final decision of the IEHP Governing Board.
6. If Level I Review is requested within the time and in the manner specified, the IEHP Medical Director shall arrange for the review to be conducted at the next scheduled meeting of the IEHP Peer Review Subcommittee, and the practitioner shall be sent a written notice via certified mail stating the date, time, and place of the Level I Review meeting. The practitioner's written response to the notice of action or proposed action shall be summarized in or attached to a report to the IEHP Peer Review Subcommittee which shall be written by the IEHP Medical Director, as a member of the IEHP Peer Review Subcommittee.

7. As provided in this “ IEHP Peer Review Process and Level I Review”, the Level I Review shall include an opportunity for the practitioner to present information and arguments in writing and/or orally. However, the Level I Review meeting is not a hearing, and the procedural rights associated with formal peer review hearings do not apply in Level I Review. The IEHP Peer Review Subcommittee shall have the discretion to prescribe such additional procedural elements as it deems appropriate to the circumstances. When the IEHP Peer Review Subcommittee is satisfied that sufficient information and arguments have been presented in this review process, it shall recommend or take such action as it deems appropriate and send written notice via certified mail to the practitioner.
8. In cases where the decision by the IEHP Peer Review Subcommittee for the Level I Review will result in the denial, suspension, reduction or termination of the practitioner’s participation status with IEHP, the written notice will include the following:
 - a. The Level I Review decision, including a brief description of the proposed recommendation, decision or action and the reasons for it;
 - b. That the action, if implemented, must be reported to the Medical Board of California under Business and Professions Code Section 805 as applicable, National Practitioner Data Bank (NPDB), or under any other applicable federal or state law;
 - c. That the practitioner may request a Level II Appeal hearing;
 - d. That a Level II Appeal hearing must be requested in writing, within thirty (30) days of receipt of the notice by the practitioner and the request must include a statement of the grounds for requesting a Level II Appeal;
 - e. A brief summary of the practitioner’s rights with respect to the Level II Appeal hearing;
 - f. A statement that the practitioner is required to exhaust the administrative remedies of the Level II Appeal hearing prior to seeking judicial review of the recommendations, decisions or actions of the IEHP Peer Review Subcommittee, or of the IEHP Governing Board; and
 - g. The Level II Appeal proceeding shall take place before a Hearing Officer, selected by the IEHP Medical Director in accordance with the procedures set forth in the Level II Appeal document and appointed by the IEHP Governing Board, and the final action shall be taken by the IEHP Governing Board.
9. Request for a Level II Appeal

The practitioner shall have thirty (30) days following the date of receipt of a notice of an adverse recommendation, decision or action resulting from a Level I Review to request a

formal Level II Appeal. The request must be submitted in writing, directed to the IEHP Medical Director, and must be received at IEHP within the prescribed period. If the practitioner does not request a formal Level II Appeal within the time and in the manner prescribed, they shall be deemed to have accepted the recommendation, decision, or action involved, and shall be deemed to have waived all administrative appellate review rights, and the recommendation, decision, or action may be adopted by the IEHP Governing Board as IEHP's final action.

10. Reporting

IEHP shall comply with the reporting requirements of the Medical Board of California (MBOC) as required by law. IEHP shall comply with the reporting requirements of the California Business and Professions Code, the Federal Health Care Quality Improvement Act, and the National Practitioner Data Bank (NPDB) regarding adverse credentialing and peer review actions. The practitioner will be notified of the reports and its contents.

MBOC requires Reports whenever: a licentiate's application for staff privileges or membership is denied or rejected for a 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 thirty (30) days or more for any 12-month period, for a medical disciplinary cause or reason; and/or a licentiate's resignation or leave of absence from membership, staff, or employment following notice of impending investigation based on information indicating medical disciplinary cause or reason.

11. Confidentiality

All credentialing and peer review records and proceedings shall be confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law.

CERTIFICATE OF THE SECRETARY TO THE GOVERNING BOARD

I, the undersigned do hereby certify:

That I am the duly appointed Secretary to the Inland Empire Health Plan (IEHP) Governing Board, a joint powers authority, a local public agency and a public entity of the State of California; and,

That the foregoing “Peer Review Process and Level I Review” document provides 1) a mechanism for peer review of IEHP practitioners, 2) a process for practitioners to request and obtain Level I Review of negative peer review recommendations, decisions or actions based on any reason related to quality of care issues and/or credentialing requirements, and 3) a mechanism for appropriate action. The foregoing document to which this Certificate is attached, was duly adopted by the IEHP Governing Board.

Date

Vickie Hargrove, Secretary to the Governing Board

INLAND EMPIRE HEALTH PLAN

PEER REVIEW PROCESS AND LEVEL II APPEAL

Denial, Reduction, Suspension or Termination of Practitioner Status

(Adopted April 14, 1997)

(Amended July 2010)

INLAND EMPIRE HEALTH PLAN

PEER REVIEW PROCESS AND LEVEL II APPEAL

Denial, Reduction, Suspension or Termination of Practitioner Status

A. Purpose:

To provide 1) a mechanism for peer review of IEHP providers of service (Providers); 2) a process for practitioners (as defined below under section B, "Scope") to appeal negative peer review recommendations, decisions and actions for any reason related to quality of care and/or other professional conduct issues including, but not limited to, denial, reduction, suspension or termination of practitioner status, as requested by the Inland Empire Health Plan (IEHP) Peer Review Subcommittee, the Credentialing Subcommittee, the IEHP Quality Management (QM) Committee, the IEHP Chief Medical Officer, or the IEHP Governing Board (peer review body); and 3) a mechanism for appropriate final action.

B. Scope:

The following policies and procedures apply to all health care professionals participating or requesting participation as a practitioner for IEHP (Practitioners), including, but not limited to, the following licentiates: Physicians (MD), Osteopathic Physician= (DO), Podiatrists (DPM), Pharmacists (Pharm D or RPh), Dentists (DDS, or DMD), Optometrists (OD), Chiropractors (DC), Clinical Psychologists, (PhD), Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Physical Therapists (PT), Occupational Therapists (OT), and Speech/Language Therapists (S/LT), psychiatrists, psychologists, master level clinical nurses, Licensed Clinical Social Workers (LCSW), Marriage, Family and Child Counselors (MFCC) and other behavioral health professionals licensed to provide behavioral health services in the state of California.

C. Policy:

1. A Practitioner's status or participation 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; a determination by IEHP that the practitioner cannot be relied upon to deliver the quality or efficiency of patient care desired by IEHP; a determination by IEHP that the practitioner cannot be relied upon to follow IEHP's clinical or business guidelines or directives; or a change in IEHP's business needs.
2. A Practitioner may appeal any Adverse Level I Review recommendation, decision or action by IEHP that is based on quality of care and/or other professional conduct issues and impacts his or her participation status with IEHP, including denial, reduction, suspension, or termination of participation status with IEHP, in accordance with the Level II Appeal procedures, as provided herein. A Practitioner may not appeal a recommendation, decision or action based on reasons unrelated to quality of care and/or other professional conduct issues

or credentialing requirements. For example, there is no right to appeal if any application is denied or not processed because the applicant fails to provide requested information.

D. Procedure:

1. Final Authority

Inland Empire Health Plan (IEHP), as a health care service plan, is defined as a peer review body under applicable law. The IEHP Governing Board has delegated certain peer review functions to the IEHP Peer Review Subcommittee and the Credentialing Subcommittee. The IEHP Governing Board serves as the final level of review and is the final authority in credentialing and peer review decisions. The IEHP Governing Board has delegated the hearing of any Level II Appeal to a Judicial Hearing Committee (JHC).

2. Judicial Hearing Committee

Whenever a Level II Appeal is required pursuant to this document “Peer Review Process and Level II Appeal” the Chief Medical Officer shall appoint a JHC consisting of at least three (3) physician Providers, and alternates as appropriate. The physician Providers selected to serve on the JHC shall be physicians from within the IEHP network who shall gain no direct financial benefit from the outcome and are neither in direct economic competition nor professionally associated (including in a referral relationship) with the subject of the hearing. None of the JHC members may have acted as an accuser, investigator, fact-finder or initial decision maker, or otherwise actively participated in consideration of the matter that forms the subject of the appeal prior to the recommendation or action. JHC members also should not have participated in the care of the patients (if any) whose care forms the subject of the appeal. Where feasible, the JHC shall include at least one member who practices in the same specialty as the Practitioner who requested the hearing. The Chief Medical Officer shall designate a Chairperson who shall handle pre-hearing matters and preside until a hearing officer, as described in the Hearing Officer Section 4, is appointed. The JHC shall make findings of fact, and issue a recommended decision for action by the IEHP Governing Board.

3. Request for a Level II Appeal

Notice of the right to a Level II Appeal shall be sent as provided in Level I Review, Section 9 (Request for a Level II Appeal). The practitioner shall have thirty (30) days following the date of receipt of a notice of an adverse recommendation, decision or action resulting from a Level I Review to request a formal Level II Appeal. The request must be submitted in writing, directed to the IEHP Chief Medical Officer, and must be received at IEHP within the prescribed period. If the practitioner does not request a formal hearing within the time and in the manner prescribed, the practitioner shall be deemed to have accepted the recommendation, decision, or action involved, and shall be deemed to have waived all administrative appellate review rights, and the recommendation, decision, or action may be forwarded to the IEHP Governing Board for final action in accordance with subsection D.18 below.

4. Hearing Officer

a. Selection

The Governing Board, or its designee shall appoint a hearing officer to preside at the JHC hearing. The hearing officer shall be an attorney at law who has been admitted to practice before the courts of this State for at least five (5) years prior to appointment, and who is qualified by knowledge and experience to preside over a quasi-judicial peer review hearing. The hearing officer shall gain no direct financial benefit from the outcome of the hearing. The hearing officer must not act as a prosecuting officer, or as an advocate for IEHP, the Governing Body, the body whose action prompted the hearing, or the Practitioner. If requested by the JHC, the hearing officer may participate in the deliberations of the JHC and be legal advisor to it, but he/she shall not be entitled to vote. The hearing officer may be a hearing officer for either Riverside or San Bernardino counties, provided he or she meets the other criteria established by this subsection. The hearing officer will be sent a letter of appointment by the IEHP Governing Board.

The Practitioner shall have the right to a reasonable opportunity to voir dire any JHC member and the hearing officer, and the right to challenge the impartiality of any JHC member and the hearing officer. Such challenges to the impartiality of any JHC member or the hearing officer shall be ruled on by the hearing officer.

b. Duties

The duties of the hearing officer shall be to preside over the hearing, including any pre-hearing and/or post-hearing procedural matters; to rule on the challenges to the impartiality of JHC members and/or the hearing officer; to rule on requests for access to information and/or relevancy; rule on requests for continuances; to rule on evidentiary and burden of proof issues; to prepare the written report and recommendation of the JHC; and to perform such other functions as may be necessary or appropriate to facilitate completion of a fair hearing process as expeditiously as possible.

5. Scheduling of Appeal/Notice of Hearing

Upon the selection of the JHC, the Level II Appeal shall be scheduled at a time and place mutually agreeable to the Practitioner and to IEHP. The Practitioner shall be given notice of the time, place and date of the hearing. IEHP shall make it's best efforts to ensure that the date of the commencement of the hearing shall be not less than thirty (30) days nor more than sixty (60) days from the date that IEHP receives the request for a Level II Appeal. The time frames set forth herein may be shortened or extended for a reasonable time by mutual written agreement of the parties (or by the Chairperson of the JHC if the hearing officer has not been appointed yet) upon a showing of good cause in accordance with Section 11 below. The peer review process shall be completed within a reasonable time after the Practitioner receives notice of a final proposed action or an immediate suspension or restriction of clinical

privileges, unless the JHC issues a written decision that the Practitioner failed to comply with the discovery provision herein, or consented to the delay in the proceedings.

6. Notice of Charges

A Notice of Charges shall be sent to the Practitioner along with the Notice of Hearing, further specifying, as appropriate, the acts or omissions with which the Practitioner is charged. This Notice of Hearing also shall provide a list of the patient records, if any, which are to be discussed at the hearing, if that information has not been provided previously.

Witness lists (see Section D.8) shall be amended as soon as possible when additional witnesses are reasonably known or anticipated. A failure by either party to comply with this requirement, shall be good cause to postpone the hearing.

7. Discovery

a. Rights of Discovery and Copying

The Practitioner may inspect and copy (at his/her own expense) any documentary information relevant to the charges that the IEHP Peer Review Subcommittee has in its possession or under its control, as soon as practicable after the receipt of the Practitioner's request for a Level II Appeal. The IEHP Peer Review Subcommittee shall have the right to inspect and copy (at its own expense) any documentary information relevant to the charges that the Practitioner has in his/her possession or control, as soon as practicable after the Practitioner's receipt of the IEHP Peer Review Subcommittee's request for such documents.

This Right of discovery and copying does not create or imply an obligation to modify or create documents in order to satisfy a request for information. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable Practitioners, other than the practitioner under review. Failure to comply with reasonable discovery requests at least ten (10) days prior to the Level II Appeal hearing shall be good cause for a continuance of the Level II Appeal hearing.

b. Limits on Discovery

The Hearing Officer, upon the request of either side, may impose safeguards including, but not necessarily limited to, the denial of a discovery request. The Hearing Officer when ruling upon requests for access to information and determining the relevancy thereof shall, among other factors, consider the following:

- 1) Whether the information sought may be introduced to support or defend the charges;

- 2) Whether the information is “exculpatory” in that it would dispute or cast doubt upon the charges or “inculpatory” in that it would prove or help support the charges and/or recommendation;
- 3) The burden on the party of producing the requested information;and
- 4) Other discovery requests the party has previously made or has previously resisted.

8. Pre-Hearing Witness List and Document Exchange

At least (10) working days prior to Level II appeal hearing, the parties shall exchange lists of the names of witnesses expected to be called at the hearing and copies of all documentation expected to be introduced in the evidence at the hearing. A failure to comply with this rule shall be good cause for the hearing officer to grant a continuance. Repeated failures to comply shall be good cause for the hearing officer to limit introduction of any documents or witnesses not provided or disclosed to the other side in a timely manner.

9. Representation

Level II Appeals are provided for the purpose of addressing issues of professional conduct or competence in health care. Practitioner is required to notify IEHP if they intend to be represented by legal counsel. Accordingly, neither the Practitioner nor the peer review body whose decision prompted the hearing may be represented by an attorney at the hearing unless a majority of the JHC members, in their discretion, permit both sides to be so represented. In no case may the IEHP Peer Review Subcommittee be represented by an attorney if the Practitioner is not so represented. The foregoing shall not be deemed to deprive any party of its right to the assistance of an attorney for the purpose of preparing for the hearing. When attorneys are not allowed in the hearing, the Practitioner and the IEHP Peer Review Subcommittee each may be represented at the hearing by a licensed Practitioner who is not an attorney.

10. Failure to Appear

Failure, without good cause, of the Practitioner to appear and proceed at the Level II Appeal shall be deemed to constitute voluntary acceptance of the recommendation or action involved and it shall thereupon become the final action of IEHP after approval by the IEHP Governing Board.

11. Postponements and Extensions

After a timely request for a hearing has been received as described above, postponements and extensions of time beyond the times expressly permitted in this Level II Appeal Process may be effected upon written agreement of the parties or granted by the hearing officer (or the Chairperson of the JHC if the hearing officer has not been appointed yet) on a showing of

good cause and subject to the hearing officer's discretion to assure that the hearing proceeds and is completed in a reasonably expeditious manner under the circumstances.

12. Record of the Hearing

A record of the Level II Appeal shall be produced by using a certified court reporter to record the hearing (an audio tape recording of the proceedings may be made in addition). The Practitioner shall be entitled to receive a copy of the transcript upon paying his or her share of the court reporter's fees, and the reasonable cost for preparing the transcript. Oral evidence shall be taken under oath administered by the court reporter.

13. Rights of the Parties

Both parties shall have the following rights, which shall be exercised in an efficient and expeditious manner and within reasonable limitations imposed by the hearing officer:

- a. To be provided with all of the information made available to the JHC;
- b. To have a record made of the proceedings as provided herein;
- c. To call, examine and cross-examine witnesses;
- d. To present and rebut evidence determined by the hearing officer to be relevant; and
- e. To submit a written statement at the close of the hearing.

The Practitioner may be called by the IEHP Peer Review Subcommittee's representative and examined as if under cross-examination. The JHC may interrogate the witnesses, or call additional witnesses, as the JHC deems appropriate. Each party has the right to submit a written statement at the close of the Level II Appeal. The JHC may request such a statement to be filed following the conclusion of the presentation of oral testimony.

14. Rules of Evidence

Rules relating to the examination of witnesses and the presentation of evidence in courts of law shall not apply in any hearing conducted herein. Any relevant evidence, including hearsay, shall be admitted by the hearing officer if it is evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs. A Practitioner shall not be permitted to introduce information not produced upon request of the peer review body during the application or other credentialing process, unless the Practitioner establishes that the information could not have been produced previously in the exercise of reasonable diligence.

15. Basis of Recommended Decision

The recommended decision of the JHC shall be based on, but may not be limited to, the

evidence produced at the hearing and any written statements submitted to the JHC.

16. Burden of Going Forward and Burden of Proof

In all Level II Appeals, the IEHP Peer Review Subcommittee shall have the burden of initially presenting evidence to support its recommendation, decision or action. Thereafter the burden differs, depending upon whether the Practitioner is disputing a decision not to accept the Practitioner for participation in the Practitioner network, or whether the Practitioner has already been credentialed and accepted by IEHP.

- a. If the IEHP Peer Review Subcommittee's recommendation is to deny initial IEHP affiliation, the Practitioner shall bear the burden of persuading the JHC, by a preponderance of the evidence, that he/she is sufficiently qualified to be awarded such affiliation in accordance with the professional standards of IEHP. This burden requires the production of information that allows for an adequate evaluation and resolution of reasonable doubts concerning the practitioner's qualifications, subject to the IEHP Peer Review Subcommittee's right to object to the production of certain evidence as provided herein. A Practitioner shall not be permitted to introduce information not produced upon request of the peer review body during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.
- b. If the IEHP Peer Review Subcommittee's action involves the termination of existing IEHP participation; or the suspension, reduction or limitation of privileges to perform patient care services, the IEHP Peer Review Subcommittee shall have the burden of persuading the JHC, by a preponderance of the evidence that its action is reasonable and warranted. The term "reasonable and warranted" means within the range of reasonable and warranted alternatives available, and not necessarily that the action is the only measure or the best measure that could be taken in the opinion of the JHC .

17. Preparation of Recommended Findings of Fact, Recommended Conclusions of Law and Recommended Decision

Within a reasonable time after the final adjournment of the Level II Appeal hearing, the JHC shall issue a decision that shall include finding of fact and conclusions of law articulating the connection between the evidence produced at the hearing and the result. A copy shall be sent to the IEHP Chief Medical Officer, the Practitioner involved, and the IEHP Chief Executive Officer. Final action shall be taken by the IEHP Governing Board, as provided below.

18. Governing Body Action

The IEHP Governing Board shall receive and review the recommended findings of fact, recommended conclusions of law, and recommended decision of the JHC. Exercising its independent judgment in accordance with applicable law, the IEHP Governing Board shall take final action, and may approve or modify the findings of fact, conclusions of law, and/or

recommendations of the JHC in any way that is supported by substantial evidence in the record.

There shall be no right of further appeal to the IEHP Governing Board following a formal Level II Appeal. However, the IEHP Governing Board shall have the discretion to defer taking final action pending such further proceedings as it may in its sole discretion direct or allow, including but not necessarily limited to, further proceedings before the JHC, further fact-finding at the IEHP Governing Board level, or an opportunity for oral and/or written argument at the IEHP Governing Board level.

The decision of the IEHP Governing Board shall be the final decision of IEHP. The Practitioner shall receive a written decision of the IEHP Governing Board, including a statement of the basis for the decision, which shall be sent via certified mail by the Secretary of the Governing Board. The notice shall contain a statement that there is no right of appeal to the IEHP Governing Board following the final decision of the IEHP Governing Board.

19. Reports

IEHP shall comply with the reporting requirements of the California Business and Professions Code, the Federal Health Care Quality Improvement Act, the National Practitioner Data Bank (NPDB), and any other applicable law regarding adverse credentialing and peer review actions.

20. Confidentiality

All peer review records and proceedings held pursuant to this procedure shall be confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable State and/or Federal law.

21. Privileges and Immunities

All activities conducted pursuant to this Level II Appeal Process are in reliance on the privileges and immunities afforded by the Federal Health Care Quality Improvement Act (42 USC Section 11101, et seq.) California Business and Professions Code Section 805, et seq. and the California Civil Code Sections 43.7, 43.8 and 47(b)(4) and (c).

22. Severability

This document and the various parts, sections and clauses thereof are hereby declared to be severable. If any part, sentence, paragraph, section or clause is adjudged unconstitutional or invalid, such unconstitutionality or invalidity shall affect only that part, sentence, paragraph, section or clause of this document, or person or entity; and shall not affect or impair any of the remaining provisions, parts, sentences, paragraphs, sections or clauses of this document, or its application to other persons or entities.

23. Applicability

This document shall be applicable to all peer review Level II Appeals, and shall be controlling.

24. Costs of Hearing

- a. The costs associated only with the conduct of the Level II Appeal hearing, excluding the costs listed in subsection 24.b below, shall be divided equally between the Practitioner and IEHP. Such costs shall include, but not be limited to, the costs of the certified shorthand reporter and rental of a hearing room, if applicable.

- b. The costs to be divided between the practitioner and the IEHP shall not include the costs, fees, and any other charges associated with legal representation of either party; the cost of the JHC, if any; the costs of discovery; the costs of preparation for the hearing; mileage costs for either party or witnesses; witness fees; or the costs of obtaining copies of the hearing transcripts or tapes. Except for the costs of the hearing officer and JHC , which shall be borne by IEHP, each party shall bear its own costs for these items individually.

25. Exhaustion of Administrative Remedies

A Practitioner shall be required to exhaust the administrative remedies herein prior to seeking judicial review of the actions of the IEHP Peer Review Subcommittee, or of the IEHP Governing Board.

CERTIFICATE OF THE SECRETARY TO THE GOVERNING BOARD

I, the undersigned do hereby certify:

That I am the duly appointed Secretary to the Inland Empire Health Plan (IEHP) Governing Board, a joint powers authority, a local public agency and a public entity of the State of California; and, That the foregoing "Peer Review Process and Level II Appeal" document provides 1) a mechanism for peer review, 2) a final level of review for appealing any adverse Level I Review recommendation, decision or action based on reasons relating to quality of care issues or credentialing requirements, and 3) a mechanism for appropriate action. This document establishes that the IEHP Governing Board is the final authority in peer review or credentialing decisions. The foregoing document to which this Certificate is attached, was duly adopted by the IEHP Governing Board.

_____ Date

_____ Vic



INLAND EMPIRE HEALTH PLAN

IEHP CREDENTIALING VERIFICATION

IPA Name: _____ PCP Specialist (Circle one or both)
Physician Name: _____ Specialty: _____

IPA: Initial Recred (circle one)

- A. Copies of the following are enclosed:
 - Malpractice History, if applicable
 - Curriculum Vitae
 - Completed W-9 form
 - CME, if applicable
 - Front and signature pages of signed PCP/Specialist Agreement.

- B. The following information has been verified. **(Please check all boxes that apply.)**
 - Admitting privileges at a participating IEHP Hospital (or privileges arranged through IPA)
 - Malpractice Coverage
 - Medical Education History including medical school and residency
 - Work History
 - Current California Medical License
 - Current DEA Registration Certificate
 - Signed application including a statement of physical or mental health problems, any history of chemical dependency or substance abuse, history of loss of license and/or felony convictions, history of loss or limitation of privileges or disciplinary actions

- C. The following queries have been performed. **(Please check all boxes that apply and circle "YES" or "NO" to indicate any history or negative actions. Include supporting documentation for any items marked "yes".)**
 - Malpractice Claims History **(HISTORY? YES/NO)**
 - National Practitioner Data Bank query **(HISTORY? YES/NO)**
 - Federation of State Medical Boards, as applicable
 - Medical Board of CA query **(HISTORY? YES/NO)**
 - History of Medicaid or Medicare sanctions **(HISTORY? YES/NO)**
 - Review of quality issues for recredentialing; e.g., Member complaints/grievances, results of quality reviews, utilization management, Member satisfaction surveys and facility reviews **(NEGATIVE FINDINGS? YES/NO)**

IEHP staff is authorized, upon two (2) business days notice, to examine appropriate credentialing files on-site as needed to respond to a complaint/grievance.

To the best of my knowledge, the above information is true and accurate.

IPA Initial Credentialing Committee Approval Date: _____

IPA Recred Credentialing Committee Approval Date: _____

Date

IPA Medical Director



January 1, 2007

Name
IPA Name
Address
City, State Zip

RE: Incomplete Credentialing Information:
Physician Name(s):

Dear Name:

IEHP is in receipt of practitioner credentialing information submitted for the above-referenced provider(s). This information is being returned to you due to one or more of the following reasons:

- ___ 10-day pended information was not received within required timeframe.
- ___ Specialty not covered by IEHP.
- ___ Incomplete Practitioner Profile.

Other

Please review policy 5B and resubmit the practitioner with all required information. Once the completed information is returned to IEHP, we will gladly proceed with the credentialing process. If you have further questions or concerns please contact me at (909) 890-XXXX.

Sincerely,

Credentialing Coordinator, IEHP

cc. IPA file 140.C
IEHP PSR

EXAMPLE

**DELEGATION OF SERVICES AGREEMENT BETWEEN SUPERVISING PHYSICIAN
AND PHYSICIAN ASSISTANT (Title 16, CCR, Section 1399.540)**

PHYSICIAN ASSISTANT. _____

(Name)

Physician assistant, graduated from the _____

(Name)

physician assistant training program, on _____

(Date)

He/she took (or is to take) the licensing examination for physician assistants recognized by the State of California (e.g. Physician Assistant

National Certifying Examination or a specialty examination given by the State of California) on _____

(Date)

He/she was first granted licensure by the Physician Assistant Examining Committee on _____, which expires on

(Date)

_____, unless renewed. (Or was granted interim approval by the Physician Assistant Examining Committee on

(Date)

_____, which expires on _____.)

(Date)

(Date)

SUPERVISION REQUIRED. The physician assistant named above (hereinafter referred to as PA) will be supervised in accordance with the written supervisor guidelines required by Section 1399.545 of the Physician Assistant Regulations. The written supervisor guidelines are incorporated with the attached document entitled, "Approved Supervising Physician's Responsibility for Supervision of Physician Assistants."

AUTHORIZED SERVICES. The PA is authorized by the physician whose name and signature appear below to perform all the tasks set forth in subsections (a), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant Regulations, when acting under the supervision of the herein named physician. (In lieu of listing specific lab procedures, etc., the PA and physician may state as follows: "Those procedures specified in the practice protocols or which the supervising physician specifically authorizes.")

The PA is authorized to perform the following laboratory and screening procedures:

The PA is authorized to assist in the performance of the following laboratory and screening procedures:

The PA is authorized to perform the following therapeutic procedures:

The PA is authorized to assist in the performance of the following therapeutic procedures:

The PA is authorized to function as my agent bylaws and/or rules and regulations of (name of hospital):

CONSULTATION REQUIREMENTS. The PA is required to always and immediately seek consultation on the following types of patients and situations (e.g. patient's failure to respond to therapy; physician assistant's uncertainty of diagnosis; patient's desire to see physician; any conditions which the physician assistant feels exceeds his/her ability to manage, etc.):

(List Types of Patients and Situations)

MEDICAL DEVICES AND PHYSICIAN'S PRESCRIPTIONS. The PA may transmit by telephone to a pharmacist, and orally or in writing on a patient's medical record or a written prescription transmittal order, the supervising physician's prescription in accordance with Section 3502.1 of the Business and Professions Code.

The supervising physician authorizes the delegation and the use of the transmittal form under the established practice protocols and drug formulary: _____ YES _____ NO

The PA may also enter an order on the medical record of a patient at _____
(Name of Institution)
in accordance with the Physician Assistant Regulations and other applicable laws and regulations.

Any medication handed to a patient by the PA shall be authorized by the physician's prescription and be prepackaged and labeled in accordance with Sections 4047.5, 4048, and 4228 of the Business and Professions Code.

PRACTICE SITE. All approved tasks must be performed for care of patients in this office or clinic located at _____

and, in _____ hospital(s) and _____ skilled nursing facility (facilities) for care of patients admitted to those institutions by physician(s) _____.

EMERGENCY TRANSPORT AND BACKUP. In a medical emergency, telephone the 911 operator to summon an ambulance. The

_____ emergency room at _____
(Name of Hospital) (Phone Number)

is to be notified that patient with emergency problem is being transported to them for immediate admission. Give name of admitting physician. Tell ambulance crew where to take patient and brief them on known and suspected health condition of patient.

Notify _____ at _____ immediately
(Name of Physician(s)) (Phone Number)

(or within _____ minutes).

PHYSICIAN ASSISTANT DECLARATION

My signature below signifies that I fully understand the foregoing Delegation of Services Agreement, having received a copy of it for my possession and guidance, and agree to comply with its terms without reservations.

Date

Physician's Signature

Physician's Printed Name

Date

Physician Assistant's Signature

THIS DOCUMENT IS NOT TO BE RETURNED TO THE PAEC SAMPLE ONLY

Physician Assistant's Printed Name

EXAMPLE

**APPROVED SUPERVISING PHYSICIAN'S RESPONSIBILITY
FOR SUPERVISION OF PHYSICIAN ASSISTANT**

SUPERVISOR _____, M.D. (D.O.) physician
(Full Name)

is licensed to practice in California as a physician and surgeon with medical license number _____.
Hereinafter, the above named approved supervising physician shall be referred to as the supervising physician.

PRACTICE SITE. All approved tasks must be performed for the care of patients in this office or clinic located at _____.

SUPERVISION REQUIRED. The physician assistant (PA) named in the attached Delegation of Services Agreement will be supervised by the supervising physician in accordance with these guidelines, set forth as required by Section 1399.545 of the Physician Assistant Regulations, which have been read by the physician whose signature appears below.

The physician shall review, countersign, and date within seven (7) days the medical record of any patient cared for by the physician assistant for whom the physician's prescription was transmitted or carried out.

REPORTING OF PHYSICIAN ASSISTANT SUPERVISION. Each time the physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her approved supervising physician who is responsible for the patient. When the physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

MEDICAL RECORD REVIEW. One or more of the following mechanisms, as indicated below, by a check mark (x), shall be utilized by the supervising physician to **partially** fulfill his/her obligation to adequately supervise the actions of the physician assistant named _____.

(Give Name of PA)
_____ Examination of the patient by a supervising physician the same day as care is given by the PA.

_____ The supervising physician shall review, audit, and countersign every medical record written by the PA within _____ of the encounter.
(Number of Days-May Not Exceed 30 Days)

_____ The physician shall audit the medical records of at least 10% of patients managed by PA under any protocols which shall be adopted by the supervising physician and the physician assistant. The physician shall select for review those cases which by diagnosis, problem, treatment, or procedure represent, in his or her judgement, the most significant risk to the patient.

_____ Other mechanisms approved in advance by the Physician Assistant Examining Committee may be used. Written documentation of those mechanisms are located at _____.
(Give Location)

_____ **INTERIM APPROVAL.** For physician assistants operating under interim approval, the supervising physician shall review, sign and date the medical records of all patients cared for by the physician assistant within seven (7) days if the physician was on the premises when the physician assistant diagnosed or treated the patient. If the physician was not on the premises at that time, he or she shall review, sign and date such medical records within 48 hours of the time the medical services were provided.

BACK UP PROCEDURES. In the event this approved supervising physician is not available when needed, the following physician(s) has (have) agreed to be a consultant(s) and/or to receive referrals:

(Printed Name and Specialty) Phone: _____

(Printed Name and Specialty) Phone: _____

The consultant and referral physicians are not authorized to act as a supervising physician for the PA unless they have received prior approval of the Medical Board of California to be a supervising physician.

PROTOCOLS. NOTE: This document does not meet the regulation requirement to serve as a protocol. Protocols, if adopted by the supervising physician, must fully comply with the requirements authorized in Section 1399.545(e)(3) of the Physician Assistant Regulations.

(Date) _____
(Physician's Signature)

**THIS DOCUMENT IS NOT TO BE RETURNED TO THE PAEC
SAMPLE ONLY**