Anthem is providing this information as a general educational tool to assist Provider Organizations with compliance. Anthem does not represent this information as legal advice. Provider Organizations are responsible for conducting final research regarding health plan and regulatory requirements.
# Table of Contents

Required Credentialing Submissions .......................................................... 3  
Provider Organization Reporting and Documentation Requirements .......... 4  
Corrective Action Plan ............................................................................. 5  
Provider Additions and Terminations ....................................................... 6  

**Delegation of Credentialing** ..................................................................... 7  
Delegation .................................................................................................. 8  
Guide to Delegation .................................................................................... 9  
Delegating to an NCQA-Accredited or NCQA-Certified Entity .................. 10  
Credentialing Delegation Example ................................................................ 11  

**Industry Collaborative Effort (ICE) Shared Audit Program** ..................... 12  

**Sample Policies and Procedures and Informational Attachments - Commercial** .................................................. 15  
  Credentialing and Recredentialing Guidelines ............................................ 16  
  Credentialing Verification Resource Table .................................................. 19  
  Credentialing Committee .......................................................................... 20  
  Sample Provider Organizational Credentialing Meeting Minutes ............... 22  
  Sample Nondiscrimination and Confidentiality Statement ......................... 23  
  Practitioner Rights .................................................................................. 24  
  Practitioner Office Site Quality/Site Visits and Ongoing Monitoring ........... 25  
  ICE Health Plan Complaint Threshold Table ............................................ 27  
  Office Site Complaint Tool ....................................................................... 28  

**Ongoing Monitoring** .............................................................................. 29  
  Colorado Boards ..................................................................................... 31  
  Dept of Regulatory Agencies (DORA) Monthly Disciplinary Reports Tutorial .... 31  
  Novitas .................................................................................................... 36  
  Medi-Cal Suspended Ineligible List Instructions ....................................... 37  
  Medi-Cal Suspended and Ineligible Lists .................................................. 44  
  Ongoing Monitoring Website .................................................................... 46  
  Notification to Authorities and Practitioner Appeal Rights ......................... 47  
  Medical Board of California 805.01 Requirement ...................................... 49  

**Assessment of Organizational Providers** ................................................. 52  
  ICE Share Audit Organizational Provider Worksheet .................................. 54  
  Identification of HIV/AIDS Specialists ..................................................... 55  
  Suggested Instructions on Conducting Annual Screening for HIV/AIDS Specialists ................................................................. 57  
  Practitioner Letter ................................................................................... 58  

**Sample Policies and Procedures and Information Attachments - Medicare** ........ 60  
  Performance Monitoring - Medicare ......................................................... 61  
  Monitoring Medicare Opt-Out Verification - Medicare ............................... 62
Required Credentialing Submissions
## Anthem Provider Organization Reporting and Documentation Requirements

The following table lists each required report, due dates, and reporting content.

All reports are to be sent to your assigned Anthem Auditor. An evaluation of each report will be completed and sent to you within 30 calendar days of receipt. The evaluations are based on timeliness of submitting the report and content comprehensiveness per report instructions. The results of the report evaluations will be reflected on the Provider Organization's annual audit score summary report.

<table>
<thead>
<tr>
<th></th>
<th>Reporting Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credentialing</td>
<td>Credentialing Policies</td>
</tr>
<tr>
<td></td>
<td>15 calendar days after Committee approval</td>
</tr>
<tr>
<td></td>
<td>1st Semi-Annual Report and Submission Form</td>
</tr>
<tr>
<td></td>
<td>August 15th</td>
</tr>
<tr>
<td></td>
<td>2nd Semi-Annual Report and Submission Form</td>
</tr>
<tr>
<td></td>
<td>February 15th of the following year</td>
</tr>
<tr>
<td>Corrective Action Plan (if applicable)</td>
<td>Corrective action plan addressing any identified audit deficiencies from either the Anthem Annual Audit or the Anthem Follow-up Audit.</td>
</tr>
<tr>
<td></td>
<td>30 calendar days from Audit Summation letter date</td>
</tr>
<tr>
<td></td>
<td>Completed action plan for any deficiencies identified in Anthem Audit Summation Letter and attached CAP</td>
</tr>
</tbody>
</table>

**Reference Sources:**

The Credentialing Semi-Annual Submission form may be downloaded from:

## CORRECTIVE ACTION PLAN

<table>
<thead>
<tr>
<th>Provider Organization Name</th>
<th>Audit Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action Plan (CAP) Date</td>
<td>Audit Conversion Year and Type</td>
</tr>
<tr>
<td>CAP Due Date</td>
<td>Re-evaluation Date</td>
</tr>
</tbody>
</table>

---

**Provider Organization:**
To ensure correction of deficiencies in all audited categories, please complete the Date CAP Sent and Completed By fields, and the last 3 columns in the grid below, and return to assigned Anthem Auditor, Regulatory and Accrediting Oversight within 30 calendar days of the date of the attached Audit Summation Letter.

**Date CAP Sent to Anthem:** ___________ **CAP Completed By:** ______________________

<table>
<thead>
<tr>
<th>Audit Category</th>
<th>Audit Indicator &amp; Applicable Indicator Header</th>
<th>Audit Score</th>
<th>Area For Improvement</th>
<th>Corrective Action Timeframe for CAP Implementation</th>
<th>Responsible Provider Organization Person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

---
Provider Additions and Terminations

The delegated Provider Organizations are required by Anthem to email a profile sheet (includes: name, DOB, address, license information, education/training, board certification/expiration dates, etc.) for all additions and terminations of practitioners.

For Anthem, information must be sent via email to:
ProviderDatabaseAnthem@Anthem.com
DELEGATION OF CREDENTIALING
Delegation

What is delegation?

Delegation occurs when the Provider Organization gives another entity the authority to carry out a function that it would otherwise perform. This authority as memorialized in the delegation agreement includes the right for the delegate to decide what, where, who, when, and why, a function will be done, within the parameters agreed on by the contracting parties. When delegation exists, the Health Plan requires the presence of a mutual agreement between the delegating organization and its delegate who performs specific functions related to its own compliance functions for CMS, NCQA, and State compliance standards. The delegation agreement must include a statement requiring the delegate to adhere to CMS regulations (with the exception of CVOs). Although the Provider Organization may not directly perform delegated functions, it must provide compliance oversight for each delegated function to ensure that the delegate is properly performing the functions and maintains full compliance for regulatory requirements. The Provider Organization may reclaim the right to carry out its delegated functions at any time.

The Provider Organization’s responsibility:

The Provider Organization is ultimately accountable for all functions performed within its purview, whether those functions are performed directly by the Provider Organization, or indirectly by a delegate or sub-delegate. A Provider Organization that delegates activities/functions associated with any of the NCQA, CMS, and State standards for Credentialing/Recredentialing must demonstrate that the ability to perform delegation oversight for the evaluation of structures, functions and processes necessary to achieve/maintain compliance and improved (or consistent, high-quality) performance across its network and membership is not compromised.

What is Sub-Delegation?

Sub-delegation occurs when the Provider Organization’s delegate gives a third entity the authority to carry out a delegated function. For example, the Provider Organization may delegate credentialing (CR) activities to a Management Services Organization (MSO), which then the MSO delegates some of those activities to a Credentials Verification Organization (CVO). In this case, the CVO is the sub-delegate.

Oversight of sub-delegates:

Sub-delegation is acceptable if either the delegate or the Provider Organization oversees the work performed by the sub-delegate to ensure that it meets Health Plan, Provider Organization, NCQA, CMS, and State compliance standards/requirements. The Provider Organization may conduct compliance oversight for the sub-delegate directly. If the delegate oversees the sub-delegate, the delegate must report the sub-delegates compliance performance status at least semi-annually to the Provider Organization. The Provider Organization is ultimately accountable for all activities performed by both the delegate and sub-delegate on its behalf.

Types of Delegation Arrangements

The most common delegation arrangements are between organizations and primary, specialty and multispecialty medical groups, IPAs, managed behavioral healthcare organizations (MBHO), hospitals, credentialing verification organizations (CVO) and disease management (DM) organizations.
## Guide to Delegation

<table>
<thead>
<tr>
<th>Ownership issues</th>
<th>Delegation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSO and group wholly owned by the same organization (e.g. hospital, integrated health system, business corporation)</td>
<td>Activities conducted by 'sister' organizations does not constitute a delegation arrangement</td>
<td>Wholly owned means 100%, anything less is not wholly owned</td>
</tr>
<tr>
<td>MSO wholly owns medical group</td>
<td>No delegation</td>
<td></td>
</tr>
<tr>
<td>Medical group wholly owns MSO</td>
<td>No delegation</td>
<td></td>
</tr>
<tr>
<td>MSO partially owned by medical group</td>
<td>Delegation</td>
<td></td>
</tr>
<tr>
<td>Medical group partially owned by MSO</td>
<td>Delegation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product</th>
<th>Activity</th>
<th>Delegation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSO</td>
<td>Credentialing</td>
<td>No delegation</td>
<td>No delegation or oversight required</td>
</tr>
<tr>
<td></td>
<td>P&amp;P development, approved by group</td>
<td>No delegation</td>
<td>Delegation agreement and oversight required (annual review for compliance with MCO requirements)</td>
</tr>
<tr>
<td></td>
<td>P&amp;P development, not approved by group</td>
<td>Delegation</td>
<td>Delegation agreement and oversight required</td>
</tr>
<tr>
<td></td>
<td>Collection of PSV by MSO</td>
<td>Delegation</td>
<td>Delegation agreement and oversight required</td>
</tr>
<tr>
<td></td>
<td>Decision made by MSO</td>
<td>Delegation</td>
<td>Delegation agreement and oversight required</td>
</tr>
<tr>
<td></td>
<td>Decision made by group</td>
<td>No Delegation</td>
<td>No Delegation agreement and oversight required</td>
</tr>
<tr>
<td>Non-certified CVO</td>
<td>PSV</td>
<td>Delegation</td>
<td>Delegation agreement and oversight required</td>
</tr>
<tr>
<td>Certified CVO</td>
<td>PSV</td>
<td>Delegation</td>
<td>Delegation agreement required but no oversight of certified activities</td>
</tr>
</tbody>
</table>
Delegating to an NCQA-Accredited or NCQA-Certified Entity

When a Provider Organization delegates defined activities to an NCQA-Accredited or NCQA-Certified organization, the expectation of a formal pre-delegation evaluation, annual evaluation and annual audit, as applicable, and the determination of meeting NCQA standards are satisfied for activities covered within the delegate’s NCQA-Accreditation or NCQA-Certification survey.

The Health Plan waives the pre-delegation assessment and annual oversight requirements of NCQA-Accredited or NCQA-Certified delegates. Oversight relief is not available for activities that are not covered—including NA activities, within the scope of a delegate’s NCQA-Accreditation or NCQA-Certification survey.

Oversight relief is only available for elements and categories (certification options) in which an NCQA certified organization received certification. For example, a CVO may elect not to seek or may not receive certification for Ongoing Monitoring of Sanction Information. If the CVO has certification in all other certification options and the Provider Organization delegates ongoing monitoring to the CVO, it does not receive oversight relief for delegated ongoing monitoring activities and is required to conduct pre-delegation and annual evaluation of the delegates. The Health Plan will give the Provider Organization 100% score on specific delegation oversight elements for NCQA-Accredited or NCQA-Certified delegates.

NCQA Certification Programs

- Credentialing Verification Organizations (CVO) Certification
- Certification in UM/CR

NCQA Deemed Status for CMS

- http://www.ncqa.org/Programs/Accreditation/MedicareAdvantage.aspx
- What is deeming: Deeming is when an Accrediting Agency for example, NCQA, JCAHO or another accrediting body has received approval (Recognition or Deeming) from CMS to conduct compliance oversight surveys for the Medicare Advantage (MA) Program that are accepted in lieu of federal CMS surveys for six key categories.
- What areas are deemed: Access to Services, Antidiscrimination, Confidentiality and Accuracy of Enrollee Records, Information on Advance Directives, Provider Participation Rules, and Quality Assurance
- How is deeming maintained: Deemed status is maintained by ensuring surveys are conducted at least every three years under the standards approved by CMS at the time of the NCQA MA Deeming Survey.

File Review Elements

The Health Plan scores all delegated file-review elements as present if the Provider Organization delegates both primary-source verification and decision making to an organization that is NCQA-Accredited or NCQA-Certified in CR.

The Health Plan reviews the delegate’s files to determine whether time-sensitive elements meet the time limits if the organization does not delegate CR decision making, or if the Provider Organization delegates to a CVO that is NCQA certified.
Credentialing Delegation Example

Does an entity other than the organization perform PSV or decide whom to include/exclude from the organization’s practitioner network?

Yes

Delegation

No

Does an entity other than the organization create the assessment tools without the involvement of the organization to assess performance?

No

Yes

Delegation

Delegation

No

No Delegation
Industry Collaborative Effort (ICE) Shared Audit Program

Purpose
The program’s objective is to reduce the number of annual credentialing audits that are conducted at Health Plan contracted Provider Organizations.

The following accredited Health Plans are part of the collaboration: Aetna Health of California Inc., Anthem Blue Cross, Blue Shield of California, Care1st Health Plan, Cigna Healthcare of California/Great West, Community Health Group, Health Net of California, Inc, Kaiser Foundation Health Plan, Inc., Molina Healthcare of California, Sharp Health Plan, UnitedHealthcare of California and Western Health Advantage. Unaccredited Health Plans are also part of this program, however they do not post the audits, but collaborate in the shared audit process.

The following unaccredited health plans are: AIDS Healthcare Foundation, Brand New Day Health Plan, Brown and Toland Health Services, CareMore Health Plan, Central Health Plan of California, Citizens Choice Health Plan, GEMCare Health Plan, Gold Coast Health Plan, Health Plan of San Joaquin, Humana Inc., Managed Health Network, Inc., Santa Clara Family Health Plan, SCAN Health Plan and Seaside Health Plan.

An auditor from a fully accredited NCQA Health Plan will conduct an audit on a Provider Organization that is common to multiple Health Plans. Once collected, the audit data will be shared with other Health Plans via a secured Web site. This process is known as “posting” the audit. Each Health Plan has the ability to download the data, measure audit outcomes against its own established performance thresholds and assign delegation status.

Program Description
The goal is to decrease the amount of audits conducted among the Health Plans. Audits can be conducted more than one time per year, if a Health Plan business rule deems it necessary and/or if the posted audit does not meet the Health Plan’s auditing timeframe.

Provider Organizations that may be delegated for credentialing are audited using the shared credentialing audit tool which covers regulatory and accreditation requirements (e.g. NCQA, DMHC, CMS, DHCS). After a Health Plan conducts an audit and receives written permission from the Provider Organization to post, the credentialing audit tool is posted in a secured area on the ICE Web site and made available to other Health Plans for their use in credentialing oversight. Other Health Plans (“Responsible Plan”) that delegate credentialing to a Provider Organization can use the posted results to make their own delegation decision and to formulate corrective action plans.

Industry Collaborative Effort (ICE) Web site
ICE is a volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve health care regulatory compliance through education of the public. Through their participation, they help to educate through clarification of issues which arise from time to time as a result of the promulgation of new regulations. ICE volunteers work cooperatively to develop policies, procedures, and tools designed to find a consistent way to implement regulations with the minimal amount of impact and the maximum amount of return for both the health plan and the provider community that enable them to more readily and easily comply with regulation.

The ICE Credentialing Audit Network (iCAN), which is part of the ICE Web site, is a database system where participating Health Plans can schedule their audits, view the audits, post the audits and generate audit reporting schedules.

Scheduling Team
This team meets monthly to coordinate audit schedules among the Health Plans. Once audits are scheduled, the assigned Health Plan will send the posting letter to the Provider Organization.

**Posting Letter**
The assigned Health Plan will send the posting letter three months prior to the audit. This letter is sent to the Medical Director via the Credentialing Director at the Provider Organization for signature.

The auditor will review and verify accuracy of the information on the posting letter and in the product line database of the iCAN system prior to audit and on actual day of the audit with the Provider Organization. Once the signature is obtained, the audit will be conducted and posted on the iCAN Web site. No audits will be posted without the Provider Organization’s permission. If a posting letter has not been signed, all Health Plans are allowed to schedule and audit accordingly.

**Posted Audits**
Only annual audits are posted on the iCAN Web site. Posting results will be uploaded by the auditing Health Plan into the iCAN Web site. If a Provider Organization requests that posted results be withdrawn from the Web site, the posted shared credentialing audit tool will be removed from the ICE Web site as requested and the Auditing Health Plans will be notified. If any Health Plan has already used the posted results, it will be the responsibility of the requesting Provider Organization to negotiate with that Health Plan. Removal of posted results from the iCAN Web site does not guarantee non-use by a Health Plan that has already obtained the results.

**Inter-rater**
The purpose of the inter-raters is to ensure that all Health Plans are auditing in the same manner. Inter-raters audits are chosen by the Scheduling Team to be conducted by two different health plans. The same files are chosen and the audit is conducted on the same day or within the same week. Once the audit is completed, the Clarification Team Leaders review and compare the audit findings and make comments on discrepancies found, if any. The shared credentialing audit tool and shared audit training tool template may be downloaded from ICE Web site Library under “Approved Documents” in the “Credentialing Shared Audit Policy Team” folder under the “Tools” folder at [http://www.iceforhealth.com/library.asp?sf=&scid=1354#scid1354](http://www.iceforhealth.com/library.asp?sf=&scid=1354#scid1354)

**Auditing Health Plan**
Once the audit is completed, the Shared Audit will be posted on the iCAN Web site within 30 calendar days of the audit. Once posted, the availability of the audit results will be communicated to all Health Plans. Each Health Plan will utilize the data to measure audit outcomes against its own established performance threshold.

**Access to Reports on ICE Web Site**
Health Plan personnel can receive access to all posted audit reports by logging in to the iCAN Web site. Provider Organizations may request a copy of their posted results from the Health Plan that conducted the on-site audit. Provider Organizations may not receive the password, but can receive copies of the reports, including their own, by contacting the auditing Health Plan personnel.

**PO Release Letter**
If the Provider Organization wishes to receive reports about Provider Organizations to which it sub-delegates, written permission must be granted from the sub-delegated entity and supplied to the Auditing Health Plan. A copy of this signed letter must be submitted to the ICE Web Site Administrator at admin@iceforhealth.org
The Provider Organization Release Letter can be downloaded from the ICE Web site Library under “Approved Documents” in the “Credentialing Shared Audit Policy Team” folder under the “Tools folder” at http://www.iceforhealth.com/library.asp?sf=&scid=1354#scid1354

Health Plan Audit Delegation Release Letter
If a Health Plan wishes to obtain reports about Provider Organizations for delegation assessments, written permission must be granted from the Provider Organization and supplied to the Auditing Health Plan. A copy of this signed letter must be submitted to the ICE Web Site Administrator at admin@iceforhealth.org. The Health Plan Release Letter template is located in Approved Documents team folder at: http://www.iceforhealth.org/library.asp?sf=&scid=1354#scid1354
Sample Policies and Procedures and Informational Attachments - Commercial

The following templates may be utilized by the Provider Organization to assist with the development of policies. The templates are based on Anthem requirements and may not be specific to other health plan requirements, including the ICE Credentialing Shared Audit.
Purpose:
“X” Provider Organization will ensure that licensed healthcare practitioners meet the credentialing and recredentialing performance standards for participation on practitioner panel.

Policy:
- “X” Provider Organization credentialing and recredentialing policies evaluate and select licensed independent practitioners to provide care to members.
- The types of practitioners credentialed and recredentialed include: [insert applicable types of practitioners, e.g. Medical Practitioners, Psychiatrists, Addiction Medicine Specialists, DCs, DDSs/DMDs (Oral Surgeons), DOs, DPMs, PAs and APNs Master’s level CCNSs, CPNPs, CNPs, and CNMs].
- Primary or NCQA accredited/certified verification sources will be used to ensure that credential decisions are based on the most accurate, current and complete information available.
- Verification sources must not be more than 180 calendar days of the credentialing committee decision.
- At a minimum, all practitioners must have: Current and valid, unencumbered license to practice medicine in state of practice, appropriate malpractice claims history, must not have engaged in any unprofessional conduct or unacceptable business practices, absence of sanctions or restrictions on licensure, current and valid DEA to practice in California, absence of use of illegal drugs, absence of criminal history.
- Delegation (choose and insert one):
  - (If there is no delegation of credentialing activities) “X” Provider Organization does not delegate any credentialing or recredentialing functions.
  - (If there is delegation) “X” Provider Organization will follow health plan, state, federal and accrediting standards for oversight of delegated activities, which include (list delegated activities).
- Credentialing and recredentialing will be conducted in a non-discriminatory manner.
- The credentialing and recredentialing decisions are not based solely on an applicant’s race, ethnic/national identity, gender, age, or sexual orientation; the types of patients (e.g., Medicaid) which are the population served by the practitioner.
- The Medical Director or other designated physician has direct responsibility and participation in the Credentialing Program.
- A review board or governing body can review a decision after the Credentialing Committee, but the decision made by the Credentialing Committee is to be final.
- All credentialing information collected in the credentialing process will be kept confidential.

Responsibility: Department or position responsible

Procedure:
- Verification is documented within the file. A signed and dated checklist including each verified element may be present in each practitioner credentialing file. Please refer to the Credentialing Verification Resource Table for the verification sources:
- State License to Practice
- DEA Registration
- Education, Training
- Board Certification
- Work History
- Malpractice Claims History
- Current Malpractice Insurance Coverage
- Hospital Admitting Privilege
- State Sanctions and Restrictions on Licensure and Limitations on Scope of Practice
- Medicare/Medicaid Sanctions

• All practitioner files are submitted to the Credentialing committee for approval.
  (If clean file process is used, insert the following) A designated Medical Director or equally qualified person with credentialing responsibility/authority can determine if the files are "clean" and can sign off on it as complete, clean and approved

• The Credentialing Committee will receive and review the credentials of practitioners being credentialed and recredentialed who do not meet the criteria. The Credentialing Committee will document in its minutes the thoughtful consideration of credentials discussed during its meetings.

• To ensure that credentialing decisions are made in a non-discriminatory manner, the following processes will be implemented annually:[insert one or more of the following for Preventing]

  • Maintaining a heterogeneous Credentialing Committee membership.
  • Requiring those responsible for credentialing decisions to sign a statement affirming that they do not discriminate when they make decisions
  • Preventing involved taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing process
    [insert one or more of the following for Monitoring]

  • Periodic audits will be conducted for credentialing files (in-process, denied and approved files) to ensure that practitioners are not discriminated against;
  • Periodic audits of practitioner grievances/complaints to determine if there are grievances/complaints alleging discrimination;
  • Monitoring involves tracking and identifying discrimination in credentialing and recredentialing process
  • Monitoring must be conducted at least annually

• The practitioner will be notified if any information obtained during the credentialing process varies substantially from the information provided to the Provider Organization by the practitioner. [insert how practitioner will be notified]

• Practitioner will be notified of the initial credentialing decision (approvals/denials) and recredentialing denials within 60 calendar days of the credentialing committee’s decision. [insert how practitioner will be notified]

"X" Provider Organization will ensure all information obtained in the credentialing process is confidential, except as otherwise provided by law. [insert process used to ensure confidentiality]
Reference Sources:
NCQA CR 1.A.1-11; 42 CFR § 422.204(a), § 422.204(b)(2)(iii), § 422.205(a); 28 CCR 1300.51(d)(H)(iii)

Attachments:
Credentialing Verification Resource Table
Credentialing Verification Resource Table

Click on icon below to display NCQA approved verification sources and timeframes for verification:

Verif
Sources_030415_Clis
Purpose:
“X” Provider Organization will designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

Policy
- “X” Provider Organization establishes a peer-review process by designating a Credentialing Committee that includes representation from a range of participating practitioners. The Credentialing Committee must include representation from the types of practitioners it reviews.
- Specialists will be consulted when necessary and appropriate, if the committee is comprised of PCPs only.
- Ad Hoc committee will convene if adequate range is not represented.
- Meetings will not be conducted through email.
- “X” Provider Organization obtains meaningful advice and expertise from participating practitioners when it makes credentialing decisions.
- Medical Director will sign and date minutes by the date of the next meeting.
- Ad hoc Credentialing Committee meeting minutes must be documented at the time of the ad hoc meeting, and must be presented at the next formal meeting.

Responsibility: Department or position responsible

Procedure:
- “X” Provider Organization Credentialing Committee must review practitioner credentials and give thoughtful consideration to the credentialing elements before making recommendations about a practitioner’s ability to deliver care. At a minimum, the Credentialing Committee must receive and review the credentials of practitioners who do not meet the “X” Provider Organization’s established criteria.
- “X” Provider Organization may submit all practitioner files to the Credentialing Committee for review, or it may implement a process for the medical director to review clean files, as described in the credentialing policies and procedures. In the latter case, there must be evidence of the designated medical director’s or equally qualified physician’s review and sign-off on a list of the names of all practitioners who meet the established criteria.
- For clean files, credentials must be verified within the specified time limits and valid at the time of the Credentialing Committee’s or medical director’s review. The practitioner may not provide care to enrollees until the final decision is rendered by the Credentialing Committee or the medical director.
- “X” Provider Organization has the right to make the final determination about which practitioners may participate within its network. If “X” Provider Organization documents unfavorable information (e.g., malpractice claims, deficient site visits and sanctions) about a specific practitioner during the credentialing process, it may credential the practitioner.
- Credentialing Community may not make any decisions on a practitioner unless all necessary credentialing information has been gathered within the specified timeframe.
Reference Sources:
NCQA CR 2.A.1-3; 42 CFR § 422.204(b)(2)(iii)

Attachments:
Sample Provider Organization Credentialing Meeting Minutes
Sample Confidentiality Statement
The regularly scheduled Credentialing meeting was held on Day/ Month/Date/Year/Time. The following members were in attendance: [list member names and titles]

<table>
<thead>
<tr>
<th>AGENDA ITEM/ISSUE</th>
<th>DISCUSSION/RECOMMENDATIONS</th>
<th>FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction if applicable</td>
<td>Guests introduced</td>
<td>None</td>
</tr>
<tr>
<td>2. Review of Previous Minutes</td>
<td>Minutes of previous CR meeting, x/xx/xx, reviewed. Minutes accepted with the following revision to Item #3: wording changed from ‘Dr. [Name] presented…’ to “Dr. [Name] presented…”</td>
<td>None</td>
</tr>
<tr>
<td>3. Old Business</td>
<td>a. Discussion of items/issues requiring follow-up from previous meeting.</td>
<td></td>
</tr>
<tr>
<td>5. Standing Agenda Items:</td>
<td>a. Ongoing Monitoring</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Ongoing Monitoring of Complaints</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Adverse Events</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Site Visits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. MediCare Opt-Out Report</td>
<td></td>
</tr>
<tr>
<td></td>
<td>f. Sanctions</td>
<td></td>
</tr>
<tr>
<td>6. Adjournment</td>
<td>All business for Credentialing meeting concluded and adjourned at 9:00 AM.</td>
<td></td>
</tr>
</tbody>
</table>

Respectfully Submitted,

______________________________
Credentialing Chairperson Signature

______________________________
Credentialing Chairperson Printed Name

_________________
Date

- 22 -
Nondiscrimination and Confidentiality Statement

As a member of the Credentialing Committee, involved in the evaluation and improvement of quality of care and service, I recognize that confidentiality is vital to the credentialing process. Therefore, I agree to respect and maintain the confidentiality of all discussions, records, and information generated in connection within the Credentialing Committee activities, and to make no voluntary disclosure of such information except to persons authorized to receive it.

As a member of the Credentialing Committee, I will ensure credentialing and recredentialing decisions will be made in a non-discriminatory manner and will not be made based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patients (e.g., Medicaid) in which the practitioner specializes.

Date: ____________________  Signed: _______________________________

Print Name: ______________________________

__________________________________________________________________________
SAMPLE

Policy Number:  
Policy Name:  Practitioner Rights 
Policy Approval Date:  
Policy Revision Date:  

Purpose:  
"X" Provider Organization will notify the practitioners of their “right” to review information that have been collected to evaluate credentialing and recredentialing application.

Policy:  
• The practitioner has the right to review information submitted to support their credentialing application, attestation or CV.
• The practitioner has the right to correct erroneous information submitted.
• The practitioner has the right to be informed of the status of their credentialing or recredentialing application upon request.
• The practitioner has the right to be notified of the process in writing during initial credentialing.

Responsibility: Department or position responsible

Procedure:  
• The practitioner may review information obtained from any outside source, such as malpractice insurance carriers, state licensing boards, with the exception of references, recommendations or other peer-review protected information.
• Practitioners will be notified of the right to correct erroneous information.  
  ➢ Erroneous information must be corrected within "X" days.  
  ➢ Submission of corrections must be in the correct format.[insert description of format].  
  ➢ Corrections must be submitted [insert where] 
    Receipt of the corrections will be documented.[insert how receipt will be documented].  
  ➢ Practitioners will be notified of the right to correct erroneous information by [insert method of notification].  
• “X” department will provide information of the status of the credentialing or recredentialing application within “X” days of request. “X” Provider Organization may share [insert] with the practitioner.
• Notification to the practitioner of these rights will be provided via: [insert how practitioner is notified (may be one or more of the following)]  
  ➢ Applications;  
  ➢ Contracts;  
  ➢ Provider Manuals;  
  ➢ Other information distributed to practitioners;  
  ➢ Web sites;  
  ➢ Letter to practitioners

Reference Sources:  
NCQA CR 1.B 1-3

Attachments:  
None
Purpose:
This policy ensures that all practitioners’ offices meet its office-site standards of physical accessibility, appearance of the office sites and adequacy of waiting and adequacy of the waiting and examination rooms where care is delivered.

Policy:
It is the policy of “X” Provider Organization will establish thresholds, criteria for office site, medical record keeping practices and develop a mechanism to monitor office site’s compliance to the standard and implement a corrective action to correct identified deficiencies.

Responsibility: Department or position responsible

Procedures:
• “X” Provider Organization will assess for sites that meet “X” threshold for grievance/complaints taking into consideration the severity of the issue. Site visits are required for complaints related to:
  ➢ Physical Accessibility (handicapped accessible and ease of entry into the building or practice site and accessibility of space within the building or practice site)
  ➢ Physical Appearance (cleanliness, lighting and safety)
  ➢ Adequacy of waiting and examining room space (address appropriate size and seating for waiting room space)
  ➢ Adequacy of treatment record keeping (record orderliness, security, confidentiality and documentation practices).

• “X” Provider Organization implements appropriate interventions by:
  ➢ Continually monitoring member complaints for all practitioner sites
    - The process for detecting deficiencies includes continual monitoring of member complaints for physical accessibility, physical appearance and adequacy of waiting and examining room space and other data. (e.g., complaint monitoring, practice-specific member surveys, reports from provider relation staff visits and staff audits), taking into consideration the severity of an issue.
    - Member complaints will be tracked against threshold.
  ➢ Conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met for the following:
    - Physical accessibility (e.g., handicapped accessibility), physical appearance (e.g., cleanliness, lighting and safety) and adequacy of waiting and examining room space (e.g., adequate waiting room space, adequate number of examining rooms per practitioner) including established reasonable thresholds, taking into consideration the severity of the issue, for the number of complaints received before conducting an office site visit.
  ➢ Instituting actions to improve offices that do not meet thresholds.
    - There is a stated process for developing and ensuring implementation of corrective action plan (CAP) to improve offices that did not meet the established threshold, including practitioner education.
- Evaluating the effectiveness of the actions at least every six months, until deficient offices meet the thresholds.
  - There is a stated process for evaluating the effectiveness of the action plan at least every six months, until the offices meet the threshold and if a deficiency is found during the site visit, a follow-up visit must occur within 6 months.
- Documenting follow up visits for offices that had subsequent deficiencies.
  - “X” Provider Organization conducts a follow-up visit of a previously deficient office if the practice site meets the reasonable complaint threshold subsequent to correcting the deficiencies.
  - “X” Provider Organization conducts a follow up visit of a previously deficient office if the site meets the complaint threshold subsequent to correcting the deficiencies.
  - “X” Provider Organization conducts follow up visits within 60 calendar days of the reasonable complaint threshold being met for a new complaint.

- Grievances/complaints and other data will be continually monitored for all practitioner office sites.
- “X” Provider Organization Office Site tool will be utilized for the audit.
- Site visit results will be reported to the Quality Management or Credentialing Committee.
- Complaints will be forwarded to applicable health plan.
- All site assessments will be documented in a spreadsheet or log, including follow up visits for offices that had subsequent deficiencies.

References:
NCQA CR 5.A.1-4; NCQA CR 5.B.1-5; 42 CFR § 422.204(b)(2)(i);

Attachment:
ICE Complaint Threshold
ICE Office Site Complaint Tool
ICE Health Plan Complaint Threshold Table

The shared ICE Health Plan complaint threshold table details each of the Health Plan’s thresholds and what each Health Plan’s delegation is for CR6.

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Site Visit Delegation</th>
<th>Threshold Determination</th>
<th># of Complaint meeting Health Plan Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Health of California Inc.</td>
<td>Yes</td>
<td>Health Plan</td>
<td>1</td>
</tr>
<tr>
<td>Alameda Alliance for Health</td>
<td>No</td>
<td>Health Plan</td>
<td>2</td>
</tr>
<tr>
<td>Anthem Blue Cross</td>
<td>Yes</td>
<td>Health Plan</td>
<td>3</td>
</tr>
<tr>
<td>Blue Shield of California</td>
<td>No</td>
<td>Health Plan</td>
<td>3</td>
</tr>
<tr>
<td>Care1st Health Plan</td>
<td>No</td>
<td>Health Plan</td>
<td>1</td>
</tr>
<tr>
<td>Cigna Healthcare of California/Great West</td>
<td>No</td>
<td>Health Plan</td>
<td>1</td>
</tr>
<tr>
<td>Community Health Group</td>
<td>No</td>
<td>Health Plan</td>
<td>3</td>
</tr>
<tr>
<td>Health Net of California, Inc.</td>
<td>No</td>
<td>Health Plan</td>
<td>3</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan, Inc</td>
<td>Yes</td>
<td>Health Plan</td>
<td>1</td>
</tr>
<tr>
<td>Molina Healthcare of California</td>
<td>No</td>
<td>Health Plan</td>
<td>1</td>
</tr>
<tr>
<td>UnitedHealthCare of California</td>
<td>Yes</td>
<td>PO</td>
<td>N/A</td>
</tr>
<tr>
<td>Western Health Advantage</td>
<td>Yes</td>
<td>Health Plan</td>
<td>3</td>
</tr>
</tbody>
</table>

ICE Health Plan Complaint Table - revised 5/19/12

This table is in the SA Training Tool. This may be downloaded from ICE website Library under “Approved Documents” in the “Credentialing Shared Audit Policy Team” folder under the “Tools” folder of the 2014 Shared Audit Training Tool 11/24/2014) at http://www.iceforhealth.com/library.asp?sf=&scid=1354#scid1354
### Office Site Complaint Tool
(Year)

<table>
<thead>
<tr>
<th>Office Site Address</th>
<th>Practitioner Name</th>
<th>Contracted Health Plan</th>
<th>Date of Complaint</th>
<th>Type of Complaint</th>
<th>Met Threshold (Y/N)</th>
<th>Date Site Visit Completed</th>
<th>Completed w/in 60 calendar days (Y/N)</th>
<th>Site Findings</th>
<th>Corrective Action Plan</th>
<th>Follow-Up</th>
<th>Date CAP Sent</th>
<th>Date CAP completed</th>
<th>F/U Required (None/3mos/6mos)</th>
<th>F/U Date</th>
<th>F/U Site Findings</th>
<th>Pass Fail (P/F)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Purpose:
This policy ensures that "X" Provider Organization will monitor all contracted practitioners on an ongoing basis to assess occurrences of sanctions, complaints and quality issues.

Policy:
This policy will describe the mechanism to assess whether participating practitioners have sanctions, complaints and quality issues between recredentialing cycles and takes appropriate actions against practitioners when it identifies occurrence of poor quality.

Responsibility: Department or Position responsible

Procedure:
- "X" Provider Organization will verify for Medicare and Medicaid sanctions using the following sources: [insert the source the Provider Organization utilizes]
  - NPDB will be run at least monthly on each practitioner.
  - Continuous Query (Proactive Disclosure Service of the National Practitioner Data Bank).
    Continuous query enrollment evidence and evidence of review within 30 calendar days of its release will need to be documented in the file or on the checklist. Monthly documentation can be kept electronically or via a paper log/spreadsheet.
  - FSMB will be run at least monthly on each practitioner.
  - OIG Reports will be run monthly.

- "X" Provider Organization will collect and review Medicare and Medicaid sanctions within 30 calendar days of its release.

- "X" Provider Organization will collect, monitor and review Medi-Cal sanction information using the Medi-Cal Suspended and Ineligible Provider Reports within 30 calendar days of release.

- "X" Provider Organization will collect and review sanctions or limitations on licensure within 30 calendar days of its release using one of the following: [insert the source the Provider Organization utilizes] 
  - Appropriate state licensing agencies:
    - MBC “The Hot Sheet-Monthly Disciplinary Summary” (As a subscriber, reports will be sent daily). FSMB will be run at least monthly on each practitioner.
    - Board of Acupuncture must be run monthly.
    - Board of Behavioral Sciences (MFT, LCSW) – (As a subscriber, updates will be sent quarterly)
    - Board of Chiropractic Examiners – must be run monthly.
    - Board of Occupational Therapy must be run quarterly.
    - Board of Optometry it must be run monthly.
    - Board of Physical Therapy must be run monthly.
    - Board of Occupational Therapy must be run monthly.
    - Board of Podiatric Medicine must be run monthly.
    - Board of Psychology must be run monthly.
    - Board of Registered Nursing must be run monthly.
- Board of Speech Therapy must be run quarterly.
- Dental Board of California must be run monthly.
- Osteopathic Medical Board of California must be run quarterly.
- Physician Assistant Committee must be run monthly.
- Continuous Query
- FSMB

- "X" Provider Organization will query sanction information at least every six months, if applicable, if reporting entities do not publish sanction information on a set schedule.
- "X" Provider Organization will query practitioners individually for reporting entities who do not release sanction information 12-18 months after the practitioner’s last credentialing cycle.
- "X" Provider Organization will [insert description of how grievance/complaints from members are received/collection and reviewed at least every 6 months]
- "X" Provider Organization will [insert description of how adverse events are monitored every six months.]
- "X" Provider Organization will [insert description of how the process for determining appropriate interventions if poor quality is identified.]

Reference Sources:
NCQA CR 6.A.1-5; 42 CFR § 422.204(b)(4); Medicare Managed Care Manual, Chapter 6, § 60.2, 60.3

Attachments:
- Office of the Inspector General (OIG) Report Instructions
- Medi-Cal Suspended Ineligible List Instructions
- Ongoing Monitoring Web sites - This table may be downloaded from ICE Web site library under “Approved Documents” in the “Credentialing Shared Audit Policy Team” folder at http://www.iceforhealth.com/library.asp?sf=&scid=1354#scid1354
Colorado Boards
Department of Regulatory Agencies (DORA)
Monthly Disciplinary Reports Tutorial

1) Go to DORA located at [http://cdn.colorado.gov/cs/Satellite/DORA-Reg/CBON/DORA/1251627010303](http://cdn.colorado.gov/cs/Satellite/DORA-Reg/CBON/DORA/1251627010303) and find the board (alpha order) for the monthly disciplinary reports. The following 1-6 steps will be the example for the Medical Board’s monthly disciplinary report.

Note: Medical Doctors (MD), Doctors of Osteopathy (DO), Physicians Assistants (PA) and Anesthesiology Assistants (AA) are located within the Medical Board of Colorado.

2) Once the board is chosen, go to the (L) side of page and click on “Disciplinary Actions”.

3) Go to Monthly Board Actions, Board Action Summary & Outcomes and Immediate Board Actions. All of these options allow a report to be downloaded, reviewed and printed. If not printed, the file must be saved to the desktop or to a designated drive/folder. Initial/date each report as proof that it has been checked against the Provider Organization’s existing network.
4) Some boards do not update information on a set schedule; therefore, monthly reports will not appear on the board website. If this is the case, individual queries or printing the “Live” report will be necessary.

5) For individual provider queries: Go to https://www.colorado.gov/dora/licensing/Lookup/LicenseLookup.aspx and click “Lookup a Colorado License”. Enter all pertinent information (i.e., license number, first and last name) into the fields provided, click on “Search” and print results for verification purposes. Initial and date the reports as proof that it has been checked against the Provider Organization’s existing network.

6) For “Live” (Updated every day) Report: Go to
https://www.colorado.gov/dora/licensing/Lookup/LicenseLookup.aspx
Go to (L) side of Online Services and click on “Generate List of Licensed Professionals/Entities”.

![Screenshot of the Colorado Licensing Lookup website](image)
7) Click on applicable profession. For this tutorial we are reviewing for Chiropractors. Check the box for “CHR-Chiropractic-Active” and download the excel spreadsheet by clicking on “Continue” at the bottom of the page.

8) Click on “Download” for the Chiropractic list

9) Once the spreadsheet is downloaded, go to column U (License Status Description) and filter out the selections

10) To filter, go to “Home” at top of excel spreadsheet, go to “Sort Filter and click on “Filter”. Review for any licenses that are active with conditions in column U.
11) Go back to step 7 and choose each selection (Expired, Inactive, Revoked, Summary Suspension, Surrendered, and Suspension) as applicable and review/print out reports as necessary.

12) File all reports into a binder or into computer file folders. Type the month of the report in the header and initial/date each report.
Novitas

Novitas is the official site for Medicare providers to verify Medicare Opt-Out in the state of Colorado. Click on the link below to access the site:

Medi-Cal Suspended Ineligible List Instructions

Go to www.medi-cal.ca.gov to obtain Medi-Cal Suspended Ineligible List


1) Click on "Publications" tab
2) Click on “Provider Bulletins”

3) Click on “Part 1 – Medi-Cal Program and Eligibility”
1) **Go to #6 Medi-Cal Suspended and Ineligible Provider List: (Month) Update**

This Bulletin page shows which list was updated and links directly to that list. This is now in Excel format.

6. Medi-Cal Suspended and Ineligible Provider List is Updated

The monthly updated Medi-Cal Suspended and Ineligible Provider List (S&I List) is available on the [Suspended and Ineligible Provider List](#) page of the Medi-Cal website.

Always refer to the S&I List when verifying ineligibility. Eligibility or ineligibility must also be verified through the Health and Human Services (HHS) Federal Office of Inspector General (OIG) [List of Excluded Individuals/Entities](#).

**Suspension of Entities Submitting Claims for Suspended Providers**

Entities submitting claims for services rendered by a health care provider suspended from Medi-Cal or excluded from Medicare or Medicaid by the OIG are subject to Medi-Cal suspension.

We refer to the [Medi-Cal law](#), Welfare and Institutions Code (WIC Code), section 14043.61, subdivision (a), in relevant part, that a provider shall be subject to suspension if claims for payment are submitted under any provider number used by the provider to obtain reimbursement from Medi-Cal for the services, goods, supplies or merchandise provided, directly or indirectly, to Medicare recipients for an individual or entity that is suspended, excluded, or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from Medi-Cal and the individual or entity is listed on either the Medi-Cal Suspended and Ineligible Provider List or any list published by the federal Office of Inspector General regarding the suspension or exclusion of individuals or entities from the Federal Medicare and Medicaid programs, to identify suspended, excluded, or otherwise ineligible providers.

2) **Print or save this page which contains the report’s updated date.**

3) **Open and save the updated excel into your designated file folder.**
4) Bottom of Suspended List page does not provide a run date. Go to step 5 to print page with run date. Initial and date the printed pages.
Scenario 2: Alternate tab to retrieve Excel.

1) Click on “Reference” tab

2) Link to Suspended & Ineligible Provider List (3rd from bottom)
Suspended and Ineligible Provider List

Medi-Cal, Welfare and Institutions Code (W&I Code), sections 14143.6 and 14123, mandate that the Department of Health Care Services (DHCS) suspend a Medi-Cal provider of health care services (provider) from participation in the Medi-Cal program when the individual or entity has:
- Been convicted of a felony;
- Been convicted of a misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service;
- Been suspended from the federal Medicare or Medicaid programs for any reason;
- Lost or surrendered a license, certificate, or approval to provide health care, or
- Breached a contractual agreement with the Department that explicitly specifies inclusion on this list as a consequence of the breach.

Suspension of Entities Submitting Claims for Suspended Providers
Suspension is automatic when any of the above events occurs, and suspended Medi-Cal providers will not be entitled to a hearing under the California Administrative Procedures Act.

Services rendered, prescribed or ordered by a suspended Medi-Cal provider shall not be covered by the Medi-Cal program while the suspension is in effect. California Code of Regulations, title 22, section 51939, subdivision (a), provides that at least fifteen (15) days written notice be given to all affected providers. This list constitutes such written notice. Although the period of suspension may have expired, reinstatement rights are not automatic. The provider must petition for reinstatement and re-enroll with DHCS before being reimbursed for services rendered. Providers suspended as a result of a Medicare action must appeal through the Medicare office before applying for re-enrollment with Medi-Cal.

In accordance with W&I Code, section 14143.61, subdivision (a), a provider of health care services shall be subject to suspension if claims for payment are submitted under any provider number used by the provider to obtain reimbursement from the Medi-Cal program for the services, goods, supplies or merchandise provided, directly or indirectly to a Medi-Cal beneficiary, by an individual or entity that is suspended, excluded, or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from the Medi-Cal program and the individual or entity is listed on the S&L list. The S&L list is published by DHCS to identify suspended and otherwise ineligible providers, or any list published by the federal Office of Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and Medicaid programs, to identify suspended, excluded or otherwise ineligible providers.

Examples of providers who need to be aware of the provisions of this law, and could be suspended if violating the law are:

1. Billing services that submit claims for Medi-Cal providers who are suspended
2. Pharmacists that fill prescriptions and bill for services prescribed by a suspended provider
3. Providers who bill for services under referral or prescription of a provider who is suspended
4. Providers who employ and submit claims for the services of an individual who is a suspended provider
5. Physician groups, clinics and institutions that employ and submit claims for the services of an individual who is a suspended provider
6. Any individuals or entities that enter into a business arrangement and submit claims for or in conjunction with an individual or entity that is suspended.

Always refer to the S&L list when verifying eligibility. Eligibility or ineligibility must also be verified through the Health and Human Services (HHS) Federal Office of Inspector General (OIG) List of Excluded Individuals/Entities. Cross-referencing both lists is recommended to help identify providers who have already been suspended or sanctioned. The S&L list is not all inclusive. Temporary sanctions against providers are not included on the web site. Temporary sanctions that may be imposed include temporary suspensions, withhold of payments and deactivation.

Download the S&L list
The S&L list is updated monthly and can be downloaded by clicking on the link below. Providers who do not have access to Excel may download an Excel viewer from the Web Tool box page.

- Medi-Cal Suspended and Ineligible Provider List (Excel format) Updated 3/2015

1) Print or save this page which contains the report’s updated date.

2) Save or Open and print Excel report. Initial/date report.
Medi-Cal Suspended and Ineligible Lists

Medi-Cal law (**Welfare and Institutions Code**, § 14123) mandates that the Department of Health Care Services (DHCS) suspends a Medi-Cal provider when he/she has been (a) convicted of a crime involving fraud or abuse of the Medi-Cal program, or (b) suspended from the federal Medicare program for any reason.

Suspension is automatic when either of the above events occurs, and suspended Medi-Cal providers will not be entitled to a hearing under the **California Administrative Procedures Act**.

Services rendered, prescribed or ordered by a suspended Medi-Cal provider shall not be covered by the Medi-Cal program while the suspension is in effect. **California Code of Regulations**, Title 22 § 51303(j), provides that at least fifteen (15) days written notice be given to all affected providers. This list constitutes such written notice. Although the period of suspension may have expired, reinstatement rights are not automatic. The provider must re-enroll with DHCS before being reimbursed for services rendered. Providers suspended as a result of a Medicare action must appeal through the Medicare office before applying for re-enrollment with Medi-Cal.

In accordance with **Welfare and Institutions Code**, § 14043.61, a provider shall be subject to suspension if claims for payment are submitted under any provider number used by the provider to obtain reimbursement from the Medi-Cal program for the services, goods, supplies or merchandise provided, directly or indirectly to a Medi-Cal beneficiary, by an individual or entity that is suspended, excluded or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from the Medi-Cal program and the individual or entity is listed on either the Suspended and Ineligible List published by DHCS to identify suspended and otherwise ineligible providers, or any list published by the federal Office of Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and Medicaid programs, to identify suspended, excluded or otherwise ineligible providers.

Examples of providers who need to be aware of the provisions of this law, and could be suspended if violating the law are:

1) Billing services that submit claims for Medi-Cal providers who are suspended;
2) Pharmacies that fill prescriptions and bill for services prescribed by a suspended provider;
3) Providers who bill for services under referral or prescription of a suspended provider;
4) Providers who employ and submit claims for the services of an individual who is a suspended provider;
5) Physician groups, clinics and institutions that employ and submit claims for the services of an individual who is a suspended provider;
6) Any individuals or entities that enter into a business arrangement and submit claims for or in conjunction with an individual or entity that is suspended.

The following Web sites can be utilized to check to see if an individual or entity is suspended. The **Medi-Cal Suspended and Ineligible Provider List** (S & I List) is not all inclusive. Temporary sanctions against providers are not included on the Web sites. Temporary sanctions that may be imposed include temporary suspensions, withhold of payments and deactivation.
The S&I List is updated monthly and is available on the Internet at www.medi-cal.ca.gov by clicking the “References” tab, then the “Suspended & Ineligible List” link. Providers may view or download the S&I List in Microsoft Excel format. The Office of Inspector General Excluded Provider List is also available at http://oig.hhs.gov. Cross-referencing both lists is recommended to help identify providers who have already been suspended or sanctioned.
Ongoing Monitoring

Ongoing Monitoring Websites and Information can be downloaded from ICE at the following link:
http://www.iceforhealth.org/library.asp?sf=&scid=1354#scid1354
Purpose:
This policy ensures that “X” Provider Organization will report adverse actions to the appropriate authorities and comply with all reporting requirements.

Policy:
- “X” Provider Organization’s disciplinary reporting will be implemented according to regulatory requirements.
- Provider will receive written notification of the appeal rights and process
- “X” Provider Organization will appoint a hearing officer or a panel of individuals to review the practitioner appeal.
  - The majority of the panel members will be peers of the affected practitioner
- “X” Provider Organization cannot have attorney representation if the practitioner does not have attorney representation.
  - Attorney representation is not at the discretion of the Provider Organization chairperson
- The appeal process will be available to the practitioner.

Responsibility: Department or position responsible

Procedure:
- “X” Provider Organization has a range of actions available to the practitioners to evaluate and improve practitioner performance who do not meet the quality standards before termination. **[Insert description of range of actions]**
- “X” Provider Organization’s suspensions, terminations, restrictions and revocation will be reported to the state licensing agencies, Medical Board and NPDB
  - 805 and 805.01 reports must be completed and sent to the Medical Board within 15 calendar days after a recommendation or final decision.
  - 805 reporting will be reported for the following reasons:
    - Medical Disciplinary cause or reason (Denial/rejection of application for staff privileges or membership, Termination/revocation of staff privileges, membership or employment. Restriction on staff privileges, membership or employment. Resignation and Suspension
  - 805.01 reporting will be reported for the following reasons:
    - Incompetence, gross or repeated deviation from the standard of care involving death or serious bodily injury that is dangerous or injurious to any person
    - Using or prescribing for self, or self administration of any controlled substance, dangerous drug (as specified in law), or alcoholic beverages, that dangerous or injurious to the practitioner, any other person public, or that the practitioner’s ability to practice safely is impaired by that use
    - Repeated acts of clearly excessive prescribing, furnishing, administering of controlled substances, repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason for prescribing (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing).
 Sexual misconduct with one or more patients during a course of treatment or an examination.
 “X” Provider Organization will report to NPDB within 30 calendar days.

- Staff of [insert department responsible] will be responsible for reporting to the appropriate authorities within the appropriate time frame.
- “X” Provider Organization will provide written notification of the appeal process to the practitioner which will include the following:
   Specific reason(s) for the decision
   Description of professional review action
   Reason(s) for the action
   Summary of the practitioner’s appeal rights
   Summary of the practitioner’s appeal process
   Statement that the practitioner is allowed to request a hearing
   Specific time period for submitting the request
   Statement that at least 30 calendar days is allowed after the written notification for the practitioner to request a hearing
   Statement that the practitioner may be represented by an attorney or a designee
- “X” Provider Organization will appoint a hearing officer or a panel of individuals to review the appeal.
- “X” Provider Organization will not have attorney representation if the practitioner does not have attorney representation.
- Attorney representation is not at the discretion of the chairperson
- The appeal process will be available to the practitioner by [insert method of availability, e.g., policy, contract, manual or attachment]

Reference Sources:
NCQA CR7.A-C; 42 CFR § 422.202(a)(1-4); § 422.202(d)(1)(i-ii), 422.202(d)(2), 422.202(d)(3); 42 CFR § 422.204(a)(2)(i), 45 CFR 60.3, 60.5; CA Business & Professions Code § 805, CA Business & Professions Code § 805.01, CA Business & Professions Code § 809.3(c); Medicare Managed Care Manual, Chapter 6, § 60.4

Attachments:
Medical Board of California 805.01 Law Requirement
Health Facility/Peer Review Reporting Form (Required by § 805 of the California Business & Professions Code)
Health Facility/Peer Review Reporting Form (Required by § 805.01 of the California Business & Professions Code)
Medical Board of California
805.01 Requirement

The Medical Board of California has a new requirement effective 1/11/11 that in addition to the 805, the 805.01 form will need to be filed when a final decision or recommendation has been made by the peer review board. The 805.01 will need to be filed for the following 4 reasons.

1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public;
2. The use of, or prescribing for or administering to himself or herself of any controlled substance, any dangerous drug (as specified), or alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that the licentiate’s ability to practice safely is impaired by that use;
3. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason therefore (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing, and if a report is made, the licensing board must promptly review any such report to ensure these standards are properly applied); and
4. Sexual misconduct with one or more patients during a course of treatment or an examination.

These 4 reasons do not have to go to hearing before the 805.01 form is filled out. The proposed action must be given to the practitioner within 15 days after the peer review body makes the recommendation or final decision.

Please go to http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=00001-01000&file=800-809.9 for more information.
The Health Facility/Peer Review Reporting form can be downloaded at http://www.mbc.ca.gov/Search.aspx?q=health+facility%2Fpeer+review+reporting+form&cx=001779225245372747843%3Avk6dwkmmcq&cof=FORID%3A10&ie=UTF-8
Purpose:
“X” Provider Organization will establish standards for the assessment of Organizational Providers (OPs).

Policy:
“X” Provider Organization’s OPs will be in good standing with state and federal bodies.

“X” Provider Organization’s OPs will be accredited by an approved agency, meet CMS requirements or be evaluated by site review.

Responsibility: Department or position responsible

Procedure
• “X” Provider Organization will assess OPs by completing the following before the contract begins and at least every 3 years:
  ➢ Confirm that the provider is in good standing with state and federal regulatory bodies:
    ➢ California State Business Licensure (includes license number and expiration date)
    ➢ Medicare/Medicaid Certification number
    ➢ OIG report
  ➢ Confirm that the provider has been reviewed and approved by an accrediting body
    ➢ [Insert the following only if Provider Organization only contracts with accredited facilities]: “X” Provider Organization only contracts with accredited facilities and does not contract with unaccredited facilities
  ➢ Confirm accreditation with the following Medical Care Providers: [insert only the types contracted with or may state all types as applicable] [insert the source utilized for each type]
  ➢ Confirm accreditation with the following Behavioral Healthcare Providers: [insert only the types contracted with] [insert the source utilized for each type]
  ➢ Confirm accreditation with the following Medicare Providers and will be reviewed within 180 calendar days: [insert only the types contracted with or may state all types as applicable] [insert the source utilized for each type]
  ➢ In order to determine good standing, the following sources with be verified [insert verification sources here]

• “X” Provider Organization will provide evidence of CMS/DHCS review or “X” Provider Organization will conduct an on-site quality assessment of contracted HDOs if not accredited at least every 3 years

• If free standing surgical center is not accredited by an agency accepted by State of California, “X” Provider Organization will obtain documentation to ensure surgical center is certified to participate in the Medicare program. [Insert type of acceptable documentation]
References:
NCQA CR 8A.1-3; NCQA CR 8.B.1-4; NCQA CR 8.C.1-3; NCQA CR 8.D; NCQA CR 8.E; 42 CFR § 422.204(b)(1); § 422.204(b)(1)(i)(ii); § 422.204(b)(2)(ii); § 416.26; California Health & Safety Code § 1248.1(a); Medicare Managed Care Manual, Chapter 6 § 70]

Attachment:
- Organizational Provider Worksheet - This table may be downloaded from ICE Web site library under "Approved Documents" in the "Credentialing Shared Audit Policy Team" folder at http://www.iceforhealth.com/library.asp?sf=&scid=1354#scid1354
ICE Share Audit Organizational Provider Worksheet

The ICE Shared Audit Organizational Provider Worksheet can be downloaded from the following site:
http://www.iceforhealth.org/library.asp?sf=&scid=1354#scid1354
Purpose:
“X” Provider Organization is accountable for identifying practitioners who qualify as HIV/AIDS specialists to whom appropriate members may be given a standing or extended referral when the member’s condition requires the specialist’s medical care.

Policy:
- “X” Provider Organization will identify or reconfirm the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist by sending out the annual practitioner screening letter every 12 months.
  - The definition of a HIV/AIDS Specialist is a physician who holds a valid, unrevoked and unsuspended license to practice medicine in the state of California and meets any one of the following criteria:
    - Is credentialed as a “HIV Specialist” by the American Academy of HIV Medicine.
    - Is board certified in HIV medicine, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties.
    - Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications: (A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and (B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to anti-retroviral therapy per year.
    - Meets the following qualifications: (A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and (B) Has completed any of the following:
      - In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases or 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients.
      - In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Responsibility: Department or position responsible

Procedure:
- “X” Provider Organization will identify or reconfirm the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist according to California State regulations within 12 months of previous annual screening.
“X” Provider Organization will screen only the practitioners that potentially may qualify and choose to be listed as HIV/AIDS specialists (e.g., PCPs, Internist Specialists, Pulmonologists and/or Infectious Disease physicians).

List of appropriately qualified HIV practitioners will be communicated to the appropriate department (e.g., UM or Case Management) responsible for authorizing standing referrals within 12 months of the previous annual screening.

Reference Sources:
28 CCR § 1300.67.60, 1300.74.16; California Health & Safety Code § 1374.16

Attachments:
Instructions on Conducting Annual Screening for HIV/AIDS specialists
Practitioner Letter
Suggested Instructions on Conducting Annual Screening for HIV/AIDS Specialists

1. Modify the attached Practitioner Letter with Provider Organization information.
2. Identify HMO practitioners on the Provider Organization roster that possibly qualify as HIV/AIDS specialists.
3. Identify HMO practitioners as they are initially credentialed that possibly qualify as HIV/AIDS specialists.
4. Fax the Practitioner Letter to all identified HMO practitioners when initially credentialed and every 12 months thereafter.
5. Follow-up with HMO practitioners to ensure all Practitioner letters are completed with either a “yes” or a “no” answer and returned to the Provider Organization.
Practitioner Letter

Date

Provider Name
Address
City, State Zip

Dear Dr. Provider Last Name,

Below please find the “X” Provider Organization HIV Provider Application Form. The Law requires (28 CCR § 1300.74.16; California Health & Safety Code § 1374.16) that Managed Care Organizations provide HIV infected patients with access to physicians with demonstrated expertise in treating HIV or AIDS. In order to comply with California state law, we are updating our list of qualified specialists.

If you qualify as a HIV specialist, please review the qualifications below and check the appropriate box. This information will be used for internal and external referral procedures.

Selection Criteria: HIV Experts meet one or more of the following criteria:

☐ No, I do not wish to be designated as a HIV/AIDS specialist.
☐ Yes, I do wish to be designated as a HIV/AIDS specialist based on the criteria below:
☐ I am credentialed as an “HIV Specialist” by the American Academy of HIV Medicine.

OR

☐ I am board certified in HIV medicine or have earned a Certificate of Added Qualification in the field of HIV medicine granted by a member board of the American Board of Medical Specialties;

OR

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; AND

2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; AND

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of infectious disease from a member board of the American Board of Medical Specialties;

OR

2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients;

OR

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

OR

I attest that I fulfill the criterion above and wish to be designated as a HIV/AIDS specialist within the “X” Provider Organization. The above information can be supported by documentation (if required).

Name (Print) _________________________________________ License# ___________________
Signature __________________________________________ Date ___________________________
Telephone __________________________________________
Name and Title of Person Submitting Form ________________________________

Return Application to:
“X” Provider Organization
Department
Address

Thank you,

Name
“X” Provider Organization
Title, Department
Sample Policies and Procedures
and
Informational Attachments - Medicare
**Purpose:**
To ensure recredentialing information includes quality of care information, including performance indicators, such as those collected through the QI Program.

**Policy:**
"X" Provider Organization considers ongoing performance indicators such as those collected through the Quality Improvement Program, the utilization management system, the grievance system, member satisfaction surveys, and other activities of "X" Provider Organization prior to recredentialing.

**Responsibility:** Department or position responsible

**Procedure:**
- "X" Provider Organization monitors the following quality activities and performance indicators when considering a practitioner for recredentialing:
  - Utilization Management Systems
  - Member Satisfaction Surveys
  - Medical documentation and record keeping audits
  - Access studies
  - Adverse events
- "X" Provider Organization monitors ongoing member grievances and complaints when considering a practitioner for recredentialing.

**Reference Sources:**
42 CFR § 422.204(b)(2)(ii); Medicare Managed Care Manual, Chapter 6, § 60.3

**Attachments:**
None
Purpose:
To ensure "X" Provider Organization’s Medicare members are seen by appropriately qualified practitioners who are able to receive Medicare funds.

Policy:
"X" Provider Organization prohibits employment or contracting with practitioners (or entities that employ or contract with such practitioners) who "opt-out" of Medicare.

Responsibility: Department or position responsible

Procedure:
• Prior to initial credentialing and recredentialing, the most recently issued “Complete Listing of Northern California Opt-Out Physicians” and the “Complete Listing of Southern California Opt-Out Physicians” report is run from the following Web site:
  https://med.noridianmedicare.com/web/jeb/enrollment/opt-out/opt-out-listing

  ➢ Documentation will be maintained of all reviewed information (e.g., hardcopy or electronic).
    ▪ If a checklist is used to verify review of the Opt-Out report, then the following elements are required:
      - Staff initials/signature
      - Run date
      - Indication of whether or not the practitioner(s) is/are listed on the report.
      - Review date
    ▪ Alternately, a copy of the page where the practitioner’s name would have been listed may be printed for the file. Report date/run date and staff initials/signature must be present.

• Verification is obtained quarterly and prior to initial credentialing and recredentialing.
  Verification is reviewed within 30 calendar days of its release.

Reference Sources:
42 CFR § 422.204(b)(4), § 422.220; Medicare Managed Care Manual, Chapter 6, § 60.2

Attachments:
None
Purpose:
To ensure that no employed practitioners are excluded or sanctions from participation under Medicare

Policy:
“X” Provider Organization will not employ or contract with practitioners (or entities that employ or contact with such practitioners) that are excluded/sanctioned from participation under Medicare.

Responsibility: Department or position responsible

Procedure:
• “X” Provider Organization will query the Medicare status by using one of the following:[insert the method the Provider Organization utilizes]
  ➢ FSMB (if using this source, OIG must be queried)
  ➢ NPDB - HIPDB (if using this source, OIG must be queried)
  ➢ FEHB (if using this source, OIG must be queried)
  ➢ Medicare and Medicaid Sanctions and Reinstatement Report (if using this source, OIG must be queried)
  ➢ Entry into AMA Physician Master File (if using this source, OIG must be queried)
  ➢ State Medicare agency or intermediary and Medicare intermediary (if using this source, OIG must be queried)
  ➢ Continuous Query (PDS)

Reference Sources:
42 CFR § 422.204(b)(4), § 422.752(a)(8); Medicare Managed Care Manual, Chapter 6§ 60.2

Attachments:
None