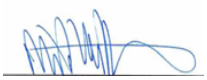
HERITAGE PROVIDER NETWORK
&
AFFILIATED MEDICAL GROUPS

Credentialing Plan

2025

(Updated 02/18/25)

Approval Signature:



03/10/2025

Committee Chair

Date

Affiliated Medical Groups

Affiliated Doctors of Orange County

Bakersfield Family Medical Center

Coastal Communities Physician Network

Desert Oasis Health Care

Greater Covina Medical Group

High Desert Medical Group

Heritage Victor Valley Medical Group

Lakeside Medical Group

Regal Medical Group

Sierra Medical Group

Chapter I Practitioner Credentialing

1 Purpose

Heritage Provider Network, Inc. (referred to herein as "HPN") has developed and implemented a comprehensive Credentialing Plan for the purpose of selecting and evaluating licensed independent practitioners or groups of practitioners in a nondiscriminatory manner, who provide services within its delivery system. The Credentialing Plan has been formulated to meet the requirements of contracted Health Plans, National Committee for Quality Assurance (NCQA) DHCS, DMHC, Medicare, Medi-Cal and other Federal and State regulations. Credentialing plan criteria is reviewed and approved annually by the HPN Quality Improvement Committee as well as the credentialing committee at each MG/IPA.

2 Scope of Authorization and Action

Licensed practitioners who treat members in the inpatient and/or outpatient setting are covered under the Credentialing Plan. This includes:

- employed practitioners
- independent practitioners or groups of practitioners
- contracted licensed hospitalists

Independent practitioners or groups of practitioners include any allied health practitioner or behavioral health care specialist who is licensed, certified, or registered by the State to practice independently (See Attachment A).

Doctors of Dental Surgery are required to be credentialed only if they provide care under the managed care organization's medical benefits.

Practitioners Not Covered Under Credentialing Plan

A. Practitioners who practice exclusively within the inpatient hospital setting and have no independent relationship with HPN is not subject to the Credentialing Plan, specifically:

   - Radiologists,
   - Anesthesiologists,
   - Emergency room physicians,
   - Pathologists,

   - Telemedicine consultants

B. Practitioners who practice in freestanding facilities, such as, mammography centers, urgent care centers, surgical centers, and ambulatory behavioral health care facilities.
   However, if these practitioners provide care in addition to the care provided in the inpatient setting or emergency room, they are subject to the Credentialing Plan.

2.1 Physician Extenders

Licensed independent practitioners who fall within the scope of Physician Extenders include Physician Assistants (PA), Nurse Practitioners (NP) and certified Nurse Midwives (CNM). Physician Extenders are required to properly identify themselves to patients as non-physician practitioners.

State licensing authorities have developed specific guidelines and standardized procedures for Physician Extenders. The Medical Director designates a Supervising Physician to provide physician collaboration/supervision of the Physician Extender that is consistent with the Physician Extender's scope of practice. Supervising physicians have continuing responsibility for all medical services provided by the Physician Extender under his/her supervision.

<u>The Physician-to-Physician Extender ratio is as follows:</u>
The supervising physician will not supervise more than 4 PAs at one time.
The supervising physician will not supervise more than 4 NPs at one time.
The supervising physician will not supervise more than 3 CNWs at one time.

Nurse Practitioner and Certified Nurse Midwives: Standardized Procedures are no longer required for Nurse Practitioners who meet the requirements of California Business and Professionals Code 2837.103 and 2837.104. (See Attachment C)

Nurse Practitioners that do not meet these requirements will require Standardized Procedures outlining Nurse Practitioner roles, duties, and responsibilities are approved by the Medical Director, Supervising Physician, and Nurse Practitioner. Nurse Practitioners who prescribe drugs and/or devices will be in accordance with standardized procedures or protocols developed by the Nurse Practitioner and supervising physician. A copy of the agreement is kept in the credentialing files of the Supervising Physician and Nurse Practitioner. The supervising physician is not required to be physically present. Availability by telephone is adequate.

Physician Assistant: A Delegation of Services Agreement outlining the authorized services to be performed by the Physician Assistant when acting under the Supervising Physician will be approved by the Supervising Physician and Physician Assistant. A copy of the agreement is kept in the credentialing files of the Supervising Physician and Physician Assistant. At all times, the supervising physician must be physically or electronically available to the PA for consultation, except in emergency situations. In cases of emergency, the physician assistant, to the extent permitted by the laws relating to license or certificate involved, may render emergency services to a patient pending establishment of contact with the physician.

2.2 Shared Credentialed Providers

HPN is accredited by the National Committee for Quality Assurance (NCQA) for Credentialing

and has recognized HPN affiliated medical groups as sister organizations. NCQA allows such entities to share practitioner credentialing with the following understanding (See Attachment B):

- Each medical group has its own credentialing committee.
- The primary medical group fully credentials the practitioner and takes them to committee for approval.
- The secondary medical group is not required to credential practitioners they wish to share but must take shared practitioners to their credentialing committee.
- The secondary group may share the primary groups approval dates for any shared practitioners.
- The secondary group is not required to contract with shared practitioners.

3 Policy

Practitioners who fall within the Scope of Authorization and Action will undergo initial credentialing prior to appointment to the HPN Groups panel. Practitioner credentials will be re-reviewed at the time of recredentialing every three (3) years.

4 Delegation of Decision Making Authority

HPN delegates authority for performing the function of credentialing to Medical Groups in accordance with the mutually agreed upon document for each delegate. The agreement describes the responsibilities of the delegated entity and the activities that are delegated. HPN maintains responsibility for ensuring that the function is being performed according to its expectations, contracted Health Plan delegation agreements, National Committee for Quality Assurance (NCQA) standards, DMHC, DHCS, Medicare, Medi-Cal and other Federal and State regulations by performing an annual delegated oversight audit and reviewing the MG/IPAs submitted reports.

The HPN Credentialing Department reports activities to the HPN Quality Improvement Committee (QIC). The QIC is responsible to:

1. Evaluate the delegated Medical Group's capacity to perform the delegated activities prior to delegation.
2. Evaluate annually whether the delegated activities are being conducted in accordance with HPN expectations, contracted Health Plan delegation agreements, National Committee for Quality Assurance (NCQA) standards, DMHC, DHCS, Medicare, Medi-Cal and other Federal and State regulations.
3. Obtain reports semi-annually from the delegated Medical Group's activities on its progress in conducting credentialing and recredentialing activities and the actions carried out to improve performance.
4. Revoke delegation if the Medical Groups do not fulfill its responsibilities.
5. To identify and follow-up on opportunities for improvement in each of the credentialing processes at least once in each of the past two years.
6. HPN has the right, based on quality issues, to approve, suspend or terminate individual practitioners, providers, and sites in situations where Heritage Provider Network, Inc. has delegated decision-making. Heritage Provider Network, Inc. does not need to review each

individual practitioner credentialed by the Medical Groups.

5 Annual Review

HPN will annually review, revise as necessary, and approve the Credentialing Plan.

6 Practitioners' Rights and Responsibilities

6.1 Right to Review Information

The practitioner has the right to review information obtained by HPN or HPN's affiliated medical groups for the purpose of evaluating the practitioner's credentialing/recredentialing application. This includes information obtained from outside sources, e.g., state licensing boards. The practitioner will not be permitted to review peer references/recommendations, or any other information protected from disclosure by law. The practitioner may schedule an appointment to review such information by sending a written request to the Medical Director.

6.2 Right to Correct Erroneous or Variant Information

The practitioner has the right to correct information that is believed to be erroneous. When information received from a primary source substantially varies from information provided on the practitioner's application, the Credentialing Department will contact the practitioner and request either verbally or in writing to provide an explanation.

Examples of information with substantial variance include reports of a practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges, or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application. Sources will not be revealed if the information received is not intended for verification of credentialing elements or is protected from disclosure by law. Documentation, which may include re-verification from the primary source, will be kept in the credentialing file.

The practitioner will be given a 30-day time period in which to respond to the request for clarification of any discrepancy. The response must be in writing and submitted to the Credentialing Department. The Credentialing Department will provide a receipt of the corrections to the provider. If the response by the practitioner is not received by the Credentialing Department in 30 days, it will be assumed that the practitioner has voluntarily withdrawn his/her application.

6.3 Right to be Informed of Application Status

The practitioner has the right, upon request, to be informed of the status of their credentialing/recredentialing application. The practitioner, upon request, will be notified of the status of their application either verbally or in writing by a Credentialing Department staff member. This update will verify documents received in support of the practitioner's application and pending requests required for the completion of the credentialing process. Specific information/comments made by peer references or other information protected by law will not be discussed with the

practitioner.

6.4 Practitioner's Burden to Produce Information

The practitioner has the burden to produce information for an adequate evaluation of the practitioner's qualifications and suitability for participation, of resolving any reasonable doubts about these matters, and of satisfying requests for information. Failure to produce information could cause delay and/or eventual termination of the application process.

6.5 Notification of Practitioner's Rights

Notification to the practitioner of their right to review information, right to correct erroneous or variant information, right to be informed of application status, and burden to produce information is included as part of the initial and recredentialing applications.

7 Confidentiality

7.1 Confidentiality Statements

All Credentialing staff members and Credentialing Committee members are required to sign a Confidentiality Statement on an annual basis. Health Plan representatives are required to sign a Confidentiality Statement before viewing confidential credentialing or peer review documents.

7.2 Employee Orientation

All new employees will receive orientation training on the confidentiality of provider credentialing information regarding the rules and requirements as it relates to their job function in the Credentialing Department. Human resources will track evidence and acknowledgement of Credentialing training in the employee's personnel file for the length of employment, and for a period of 10 (ten) years following termination of employment. Ongoing education will be provided on an annual basis to the current staff.

7.3 Storage of Credentialing Files

To ensure confidentiality of credentialing file contents, all files are labeled "Confidential" and kept in locked file cabinets inside a locked Credentialing office, if applicable. Access is limited to authorized credentialing staff and after hour access is only permitted when a supervisor is on the premises. Access to the Medical Group/IPA offices is allowed with a FOB or access code.

7.4 Information Systems/Electronic Security

Practitioner data is maintained using confidential information systems. The information system is located in a secure room with limited access during and outside of business hours. Additional security is also provided by the building owners/leases limiting access to the general office space.

Credentialing staff are the only personnel permitted to access, view, and update practitioner information. Other authorized staff may be permitted to view practitioner information only

required for the performance of their job. E-mail communication regarding confidential information is limited and used with caution. Methods to ensure confidentiality of electronic and systems information include, but not limited to, firewall and password protection, including intermittent password changes, assignment of appropriate authorization levels for each user and the withdrawal of passwords when an employee leaves the organization.

The credentialing software has the ability to track when changes are made to credentialing information and to generate historical activity logs to determine who accessed what credentialing files and when and what actions were taken. All information added or changed in the system is backed up nightly and held in the data warehouse. Reports are generated ensuring successful back-up completion.

7.5 Accessing Credentialing Information

Internal: Internal access is permitted to the Medical Director and other Credentialing Committee members for necessary credentialing/ recredentialing purposes. Suspected breach of confidentiality or violations by medical staff members will be reported to the Medical Director which may prompt an investigation and disciplinary action. Suspected violations by an employee will be referred to the Medical Director for review and appropriate action pursuant to Human Resources policies.

External: Upon request to the Credentialing Department, information may be provided to contracted health plans, hospitals and Heritage Provider Network, Inc.'s, Executive Committee and QIC for necessary credentialing/recredentialing purposes. HPN requires authorization from the provider prior to the release of any credentialing information, unless otherwise permitted or required by law.

Practitioner: Upon request to the Medical Director, access is provided to an applicant or participating practitioner who would like to review information submitted in support of their application. This includes information submitted from outside primary sources but does not include information protected from disclosure by law. Reviews will be accomplished in the Credentialing Department during normal business hours, or otherwise under conditions designed to provide reasonable protection of the confidentiality of the records. Requests for copies will be considered on an individual basis.

Health Plan: Health Plan representatives are permitted to view credentialing information and de-identified peer review/disciplinary action activities for the purpose of pre-contractual delegation and oversight of delegated functions. On-site audits by Health Plans may be scheduled at a time and date mutually agreed upon by the Health Plan and HPNs. Copied or faxed credentialing files may be provided to Health Plans for the purpose of an accreditation or state/federal regulatory audit (i.e., NCQA, CMS, DMHC, DHCS). Credentialing files will not be copied or faxed for the purpose of "desktop" or "mock" audits. (?)

7.6 Disposal of Confidential Credential Information

HPN acknowledges an ethical and legal responsibility to protect the privacy of our providers. Consequently, all provider-identifiable information will be protected against indiscriminate and unauthorized access. HPN will use reasonable care to preserve providers' right to privacy within the law. Any provider-identifiable information determined to be appropriate for disposal must be discarded in the manner according to the "Disposal of Protected Information Policy". Inappropriate use of this disposal procedure or willful disregard of this policy is serious offense and will constitute cause for corrective action up to and including termination.

7.7 Data Recovery and Backup of Credentialing Information

HPN has security mechanisms in place for the protection and recovery of data. The backup software captures all files and directories encountered and saved to ensure data is not lost in the event the system is disabled, destroyed, corrupted, or accidentally deleted. Logs are created to track successful and unsuccessful backups and document when and where the media was sent offsite, the rotation of backup media, and note any problems or exceptions. A written log is kept to track successful backups that capture the date, which media was utilized. Legible, unique labels must be placed on all backup media.

Credentialing data is backed up incrementally at the end of each workday and a full system backup must be performed at least once per month. Critical data is backed up weekly, regardless of where it resides and a full backup is stored off-site.

8 Delegated Activities

HPN does not delegate or sub-delegate any activities described in the Credentialing Plan to any Credentialing Verification Organizations.

9 Credentialing Committee

A peer review process is established by designating a Credentialing Committee that includes representation from a range of participating practitioners within the HPN Groups.

9.1 Composition

Medical Director or Designee (Chairperson): The Medical Director or designee is a licensed physician in the state of California and serves as the Credentialing Committee Chairperson and is responsible for the credentialing process. The Chairperson presides over Credentialing Committee meetings and is responsible for evaluating recommendations and initiating credentialing actions in a nondiscriminatory manner with regards to the qualifications and practice patterns of applicants and participating practitioners. The Chairperson has the authority to call an ad hoc committee and reports Credentialing Committee activity to the Quality Improvement Committee and Peer Review Committee, as applicable.

Medical Staff Representation: The Credentialing Committee is multidisciplinary in structure with representation from various types of practitioners and specialties. A minimum of three (3)

physician members is required for a quorum, which is inclusive of the Chairperson and (2) two practicing physicians. Only physicians have voting rights on medical interpretation and peer review activities. Because not every specialty can be represented, at the discretion of the Committee, meaningful advice may be sought from various practitioners and specialties to assist with the decision-making process.

Credentialing Staff Representative: The Credentialing representative is responsible for timely completion of credentialing components, organizing the Credentialing Committee meeting, presentation of credentialing files to the Credentialing Committee for review, and Credentialing Committee meeting minutes.

Quality Management Representative*:* The Quality Management representative is responsible for providing performance evaluation data and results to the Credentialing Committee for review.

Administrative and Departmental Representation: Administrative and other departmental representation are decided by the voting members.

9.2 Function

The Credentialing Committee will perform the following functions:

- Reviews and approves the Credentialing Plan, Corrective Action Plan and Judicial Review Hearing Plan as necessary, at a minimum, on an annual basis.
- Ensures credentialing standards are being carried out for all practitioners who fall within the Scope of Authorization and Action.
- Approves and denies requests for credentialing applications.
- Reviews credentials of all new practitioners and participating practitioners every three (3) years.
- Reviews credentials of all new and participating Healthcare Delivery Organizations (HDO's) every three years.
- Uses a peer-review process to make decisions in a nondiscriminatory manner regarding approval, denial, and disciplinary actions.
- Ensures final decisions are well documented in Credentialing Committee minutes.

9.3 Meeting Frequency

The Credentialing Committee may meet on a monthly basis but no less than quarterly, unless otherwise specified by physician voting members or in the committee charter. Meetings and decision making may take place in the form of real-time virtual meetings (e.g. video conferencing, or web conference with audio). Meetings may not be conducted through email.

9.4 Reporting

Internal: The Credentialing Committee Chairperson reports activity to the Quality Improvement Committee, as applicable.

External: The Credentialing Department submits biannual reports to health plans and HPN, Executive Committee and QIC as required by delegation agreements.

HPN complies with the reporting requirements of the Medical Board of California, National Practitioner Data Bank, California Business and Professional Code and Federal Health Care Quality Improvement Act regarding adverse credentialing and peer review actions. Please refer to the Corrective Action Plan and Judicial Review Hearing Plan for further policies and procedures.

10 Eligibility and Decision-Making Criteria

To participate in the HPN network, practitioners must meet the following eligibility criteria. If at any time it is determined that the practitioner does not meet criteria, the Credentialing Department will notify the practitioner of his/her lack of qualifications and terminate the credentialing process. A provider may not provide care to enrollees until a final decision is rendered from the Credentialing Committee.

State Licensure
Valid, current professional licensure issued by an appropriate board in State of California.

DEA or CDS Certification
Valid, current DEA or CDS Certification (if applicable) registered with a California address.

National Provider Identifier (NPI)
Valid, current NPI.

Education & Board Certification
At the time of initial application an applying practitioner must meet this criterion by either one of the following:

- Graduation from a professional school (allied and behavioral health practitioners only), school of medicine, osteopathy, chiropractor, or dentistry
- Completion of Internship and Residency training in good standing in the practitioner's practicing medical or surgical specialty, as applicable
- Board Certification by the American Board of Medical Specialties, American Osteopathic Association, a board, or association with equivalent requirements approved by the Medical Board of California, or a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty
- Exceptions may be made for those practitioners who are grandfathered into their specialty under special circumstances. (i.e.: Family Practice Board 1970-1978).
- Exceptions may also be made for rural areas. Work history and professional training will be reviewed for these practitioners.

Clinical Privileges

Current, unrestricted clinical privileges that are consistent with the practitioner's practicing medical or surgical specialty, as applicable.

** This requirement may be waived if acceptable inpatient coverage arrangements are made. Practitioner(s) providing such coverage will have met all established credentialing eligibility criteria and participate on the HPN's panel.*

Hospital Privileges

Absence of past or present denial, suspension, restriction or termination of hospital privileges.

** This requirement may be waived if evidence exists that any such action does not adversely affect the practitioner's ability to perform his or her professional duties.*

Malpractice Insurance

Current professional malpractice insurance with minimum coverage of:

- MDs, DOs, DDSs, DPMs, Allied Health Practitioners, Behavioral Health Practitioners and Nurse Practitioners: $1,000,000 per occurrence, $3,000,000 aggregate

Liability coverage must be provided by a recognized financially viable carrier and must be in the specialty for which the provider is being credentialed for. If the practitioner does not have malpractice insurance with the limits, it must be discussed at the committee and a decision must be documented.

Malpractice Involvement

Absence of past or present involvement in a malpractice suit, arbitration, or settlement.

** This requirement may be waived if evidence exists that involvement does not adversely affect the practitioner's ability to perform his or her professional duties.*

Disciplinary Actions

Absence of past or present disciplinary actions affecting the practitioner's professional licensure, DEA, or other required certification.

** This requirement may be waived if evidence exists that any such action does not adversely affect the practitioner's ability to perform his or her professional duties.*

Sanctions

Absence of past or present sanctions by regulatory agencies, including Medicare/Medicaid sanctions.

** This requirement may be waived if evidence exists that the practitioner is not currently sanctioned or prevented by a regulatory agency from participating in a federal or state sponsored program.*

Medicare Opt Out

Absence of past or present voluntary "opt-out" from Medicare participation. The HPN Groups will not contract or employ practitioners who have opted opt out of Medicare.

** This requirement may be waived if evidence exists that the practitioner does not participate in Medicare line of business and therefore can remain in the network for other lines of business.*

Medicare Exclusions and Sanctions

Absence of present exclusion or sanctions from Medicare. HPN Groups will not contract or employ practitioners (or entities that employ or contract with such practitioners) that are excluded/sanctioned from participation in Medicare are found on the OIG report.)

** This requirement may be waived if evidence exists that the practitioner only participates in Commercial line of business and therefore can remain in the network for Commercial lines of business.*

Felony Convictions

Absence of felony convictions.

** This requirement may be waived if evidence exists that conviction does not adversely affect the practitioner's ability to perform his or her professional duties.*

Illegal Use of Drugs

Absence of present illegal use of drugs.

Impairment

Absence of impairment or likely impairment of practitioner's ability to adequately perform the professional duties for which the practitioner is employed or contracted, with or without reasonable accommodation, according to the accepted standards of professional performance and without posing a direct threat to the safety of patients.

Office Site Visit

Satisfactory results of office site visit, including medical record review, as applicable.

Language

Proficient in the English language.

11 Primary Source Verification

Primary source verification ("PSV") of practitioner credentials will be written, oral or via internet web site. Verifications will be no more than 120 calendar days old at the time of credentialing decisions.

- Written verifications must come directly from the appropriate California State Agency and the printed date on the document will be used to calculate the 120-day timeline, not the date received.
- Oral verifications will be documented by a dated, signed note in the credentialing file, stating the information verified who verified the information, and how it was verified.
- Internet web site and electronic verifications (via web-crawlers which are software that retrieve information directly from a website and save it in the credentialing application). will come from the appropriate state agency and will be dated by the credentialing staff member who verified the information, based on the system recorded date of the web-crawl

(receipt date). The PSV documents are stored in the electronic credentialing system which tracks the date and user ID any time the document is accessed, changed, or removed.

HPN will re-verify credentialing factors that are no longer within the credentialing time limits and those that will be effective at the time of the Credentialing Committee's review.

12 Credentialing Application

Acceptable Applications include California Participating Physician Application (CPPA) or, CAQH Online Credentialing Application Database Service.

For mental and behavioral health providers, upon receipt of the application by the credentialing department, the applicant will be notified within seven business days, to verify receipt and inform the applicant whether the application is complete. A determination will be made within 60-days of receipt of the completed application.

Applicant Attestation - Verification Time Limit - 180 calendar days (120 days calendar days if a CAQH attestation is used)
The signature on the acceptable applications and any relevant information may not be older than 180 calendar days at the time of the Credentialing Committee's action. If the signed attestation exceeds 180 calendar days, before review and action by the Credentialing Committee, the practitioner will have the opportunity to update it. The practitioner will be sent a copy of the completed application with the new attestation form requesting to update the application and attest that the information on the application is correct and complete. The practitioner will not be required to complete another application. The attestation will address:

- Reasons for any inability to perform the essential functions of the positions, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and/or felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance and amount of coverage
- Practitioner race, ethnicity and language.
- Correctness and completeness of application

Supporting Documentation
The following items may be requested in support of the application, as applicable:

- Current Curriculum Vitae
- Copy of valid, current professional licensure issued by the State of California
- Copy of valid, current DEA
- Copy of valid, current board certificate or letter from the certifying board announcing certification
- Copy of valid, current malpractice face sheet that includes coverage limits and expiration

date
- Copy of ECFMG certificate

13 Initial Credentialing Procedure

Upon receipt of an application by the Credentialing Department, the application will be reviewed for completeness. The signed attestation and any relevant information must be no more than 30 days old to allow adequate processing time. Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable. An incomplete application will be returned to the applicant. A tickler file in the form of a checklist, spreadsheet, or computer-generated report is used by Credentialing staff to track dates of verifications or reports, sources used, date submitted for approval, and the signature or initials of the person who verified the information.

13.1 Verifications

State Licensure (Verification Time Limit - 120 calendar days, PSV)
Valid, current professional licensure issued by an appropriate board in State of California. Confirmation that the practitioner holds a valid, current license to practice will be verified from the appropriate state licensing board in writing, verbally or via internet website.

DEA or CDS Certification (If applicable, Verification Time Limit - 180 calendar days, PSV)
Valid, current DEA (If applicable). DEA certification will be verified by obtaining a copy of the current DEA certificate, visual inspection of the original DEA certificate or confirmation from the state pharmaceutical licensing agency where applicable. The address on the DEA certificate should display a valid California address.

DEAs with a non-California address will be verified and credentialed with a written explanation. The documented explanation must include how the practitioner is in the process of updating and/or obtaining a California specific certificate within 90 days of credentialing.
** A pending DEA certificate is acceptable if there is a well-documented process in place to naming another practitioner (holding a valid, current DEA certificate) to write all prescriptions until the practitioner's DEA has been processed.*

If a qualified practitioner, under the scope of credentialing, does not have a valid DEA or does not prescribe controlled substances and that in their care do not require controlled substances, a document must be maintained in the credentialing file to naming another practitioner (holding a valid, current DEA certificate) to write all prescriptions.

Chiropractors: DEA certificates are not applicable.

NPI (Verification Time Limit - 180 calendar days, PSV)
Valid NPI type 1 (Individual) issued by National Plan and Provider Enumeration System (NPPES) will be verified from via NPPES website.

Education (PSV)

The highest of the three levels of education and training obtained by the practitioner are verified.

- Graduation from medical or professional school
- Residency, if appropriate
- Board certification, if appropriate (Note: An expired board certification may be used to verify education and training)

Below are the levels of education for particular provider degree:

- Physicians (MD's and DO's): residency regardless of specialty, or if no residency is completed, Medical School, and if applicable, fellowship in specialty to practice, will be verified by confirmation from the medical school/training program, AMA Master File, AOA Physician Profile Report or Master File, or state licensing agency. Medical school may also be verified by ECFMG for foreign medical graduates after 1986. Practitioner participation in a fellowship is verified only if the fellowship program or completion of fellowship is communicated to members.
- DC's: graduation from Chiropractic College
- DDS's: graduation from dental school and Commission on Dental Accreditation (CODA) accredited specialty training
- DPM's: graduation from podiatry school and specialty training
- Non-physician healthcare practitioners: graduation from professional school
- NP's and PA's: certification from American Nurses Credentialing Center (ANCC) and National Commission on Certification of Physician Assistant (NCCPA)

When a non-physician certifying board or state licensing agency is used for verification of education and training, annual written verification will be kept on file in the Credentialing Department that primary source verification is conducted of professional education and training.

If the practitioner submits transcripts to HPN that are in the institution's sealed envelope with an unbroken institution seal, HPN will accept this as primary source verification for education and training. HPN will provide evidence that they have inspected the contents of the envelope and confirmed that the transcript shows that the provider completed (graduated from) the appropriate training program.

If a physician states that education and training were completed through the AMA's Fifth Pathway Program, HPN will confirm it through primary source verification from the AMA.

If a physicians residency program is closed, HPN will confirm it through primary source verification from the Federation Credentials Verification Service (FCVS).

Education references on a practitioner's CV must include the month and year the education was received. Future dates of any program completion cannot be accepted.

Board Certification (Verification Time Limit - 120 calendar days, PSV)
If the practitioner states that he or she is board certified on the application, verification of good standing in the specialty they are practicing will be obtained using the most current data available from one of the following sources: an official ABMS Display Agent such as www.boardcertifieddocs.com, or https://certifacts.abms.org, where a dated certificate of primary-source authenticity has been provided.; AOA Official Osteopathic Physician Profile Report or AOA Physician Master File; confirmation from the appropriate specialty board; AMA Physician Master File; or, confirmation from the state licensing agency if the state agency conducts primary verification of board status. Foreign board certification can be confirmed by obtaining a letter from the Accreditation Council for Graduate Medical Education (ACGME) that states the foreign board receives primary source verification of education and training for every board-certified practitioner.

The ABMS Certified Doctor Verification Program, accessible through the ABMS Web site, is intended for consumers only and is not an acceptable verification source for board certification.

- Chiropractors: Board certification does not apply.
- Oral Surgeons: Board certification can be confirmed from a Commission On Dental Accreditation accredited specialty board but cannot be substituted for the verification of dental education and specialty training.
- Podiatrists: Board certification can be confirmed from the appropriate specialty board or podiatry specialty board if there is evidence that the board conducts primary source verification of podiatry school graduation and completion of residency.
- Non-Physician Health Practitioners: Board certification can be confirmed from the specialty board but cannot be substituted for the verification of education and training.

Clinical/Hospital Privileges (If applicable, Verification Time Limit - 180 calendar days, PSV not required)
Clinical privileges in good standing, in the specialty that the practitioner is being credentialed, at the hospital designated by the practitioner as the primary admitting facility will be verified in writing, verbally, via hospital roster, an/or physician application form. Confirmation will include status, date of appointment, restrictions, and recommendations.

Hospital rosters (Medical Staff Rosters) may be used only if they include necessary information (name, specialty, appointment date) and are accompanied by a dated letter from the hospital attesting that all practitioners listed are in good standing.

If the practitioner does not have clinical privileges, an explanation of the practitioner's inpatient coverage arrangement is required. Practitioner(s) providing such coverage must be credentialed HPN practitioners, if applicable. The practitioners providing coverage must be in the same specialty and same practice to avoid delay in care.

Malpractice Insurance (PSV not required)
Malpractice liability insurance is verified by a copy of the practitioner's current malpractice insurance face sheet, a federal tort letter, or employer professional liability policy, which includes effective dates, expiration dates, specialty and amounts of coverage, as defined in the Eligibility Criteria Section. Evidence of private malpractice insurance coverage or employer professional liability policy must include a roster of all individuals in the practice who are covered under the policy.

Malpractice History (Verification Time Limit - 120 calendar days, PSV)
Malpractice settlements or judgments during the past five (5) years paid by or on behalf of the practitioner, are confirmed in writing from the malpractice carrier or the NPDB is queried.

In some instances, the five (5) year period may include residency or fellowship years. It is not necessary to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship

Work History (Verification Time Limit - 120 calendar days, PSV not required)
Work history for the past five years is included on the practitioner's application, curriculum vitae, or listed separately as "Work History." Gaps six (6) months or more in time will be verbally clarified and documented as a verbal verification. Gaps of one year or longer are clarified in writing.

The work history to include the beginning month, ending month and year for each listed work experience.

If the practitioner completed his/her education and went straight into practice, this will count as continuous work history.

Office of Inspector General (OIG) (Verification Time Limit - 120 calendar days, PSV)
Confirmation that the practitioner is not listed on the List of Excluded Individuals and Entities (maintained on the Office of Inspector General website.

System for Award Management (SAM) (Verification Time Limit - 120 calendar days, PSV)
Confirmation that the practitioner is not listed on the Excluded Parties Lists System using System for Award Management (SAM) website.

Social Security Death Master File (SSDMF) (Verification Time Limit - 120 calendar days, PSV)
Confirmation that the practitioner is not listed on the Social Security Death Master File (maintained by Social Security Administration), to determine if practitioner is using a deceased person's identity.

CMS Preclusion List (Verification Time Limit - 120 calendar days, PSV)
Confirmation that the practitioner is not listed on the CMS Preclusion List (maintained by CMS

Medicare and provided by health plan), to determine if practitioner has been precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare recipients.

Medi-Cal California Children Services or Whole Child Model Program (Verification Time Limit - 120 calendar days, PSV)
To determine if practitioners, who provide services to pediatric patients regardless of specialty, are approved CCS paneled providers in order to render services to a CCS applicants or clients.
https://www.dhcs.ca.gov/services/ccs/pages/ccsproviders.aspx

ACEs Aware Clinician Participation (Verification Time Limit – one-hundred twenty (120) calendar days, PSV)

To determine if practitioners, who provide services to Medi-Cal patients for Adverse Childhood Experiences (ACEs) screening paneled are certified https://data.chhs.ca.gov/dataset/aces-aware-clinician-listing

Office Site Review and Medical Record Review (If applicable) (Not a delegated function to HPN)
A current office site and medical record review by the health plan will be required for all Primary Care Practitioners (GP/FP/IM/OBGYN) and high-volume behavioral health practitioners. The review will be performed prior to the Credentialing Committee review and must have a passing score of at least 90%. Site/Medical Record Review documents will be downloaded from health plan web site. If the health plan does not have a current office site review and medical record review, health plan's provider network development department will be notified for an office site review and medical record review.

13.2 Information from Designated Organizations

Information received from designated organizations will be no more than 120 days old at the time of Credentialing Committee review and decision. (See Attachment "F")

National Practitioner Data Bank (NPDB)
To receive information on claims that have resulted in settlements or judgments, the National Practitioner Data Bank will be queried. To receive information on healthcare practitioners, providers and suppliers regarding criminal convictions, civil judgments, exclusion from Government healthcare programs, State and Federal licensure actions, as well as other adjudicated actions.

State Board Queries
To receive information regarding past or present state sanctions and restrictions on licensure and/or limitations on scope of practice, the following queries will be made to obtain information during the most recent five (5)-year period:

- Physicians (MD's and DO's): National Practitioner Data Bank.
- DC's: State Board of Chiropractic Examiners, NPDB or Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-

BAD).

- DDS's: State Board of Dental Examiners, NPDB.
- DPM's: State Board of Podiatric Examiners, NPDB or Federation of Podiatric Medical Boards.
- Non-physician Healthcare Professionals: Appropriate state agency, or state board of licensure or certification.

Medicare Opt-Out Report

To determine if the practitioner has opted out of Medicare. The latest report from Medicare will be checked using CMS.gov.

Medi-Cal Provider Suspended and Ineligible List

To determine if the practitioner is excluded or ineligible from the state Medi-Cal program. The latest report form Medi-Cal will be checked.

Reports of disciplinary actions and their outcomes, NPDB reports of malpractice settlements, and adverse actions, 805 reports, and MBOC accusation or adverse action reports will be filed in a separate confidential Peer Review file in the Credentialing Department. These documents are protected by law and will not be reproduced or distributed. Proof of queries will be kept in the credentialing file.

Office Site Review for Complaints

HPN has established performance standards and thresholds for a Practitioner's Office regarding the physical accessibility, the physical appearance, the adequacy of waiting and examining room space and adequacy of medical/treatment record keeping.

Complaints regarding physical accessibility, physical appearance, adequacy of waiting and examining rooms, accessibility to equipment, and the adequacy of medical/treatment records keeping, and confidentiality will be brought forth to the Credentialing Committee to determine the severity of the complaint and if a site visit is warranted. If the Committee deems that a site visit is required, the visit will be performed within 60 days of the receipt of the complaint. Complaints regarding the adequacy of equipment warrant an automatic site visit. The office will be surveyed according to that corresponding section in the Provider Site Quality Audit Tool for Complaints (See Attachment D).

If a deficiency is found, a corrective action plan for improvement will be required for all items that do not meet thresholds. Follow-up of those identified deficiencies will take place at least every six months until deficiencies are resolved, which may include a re-evaluation of the site. The follow-up actions and practitioner responses will be documented in the practitioner's credentialing file.

Scoring:

The office site review initiated via a complaint and medical record review are evaluated against

set standards and thresholds set forth by HPN, and will be based on a point system, indicating percentage of compliance.
The office site and medical record review are scored together and totaled according to the following guidelines:

Approved:	**100%**
Corrective Action Plan:	**≤ 99%**

All complaints triggering a site visit will be captured on the Provider Site Quality Audit Tool for Complaints and reviewed by the Credentialing Committee annually. (See Attachment D)

If another complaint about the same office site is received within one year, regarding the same office-site criteria standard, a follow-up site visit will be conducted within 60 calendar days but only those elements will be reviewed. If another complaint is received regarding a different office-site criteria standard, then another site visit will be performed within 60 calendar days. Member complaints will be monitored for all practitioner sites at least every six months. When appropriate, complaints will be forwarded to the applicable health plan upon receipt.

Qualifications of Staff Performing the Site Review for Complaints
HPN has established that properly trained and appropriately qualified staff are capable of conducting site audits arising from complaints. The following qualification requirements for the staff conducting site audits arising out of a complaint(s).

- A licensed LVN or RN; and
- Completion of the Provider Site Quality Audit Tool for Quality Training Guide.

14 Recredentialing Criteria

A formal recredentialing process is required every three (3) years with the process being completed within the month of the recredentialing date. There is no grace period beyond the 36-month allotted time period to re-verify information that may have changed over time. The three-year cycle begins with the date of the initial credentialing decision date; and thereafter, three years from the recredentialing decision. A practitioner cannot be re-credentialed if the time is past the recredentialing date month.

Active Military Assignment, Maternity Leave, or a Sabbatical
If HPN cannot recredential a practitioner within the 36-month time frame because the practitioner is on active military assignment, maternity leave, or a sabbatical, but the contract between HPN and the practitioner remains in place, HPN may recredential the practitioner upon his or her return. HPN must document the reason for the delay in the practitioner's file.

At the minimum, HPN must verify that a practitioner who returns from military assignment, maternity leave or a sabbatical has a valid license to practice before he or she resumes seeing patients. Within 60 calendar days of when a practitioner resumes practice, HPN must complete the recredentialing cycle. On the other hand, if either party terminates the contract or there is a break in service of more than 30 calendar days, HPN must initially credential the practitioner before the

practitioner rejoins the network.

Reinstatement After Administrative Termination
If a practitioner is given administrative termination for reasons beyond HPN's control (e.g., the practitioner failed to provide complete credentialing information), and is then reinstated within 30 calendar days, HPN may recredential the practitioner as long as it provides documentation that the practitioner was termed for reasons beyond its control and was recredentialed and reinstated within 30 calendar days of termination. HPN must initially credential the practitioner if reinstatement is more than 30 calendar days after termination.

15 Recredentialing Application

Acceptable Applications include California Participating Physician Recredentialing Application (CPPR) or CAQH Online Credentialing Application Database Service.

Applicant Attestation - Verification Time Limit - 180 calendar days (120 days calendar days if a CAQH attestation is used)
The recredentialing application includes a current and signed attestation by the applicant and addresses the following:

- Reasons for any inability to perform the essential functions of the positions, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and/or felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance and amount of coverage
- Practitioner race, ethnicity and language.
- Correctness and completeness of application

Supporting Documentation
The following items may be requested in support of the application, as applicable:

- Copy of valid, current professional licensure issued by the State of California
- Copy of valid, current DEA
- Copy of valid, current board certificate or letter from the certifying board announcing certification
- Copy of valid, current malpractice face sheet that includes coverage limits and expiration date

16 Recredentialing Procedure

A tickler file in the form of a checklist, spreadsheet, or computer-generated report alerts Credentialing staff of practitioners due for recredentialing. One hundred eighty (180) days prior to expiration of the three-year (36-month) cycle, the practitioner is mailed a recredentialing application. The 36-month cycle begins with the date of the initial credentialing decision and is counted to the month, not the day.

If the application is not returned within thirty (30) days, the practitioner will be contacted by a Credentialing staff member to verify receipt of the application and request that the application is returned within fifteen (15) days. If the application is not returned within fifteen (15) days, Administration will be requested to assist in obtaining the recredentialing application. If the recredentialing application is not returned ninety (90) days prior to the expiration of the three-year (36-month) cycle, the practitioner will be notified via certified mail of intent to terminate.

Upon receipt of an application by the Credentialing Department, the recredentialing application will be reviewed for completeness. The signed attestation by the applicant should be no more than 30 days old to allow for adequate processing time. Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable. An incomplete recredentialing application will be returned to the applicant.

16.1 Verification

- State Licensure (Verification Time Limit - 120 calendar days, PSV)
- DEA or CDS Certification (If applicable, Verification Time Limit - 180 calendar days, PSV)
- NPI (Verification Time Limit - 180 calendar days, PSV)
- Board Certification if newly certified or recertified in the past three years/36 months (Verification Time Limit - 120 calendar days, PSV)
- Clinical/Hospital Privileges (If applicable, PSV not required)
- Malpractice Insurance (PSV not required)
- Malpractice History (Verification Time Limit - 120 calendar days, PSV)
- Office of Inspector General (OIG) (Verification Time Limit - 120 calendar days, PSV)
- System for Award Management (SAM) (Verification Time Limit - 120 calendar days, PSV)
- Office Site Review and Medical Record Review (If applicable) (Not a delegated function)
- CMS Preclusion List
- Social Security Death Master File (SSDMF)

16.2 Information from Designated Organizations

Same as Chapter I, Section 13.2.

16.3 Performance Monitoring

Information derived from the practice experience of all practitioners is incorporated into the recredentialing process and reviewed by the Credentialing Committee. At a minimum, confidential member complaint data, information from quality improvement activities, utilization management performance data, and member satisfaction data will be used to assess professional performance, judgment and clinical competence and will be used in the recredentialing decision process. The data used for performance monitoring is obtained no earlier than 1 months, prior to the Credentialing Committee.

17 Credentialing Committee Review and Action

In preparation for Credentialing Committee review, an internal audit of credentialing file contents is performed to ensure all information is present and received within the required timeframes. Each item is recorded on a Credentialing Committee preparation checklist, which includes a brief summary of the file and identifies, if any, "red flag" (adverse or unfavorable) issues for Committee review. The Preparation Checklist is signed by both the credentialing staff member who prepares the file and a physician-voting member upon final decision. For those files that the Committee decides should include more information, the file will be pended, and the Committee will re-review the file at a later date. At that time, the Committee will evaluate the credentials, offer advice if necessary, and make a final decision regarding the practitioner. All of the information in the file must meet CMS, DMHC, DHCS, NCQA, and health plan timeliness requirements. If any information is out of date, it will be re-verified before brought to Committee for review.

Completed credentialing files will be divided into two (2) categories: (1) Routine/Clean File Review (2) Intensive Review. The files will be scheduled for review at an upcoming Credentialing Committee meeting.

17.1 Routine/Clean File Review

Credentialing files **without** adverse or unfavorable credentialing/ recredentialing findings that meet established criteria.

Clean File Review criteria for the credentialing process:

- NPDB reports no disciplinary actions/malpractice payments
- NPDB reports no criminal convictions, civil judgments, exclusions from Government health care programs, State and Federal licensure actions, as well as other adjudicated actions
- No record of malpractice payments during the previous five (5)-year period for the initial credentialing process and three (3)-year period for subsequent recredentialing cycles
- No licensure restrictions
- Good standing at reputable hospital or stated inpatient coverage arrangement that meets criteria
- No time gaps
- Information returned in a timely manner containing nothing to suggest that the practitioner is anything other than highly qualified in all areas; and,
- Passing score on office site visit, including medical record review (if applicable)
- No identified member complaint data, quality improvement activity or utilization management performance problems for recredentialing

A Medical Director or an equally qualified practitioner designated by the Credentialing Committee has the authority to review and sign off on clean files which have met HPN Groups credentialing or recredentialing criteria. The date the file is signed by the Medical Director is the date that will be considered the “Committee Review Date”. These files do not have to be reviewed by the

Credentialing Committee to be approved.

17.2 Intensive Review

Describes credentialing files **with** adverse or unfavorable credentialing/recredentialing findings that meet established criteria.

Intensive Review criteria for the credentialing process:

- NPDB reports disciplinary actions or malpractice payments
- NPDB reports criminal conviction, civil judgment, exclusion from Government health care program, State and Federal licensure action, or other adjudicated action
- Licensure restrictions or licensed in more than five (5) states in five (5) years (a lot of moving around, excluding military)

- Many hospital affiliations in a short time period (unless this would be expected, given the practitioner's specialty and the area in which he/she practices) or information provided from hospital affiliations is "guarded" or suggests problems
- Time gaps (identified from application and work history form)
- Difficulty obtaining information
- Identified member complaint data, quality improvement activity or utilization management performance problems for re-credentialing

Intensive Review credentialing files will be presented to the Credentialing Committee for intensive review. Possible action by the Credentialing Committee includes, approval, denial, recommendation for improvement and/or monitoring, disciplinary action, or request for further information. These files require two signatures for approval.

All credentialing files regardless of Routine/Clean File Review or Intensive Review criteria are brought to the Credentialing Committee. Possible action by the Credentialing Committee includes, approval, denial, recommendation for improvement and/or monitoring, disciplinary action, or request for further information.

18 Nondiscriminatory Credentialing/Recredentialing

Credentialing/Recredentialing decisions are not based on a practitioner's race, ethnic/national identity, gender, age, sexual orientation, the types of procedures (e.g., abortions), or types of patients (e.g., Medicaid) to which the practitioner provides services. This will not preclude actions regarding practitioners who meet certain demographic or specialty needs, or to meet cultural needs of members. HPN monitors and prevents discriminatory credentialing through the following process:

- The presence of a nondiscrimination statement on the "Statement of Confidentiality" to be signed by members, staff, and guests of the Credentials Committee at least annually .
- Audits of practitioner complaints will be done on a quarterly basis to determine if there are complaints alleging discrimination.

Documents, and/or information, submitted to the Credentials Committee for approval, denial or termination do not designate a practitioner's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed or payor sources.

19 Provisional Credentialing

Provisional credentialing is acceptable under very limited circumstances and is only available to practitioners who are applying to HPN for the first time. A practitioner can only be provisionally credentialed once. Practitioners who have been in the organization's network via delegation arrangement are not eligible for Provisional Credentialing by the organization if the delegation arrangement is terminated or if the practitioner is no longer affiliated with the delegate. Provisional status expires after sixty (60) calendar days and cannot be renewed. Locum tenens or other practitioners who work 60 calendar days or more will require full credentialing.

The Credentialing Committee bases provisional credentialing actions on the following information:

- Primary-Source verification of a current valid license to practice
- Primary Source verification of the past five (5) years of malpractice claims or settlements from the malpractice carrier or the results of the NPDB query.
- A current and signed application with attestation.

Each factor must be primary sourced verified within 120 calendar days of the Credentialing Committee decision. Provisional credentialing files must be valid and verified within the specified timeframes. Provisional Credentialing files must contain a medical director or equally qualified practitioner sign off, if the file meets HPN's definition of a clean file or be presented to the Credentialing Committee for review and consideration for participation into the network.

20 Communication of Committee Action

The practitioner will be notified in writing within thirty (30) calendar days of the Credentialing Committee's credentialing/recredentialing decision. A copy of the written correspondence will be kept in the credentialing file. Documentation of adverse decisions will be kept in a file.

21 Practitioner Termination and Reinstatement

If a practitioner receives an adverse decision which entitles the practitioner to a hearing, then that practitioner shall not be eligible to reapply until one (1) year(s) after the adverse decision is final and the practitioner has exhausted all applicable hearing rights. If a practitioner terminates and later wishes to rejoin, the practitioner must undergo the initial credentialing process if the break in service is greater than 30 days or more. The credentials of the practitioner will be re-verified following the same guidelines as described in the Initial Credentialing Procedure and Credentialing Committee Review and Action. It is not required to re-verify credentials that do not expire, such as, completion of education and training and board certification that is not time limited.

22 Ongoing Monitoring

Practitioners reported to a State Board, patient complaints, and adverse events are brought to the Credentialing Committee for peer review and are tracked until a final determination is made. Patient complaints and adverse events are brought to the attention of the medical director and reviewed at the next Credentialing Committee meeting to determine any required actions and continued participation in the network and the payment of Medicare/Medicaid claims.

Ongoing monitoring documentation is centralized for the HPN Groups via secured intranet located at http://hpnweb1/msowreports. Evidence of ongoing monitoring can also be found in the Ongoing Monitoring Spreadsheet and the Credentialing Committee minutes.

22.1 Licensing Boards

Medical Board of California (MBOC) Disciplinary Notifications: The e-mail notifications are reviewed at least monthly or within 30 days of their release to identify participating practitioners that have recent accusations or disciplinary actions. The e-mails will be reviewed, dated, and initialed by credentialing staff as notified by MBOC.

Osteopathic Medical Board of California Enforcement Actions: The email notifications or quarterly reports are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The reports will be reviewed, dated, and initialed by credentialing staff within 30 days of publication.

Board of Podiatric Medicine Disciplinary Actions: The monthly reports are reviewed within 30 days of their release to identify participating practitioners that have recent disciplinary actions. The reports will be reviewed, dated, and initialed by credentialing staff on a monthly basis.

Board of Behavioral Sciences Enforcement Actions: The e-mail notifications are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The e-mails will be reviewed, dated, and initialed by credentialing staff as notified by the BBS.

Board of Psychology Enforcement Actions: The e-mail notifications are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The e-mails will be reviewed, dated, and initialed by credentialing staff on a monthly basis (if published).

California Board of Chiropractic Examiners Disciplinary Actions: The monthly reports are reviewed within 30 days of their release to identify participating practitioners that have recent disciplinary actions. The reports will be reviewed, dated, and initialed by credentialing staff on a monthly basis.

Acupuncture Board Disciplinary Actions: The monthly reports are reviewed within 30 days of

their release to identify participating practitioners that have recent disciplinary actions. The reports will be reviewed, dated, and initialed by credentialing staff on a monthly basis.

Dental Board of California Disciplinary Actions: The monthly reports are reviewed within 30 days of their release to identify participating practitioners that have recent disciplinary actions. The reports will be reviewed, dated, and initialed by credentialing staff on a monthly basis.

Board of Occupational Therapy Disciplinary Actions: The e-mail notifications are reviewed within 30 days of their release to identify participating practitioners that have recent accusations or disciplinary actions. The e-mails will be reviewed, dated, and initialed by credentialing staff as notified.

California Board of Optometry Enforcement Actions: The monthly reports are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The reports will be reviewed, dated, and initialed by credentialing staff on a monthly basis.

Physical Therapy Board of California Citations & Disciplinary Actions: Does not publish disciplinary actions. The organization will conduct individual queries every 12-18 months on credentialed providers. Actions are also received via email from e-mail notifications are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The e-mails will be reviewed, dated, and initialed by credentialing staff as notified.

Physician Assistant Committee Enforcement Actions: The monthly reports are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The reports will be reviewed, dated, and initialed by credentialing staff on a monthly basis.

California Board of Registered Nursing Enforcement Actions: The email reports received from National Council of State Board of Nursing Nursys e-Notify system are reviewed within 30 days of their release to identify participating practitioners that have recent enforcement actions. The reports will be reviewed, dated, and initialed by credentialing staff on a monthly basis.

Speech-Language, Pathology and Audiology Board Disciplinary Actions: The quarterly reports are reviewed within 30 days of their release to identify participating practitioners that have recent disciplinary actions. The reports will be reviewed, dated, and initialed by credentialing staff on a quarterly basis.

Exceptions will be made when the boards do not update the reports in a timely fashion. Such information will be documented. If the board does not release sanction information reports for more than 12 months, individual queries for the providers belong to that board. Individual queries will be conducted every 6 months thereafter.

22.2 Medicare/Medicaid Sanctions and Exclusions

HPN will only contract with or employ practitioners who are not excluded from or are not

sanctioned by Medicare/Medicaid. The Department of Health and Human Services, Officer of Inspector General and System for Award Management (SAM) is reviewed at least monthly or within 30 days of their release to identify participating practitioners who have been sanctioned or excluded from Medicare/Medicaid programs. The database will be reviewed, dated, and initialed by credentialing staff on a monthly basis.

22.3 Medicare Opt-Out Report

HPN will only contract with or employ practitioners who have not opted-out from Medicare. The Medicare Opt-Out Provider Reports are reviewed at least monthly or within 30 days of their release to identify participating practitioners who have opted not to provide services to Medicare recipients. The Medicare Opt Out report will be reviewed, dated, and initialed by credentialing staff on a quarterly basis. * *This requirement may be waived if evidence exists that the practitioner does not provide services to Medicare enrollees.*

22.4 CMS Preclusion List

HPN will review providers who have been precluded from participating in Medicare program. The CMS Preclusion List are reviewed at least monthly or within 30 days of their release to identify participating practitioners who have been precluded to provide services to Medicare recipients. The CMS Preclusion List will be reviewed, dated, and initialed by credentialing staff on a monthly basis (when received from health plan). * This requirement may be waived if evidence exists that the practitioner does not provide services to Medicare enrollees.

22.5 Medi-Cal Suspended or Ineligible Providers Report

HPN will only contract with or employ physicians who have not been suspended or terminated from Medi-Cal. The Medical Suspended and Ineligible Provider are reviewed at least monthly or within 30 days of their release to identify participating practitioners who have been terminated or suspended from Medi-Cal. The Medical Suspended and Ineligible Provider report will be reviewed, dated, and initialed by credentialing staff on a monthly basis.

22.6 Medi-Cal Fee for Service (FFS) Screening and Enrollment

HPN providers are monitored monthly to validate continuous enrollment with Medi-Cal FFS program. This monitoring is achieved by reviewing the Medicare/Medicaid Sanctions and Exclusions (OIG/SAM), Medi-Cal Suspended or Ineligible Providers Report, and ensuring the providers are in good standing. These are reviewed at least monthly or within 30 days of their release to identify participating practitioners who are not in good standing. The reports will be reviewed, dated, and initialed by credentialing staff on a monthly basis.

** This requirement may be waived if evidence exists that the practitioner does not provide services to Medi-Cal enrollees.*

22.7 DHCS Restricted Providers

HPN will review providers who have been restricted from participating in DHCS programs. The DHCS Restricted Providers list is reviewed at least monthly or within 30 days of the list being sent by the health plan to identify practitioners restricted from participating in DHCS programs. The DHCS Restricted Providers list will be reviewed, dated, and initialed by credentialing staff when received from health plan.

22.8 Complaints - Problems at Sites - Adverse Events

Complaints and identified adverse events that occur at the practitioner sites are detected by ongoing monitoring of reported member complaints and grievance data, and other means by which problems or adverse events are brought to the attention of administration and QM and UM staff (i.e., practice-specific member surveys and reports from Provider Relations visits).

Provider Complaint Monitoring: Any practitioner specific member complaints will be investigated upon receipt and brought to the Quality Improvement Committee for review to determine if there is evidence of poor quality that could affect the health and safety of members and then implement appropriate actions/interventions. The Credentialing Committee will review the provider complaints at the next Credentialing Committee after the identified occurrence. The Credentialing Committee will evaluate practitioner history of complaints, at least every six months. More than one complaint or grievance per provider (other than those for physical accessibility, appearance, and the adequacy of waiting and examining rooms and equipment) within a six (6)-month period could initiate a visit to the practitioner's site for an office site evaluation, medical record audit, or submission of a corrective action plan. If deficiencies are found upon the visit to the practitioner's site, a corrective action plan for improvement will be implemented and follow-up site evaluations will be required until performance thresholds are met.

Adverse Event Monitoring: An adverse event is an injury that occurs while a member is receiving healthcare services from a provider. On a monthly basis, adverse events are identified and appropriate interventions are implemented. Oversight of the corrective actions and resolution are provided by the Quality Management Department and when necessary, the Medical Director may be involved to ensure that the problem or adverse event is corrected. If the problem or event is determined to require further review, the provider is subject to peer review and appropriate disciplinary action and follow-up (See page 31 of the Quality Improvement Program). Review may be limited to primary care practitioners and high-volume behavioral health practitioners.

22.9 HIV/AIDS Specialist Identification (AB2168)

An "HIV/AIDS specialist" is a practitioner who holds a valid, unrevoked, and unsuspended certificate to practice medicine in the state of California who meets any one of the following criteria:

- Member of the American Academy of HIV Medicine
- Board certified in Infectious Disease and in the past 12 months has clinically managed at least 25 HIV patients and completed 15 hours of category I CME in HIV medicine, five hours of which was related to antiretroviral therapy

- In the past 24 months, has provided clinical management to 20 HIV patients and in the past 12 months has completed board certification in Infectious Disease
- In the past 24 months, has provided clinical management to 20 HIV patients and in the past 12 months has completed 30 hours of category 1 CME in HIV medicine
- In the past 24 months, has clinically managed at least 20 HIV patients and in the past 12 months has completed 15 hours of category 1 CME in HIV medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of the HIV Medicine

On an annual basis, HPN Groups will review the current and previous year's lists and send a letter to these practitioners to identify or reconfirm if he/she meets the HIV/AIDS specialist definition.

If the practitioner wishes to be designated as an HIV/AIDS specialist, he/she will attest to the best of their knowledge that they can provide documentation to support their qualifications. Once the HPN Groups has determined which, if any, of its practitioners qualify as HIV/AIDS specialists, a list of qualifying practitioners is sent to the department that issues standing referrals, identifying these types of practitioners.

Practitioners and specialty care centers that provide specialized care for HIV/AIDS can be identified using the members health plan provider directory, the medical groups referral system, or by calling the medical groups UM department for assistance an appropriately trained provider.

22.10 Continuous Updates

Licenses, and DEA Certifications (expirable/s) are kept current via ongoing monitoring by the HPN's credentialing application (Morrisey) which automatically checks for updates via the internet and stores them in the practitioner's file. The following steps are performed before and after expiration:

- The credentialing application checks for expirables 10 days before expiration. If the expirable is renewed, then the credentialing application captures the information and stores it in the practitioner files. If the expirable is not renewed, then the credentialing application posts the letter on the employee work list to print expired document letters to be mailed or faxed to the practitioners.

- The credentialing application checks for the expirables 1 day prior to expiration. If the expirable is renewed, then the credentialing application captures the information and stores it in the practitioner files. If the expirable is not renewed, then the credentialing application notifies the credentialing coordinator. The credentialing coordinator tries to resolve the issue with the practitioner and obtain necessary documentation. The credentialing committee is notified of such actions. If the provider has not renewed the license the credentialing status is made inactive (terminated) immediately, the practitioner is notified,

and all the pertaining departments are notified.

- Malpractice insurance copies are obtained from the provider when the insurance copy on file expires.

23 Meeting Minutes

The Credentialing Committee's thoughtful consideration of credentials and actions taken are well documented in Credentialing Committee minutes. Minutes are approved at the next Credentialing Committee meeting and kept in the Credentialing Department. If a tape recorder is used or notes taken, such tape or notes will be discarded or recycled immediately after the minutes are approved, unless specifically directed by the Medical Director.

24 Altering Conditions of Practitioner Participation & Appeal Rights

Please refer to the Corrective Action Plan and Judicial Review Hearing Plan.

25 Member Communication

Information provided to health plan clients for dissemination to members will be reviewed at the time of submission to ensure that the information provided regarding practitioner's education, training, board certification and designated specialty is consistent with the information gathered during the credentialing process. Practitioner participation in a fellowship is verified only if the fellowship program or completion of fellowship is communicated to members. HPN does not publish and is not delegated to publish any member materials.

Chapter II Healthcare Delivery Organizations

1 Definition

A Healthcare Delivery Organization (HDO) is an organization delivering health care services in the State of California that is subject to review by the State of California Department of Health Services (DHCS) and the Centers for Medicare and Medicaid (CMS).

2 Purpose

To ensure Healthcare Delivery Organizations meet established standards of participation.

3 Scope of Authorization and Action

HDOs covered under the Credentialing Plan include, but are not limited to, the following:

- Hospitals
- Behavioral Health Organizations - Mental health and substance abuse services to inpatient, residential and ambulatory settings
- Comprehensive Outpatient Rehabilitation Facilities
- Durable Medical Equipment Entities
- Federally Qualified Health Center (FQHC)
- Free-Standing Surgical Centers
- Home Health Agencies
- Hospice
- Laboratories
- Outpatient Diabetes Self-Management Training
- Outpatient Physical and Speech Therapy Centers
- Portable X-Ray Suppliers
- Renal Dialysis Facilities
- Rural Health Clinics (RHC)
- Skilled Nursing Facilities (SNF) and Nursing Homes
- Telemedicine Organizations – Only if the organizations telemedicine practitioners are not credentialed
- Urgent Care Centers

HDOs not requiring credentialing under the HPN Credentialing Program are free standing facilities where practitioners practice and/or provide care exclusively for member directed to the facility. These HDOs include, but are not limited to, the following:

- Mammography Centers
- Ambulatory Behavioral Healthcare Facilities
- Psychiatric and Addiction Disorder Clinics

- Facilities that primarily host 12-Step Programs

4 Policy

Healthcare Delivery Organizations that fall within the Scope of Authority and Action will undergo initial HDO credentialing and be reviewed again at recredentialing every three (3) years (36 months) thereafter, to ensure that the provider continues to be in good standing with federal and state regulatory bodies and reviewed and approved by an accrediting body.

5 Eligibility Criteria

A qualifying HDO must meet the following eligibility criteria. If at any time it is determined that the HDO does not meet criteria, the Credentialing Department will notify the HDO of its lack of qualifications and terminate the credentialing process. The HDO may not provide care to enrollees until a final decision is rendered from the Credentialing Committee.

State Licensure (Facility/Business)
Valid, current licensure issued by State of California.

National Provider Identifier (NPI)
Valid, current NPI.

Accreditation & Onsite Quality Assessment
At the time of application, an HDO must meet these criteria by either one of the following:

- Current accreditation by an approved accrediting body or
- A current onsite quality assessment (conducted by HPN)
- A DHCS or CMS site survey

Professional Malpractice Insurance
Current professional malpractice insurance with minimum coverage of:

- Hospitals: $3,000,000 per occurrence, $10,000,000 aggregate
- Others: $1,000,000 per occurrence, $3,000,000 aggregate

Liability coverage must be provided by a recognized financially viable carrier.

General Liability Insurance
Current general liability insurance with minimum coverage of $1,000,000 per occurrence and $3,000,000 aggregate is required. Liability coverage must be provided by a recognized financially viable carrier.

Sanctions
Absence of past or present sanctions by regulatory agencies, including Medicare/Medicaid sanctions.

** This requirement may be waived if evidence exists that the HDO is not currently sanctioned or*

prevented by a regulatory agency from participating in a federal or state sponsored program.

- Compliance with Federal requirements prohibiting employment or contracts with individuals excluded from participation under either Medicare or Medicaid
- Compliance with State, Federal and Local requirements for handicap access as well as the standards required by the 1992 Federal American Disabilities Act

6 Credentialing Application

Acceptable Applications include Hospital Participation Application or Ancillary Facility Application.

Applicant Attestation - Verification Time Limit - 180 calendar days (120 days calendar days if a CAQH attestation is used)
The authorized signature on the acceptable applications and any relevant information may not be older than 180 calendar days at the time of the Credentialing Committee's action. If the signed attestation exceeds 180 calendar days, before review and action by the Credentialing Committee, the HDO will have the opportunity to update it. The HDO will be sent a copy of the completed application with the new attestation form requesting to update the application and attest that the information on the application is correct and complete. The HDO will not be required to complete another application. The attestation will address:

- History of sanctions and limitations on scope of practice or loss of licensure
- History of Medicare/Medicaid sanctions or restrictions
- History of disciplinary action or loss of accreditation
- Compliance with federal requirements prohibiting employment or contracts with individuals excluded from participation under either Medicare or Medicaid
- Compliance with state, federal and local requirements for handicap access as well as the standards required by the 1992 Federal American Disabilities Act
- Correctness and completeness of application

Supporting Documentation
The following items may be requested in support of the application, as applicable:

- Copy of valid, current licensure issued by the State of California
- Copy of valid, current accreditation certificate. If not accredited, copy of DHCS or CMS site review
- Copy of valid, current professional and general liability insurance face sheet that includes coverage limits and expiration date
- Copy of Medicare Certification (if applicable)

7 Initial Credentialing Procedure

Upon receipt of an application by the Credentialing Department, the application will be reviewed for completeness. The signed attestation and any relevant information must be no more than 30 days old to allow adequate processing time. Faxed, digital, electronic, scanned or photocopied

signatures are acceptable. Signature stamps are not acceptable. An incomplete application will be returned to the applicant.

7.1 Verifications

State Licensure (Facility/Business, PSV not required)
Valid, current licensure issued by State of California, an agent of the State of California, or a federal agency.

NPI (Verification Time Limit - 180 calendar days, PSV)
Valid NPI of type 2 (Organization) issued by National Plan and Provider Enumeration System (NPPES) will be verified from via NPPES website.

Accreditation & Onsite Quality Assessment (PSV not required)
At the time of application, a HDO must meet this criterion by either one of the following:

- Current accreditation by an approved accrediting body or agent of the approved accrediting body by certificate, accreditation report, or decision letter.
- A DHCS or CMS site survey (the survey date may not be greater than 3 years at the time of C.)
- A current onsite quality assessment, conducted by the HPN Group, using the HICE Organizational Provider/Facility Site Review Tool & Corrective Action Plan for HDOs

Acceptable Regulatory and Accrediting Bodies include:

A. Hospitals/Acute Care Facilities
    - The Joint Commission
    - Healthcare Facilities Accreditation Program (HFAP) Accrediting Program approved by the American Osteopathic Association (AOA)
    - Det Norske Veritas National Integrated Accreditation for Healthcare Organization (DNV)
    - Center for Improvement in Healthcare Quality
B. Behavioral Health Organizations
    - The Joint Commission
    - Commission on Accreditation or Rehabilitation Facilities (CARF)
    - Healthcare Facilities Accreditation Program (HFAP) Accrediting Program approved by the American Osteopathic Association (AOA)
    - Council on Accreditation for Children and Family Services
C. Comprehensive Outpatient Rehab Facilities
    - The Joint Commission
    - The Commission on Accreditation of Rehabilitation Facilities (CARF)
D. Free Standing Surgical Centers, including stand-alone abortion clinics and multi-specialty outpatient surgical centers
    - The Joint Commission
    - Accreditation Association for Ambulatory Health Care (AAAHC)

- American Association for Accreditation for Ambulatory Surgery Facilities (AAAASF)

E. Home Health Agencies
   - The Joint Commission
   - Community Health Accreditation Program (CHAP)
   - Accreditation Commission for Health Care, Inc. (ACHC)
   - Accreditation Association for Ambulatory Health Care (AAAHC)

F. Hospice
   - The Joint Commission
   - Community Health Accreditation Program (CHAP)

G. Laboratories
   - Applicable CLIA certificate or waiver
   - The Joint Commission
   - Commission on Office Laboratory Accreditation (COLA)
   - College of American Pathologists, Lab Accreditation Program

H. Outpatient Diabetics Self-Management Training Providers
   - American Association of Diabetes Educators (AADE)
   - Indian Health Service (IHS)

I. Portable X-Ray Supplier:
   - Federal Drug Administration (FDA) Certification

J. Skilled Nursing Facilities:
   - The Joint Commission
   - Continuing Care Association Commission (CCAC)
   - Commission on Accreditation of Rehabilitation Facilities (CARF)

K. Comprehensive Outpatient Rehabilitation Facilities
   - The Joint Commission
   - Continuing Care Accreditation Commission (CCAC)
   - The Commission on Accreditation of Rehabilitation Facilities (CARF)

<u>Onsite Quality Assessment</u> (PSV not required)
Facilities not accredited, or surveyed by the DHCS or CMS, will require an assessment performed by the Quality Management Department using the HICE Organizational Provider/Facility Site Review Tool & Corrective Action Plan for HDOs. The assessment may be varied according to the HDOs type, size and complexity and includes verification that all practitioners are credentialed. Interviews may be conducted with, but not limited to, senior management, chiefs of major services, key personnel in nursing, quality management or utilization management.

** Free-Standing Organizations not accredited by an agency accepted by the State of California, the organization has a documented process that the organization will ensure the Free Standing Surgical is certified to participate in the Medicare Program, in compliance with Health and Safety Code § 1248.1.*

<u>Professional and General Liability Insurance</u> (PSV not required)
The insurance is verified by a copy of the HDO's current professional and general liability

insurance face sheet, which includes effective dates and amounts of coverage, as defined in the Eligibility Criteria Section.

Medicare Certification (If applicable, PSV not required)
Copy of Medicare Certification is required for Federally Qualified Health Centers, Outpatient Physical Therapy & Speech Pathology Providers, Outpatient Diabetics Self-Management Training Providers, Renal Dialysis Facilities, and Rural Health Clinics.

Medi-Cal Suspended and Ineligible List
Confirmation that the practitioner is not listed on the Medi-Cal Suspended and Ineligible List

Medi-Cal Participation/Enrollment (Verification Time Limit - 120 calendar days, PSV)
Confirmation that the practitioner is participating in Medi-Cal.

Office of Inspector General (OIG) (Verification Time Limit - 120 calendar days, PSV)
Confirmation that the practitioner is not listed on the Office of Inspector General website.

System for Award Management (SAM) (Verification Time Limit - 120 calendar days, PSV)
Confirmation that the practitioner is not listed on the System for Award Management (SAM) website.

CMS Preclusion List (Verification Time Limit - 120 calendar days, PSV)
Confirmation that the practitioner is not listed on the CMS Preclusion List website.

8 Recredentialing Criteria

A formal recredentialing process is required every three (3) years with the process being completed within the month of the recredentialing date. There is no grace period beyond the 36-month allotted time period to re-verify information that may have changed over time. The three-year cycle begins with the date of the initial credentialing decision; and thereafter, three years from the recredentialing decision.

Exceptions: If HPN cannot recredential a HDO within the 36-month time frame, HPN must document the reason for the delay in the HDO's file.
If a HDO is given administrative termination for reasons beyond HPN's control (e.g., the HDO failed to provide complete credentialing information), and is then reinstated within 30 calendar days, HPN may recredential the HDO as long as it provides documentation that the HDO was termed for reasons beyond its control and was recredentialed and reinstated within 30 calendar days of termination. HPN must initially recredential the HDO if reinstatement is more than 30 calendar days after termination.

9 Recredentialing Application

Acceptable Applications include Hospital Participation Reapplication or Ancillary Facility Reapplication.

Applicant Attestation - Verification Time Limit - 180 calendar days (120 days calendar days if a CAQH attestation is used)
The recredentialing application includes a current and signed attestation by the applicant and addresses the following:

- History of sanctions and limitations on scope of practice or loss of licensure
- History of Medicare/Medicaid sanctions or restrictions
- History of disciplinary action or loss of accreditation
- Compliance with federal requirements prohibiting employment or contracts with individuals excluded from participation under either Medicare or Medicaid
- Compliance with state, federal and local requirements for handicap access as well as the standards required by the 1992 Federal American Disabilities Act
- Correctness and completeness of application

Supporting Documentation
The following items may be requested in support of the application, as applicable:

- Copy of valid, current licensure issued by the State of California
- Copy of valid, current accreditation certificate. If not accredited, copy of DHCS or CMS site review
- Copy of valid, current professional and general liability insurance face sheet that includes coverage limits and expiration date
- Copy of Medicare Certification (if applicable)

10 Recredentialing Procedure

A tickler file in the form of a checklist, spreadsheet or computer-generated report alerts Credentialing staff of HDO due for recredentialing. One hundred eighty (180) days prior to expiration of the three-year (36-month) cycle, the practitioner is sent to a recredentialing application. The 36-month cycle begins with the date of the initial credentialing decision and is counted to the month, not the day.

If the application is not returned within thirty (30) days, HDO will be contacted by a Credentialing staff member to verify receipt of the application and request that the application is returned within fifteen (15) days. If the application is not returned within fifteen (15) days, Administration will be requested to assist in obtaining the recredentialing application. If the recredentialing application is not returned ninety (90) days prior to the expiration of the three-year (36-month) cycle, HDO will be notified via certified mail of intent to terminate.

Upon receipt of an application by the Credentialing Department, the recredentialing application will be reviewed for completeness. The signed attestation by the applicant should be no more than

30 days old to allow for adequate processing time. Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable. An incomplete recredentialing application will be returned to the applicant.

10.1 Verification

- State Licensure (PSV not required)
- NPI (Verification Time Limit - 180 calendar days, PSV)
- Accreditation & Onsite Quality Assessment (PSV not required)
- Professional and General Liability Insurance (PSV not required)
- Medicare Certification (If applicable, PSV not required)
- Medi-Cal Suspended and Ineligible List (Verification Time Limit - 120 calendar days, PSV)
- Medi-Cal Participation/Enrollment (Verification Time Limit - 120 calendar days, PSV)
- Office of Inspector General (OIG) (Verification Time Limit - 120 calendar days, PSV)
- System for Award Management (SAM) (Verification Time Limit - 120 calendar days, PSV)
- CMS Preclusion List (Verification Time Limit - 120 calendar days, PSV)

10.2 Performance Monitoring

Information derived from the practice experience of all HDOs is incorporated into the recredentialing process and reviewed by the Credentialing Committee. At a minimum, confidential member complaint data, information from quality improvement activities, utilization management performance data, and member satisfaction data will be used to assess professional performance, judgment and clinical competence and will be used in the recredentialing decision process.

11 Credentialing Committee Review and Action

Completed HDO credentialing files are presented to the Credentialing Committee for review within 180 days in which the data gathered was verified. Possible action by the Committee includes approval, denial, and recommendation for improvement, monitoring, disciplinary action, or request for further information.

A Medical Director designated by the Credentialing Committee has the authority to review and sign off on all clean files which have met HPN's credentialing or recredentialing criteria. The date the file is signed by the Medical Director is the date that will be considered the "Committee Review Date". These files do not have to be reviewed by the Credentialing Committee to be approved.

12 Communication of Committee Action

The HDO is notified of the Credentialing Committee decision in writing. A copy of the letter will

be kept in the HDO credentialing file. Documentation of adverse decisions will be kept in the file.

Chapter III Corrective Action Plan

1 Purpose

To provide a fair and efficient means to identify, investigate, and resolve problems arising from the conduct of a practitioner who falls within the Scope of Authorization and Action that may adversely affect patient care or the operations of Heritage Provider Network, Inc., PMG/IPA (referred to herein as "HPN")

2 Scope of Authorization and Action

Practitioners covered under the Corrective Action Plan include MDs, DOs, DDSs, DPMs, DCs, NPs and PAs who care for HPNs' patients. Allied health practitioners and non-physician behavioral health practitioners are not entitled to either information review or hearing rights pursuant to the Corrective Action Plan.

3 Policy

An investigation or corrective action may be requested when a practitioner engages in or exhibits acts, statements, demeanor, or professional conduct, either within or outside of the workplace, reasonably likely to be detrimental to patient safety or the delivery of quality patient care and reasonably likely to result in the imposition of sanctions by any governmental authority (local, state or federal).

4 Delegation of Decision-Making Authority

The Heritage Provider Network Executive Committee delegates decision-making authority to the Credentialing Committee of the HPN. The PMG/IPA Credentialing Committee sub-delegates the corrective action procedure to the Peer Review Committee/Quality Improvement Committee.

5 Annual Review

The HPN Quality Improvement Committee will annually review, revise as necessary, and approve the Corrective Action Plan.

6 Corrective Action Procedure

6.1 Initiation

A proposed investigation or corrective action will be initiated by HPN on its own initiative or by a written request, which identifies the specific activities or conduct that are alleged to constitute grounds for proposing an investigation or corrective action.

6.2 Preliminary Review

Prior to investigation, HPN may, but is not obligated to conduct a preliminary review of any allegation made in support of a request for an investigation or corrective action.

6.3 Practitioner Interview

The practitioner, although not required, may be granted an interview. If any interview is granted, the practitioner will be informed of the general circumstances and may present any relevant information. Discussions and findings resulting from the interview will be documented. Interviews will not be constituted or deemed an "investigation" or "hearing". Following the interview, HPN may choose to proceed with the investigative process.

6.4 Investigation

The Medical Director will identify members to participate in a committee or ad hoc committee to investigate the alleged issue or problem. The Chairperson of the assigned committee will prepare a written report as soon as feasible. No investigative process will be constituted or deemed a "hearing", as described in the Judicial Review Hearing Plan. The investigative process may be terminated at any time to proceed with action as described in Section 6.5.

6.5 Action

At the conclusion of the investigative process, but not more than sixty (60) days after receipt of the proposed investigation or corrective action, unless deferred pursuant to this policy, such action may include, without limitation, the following:

- No corrective action
- Rejection or modification of the proposed corrective action
- Letter of admonition, reprimand, or warning
- Terms of probation or individual requirements of consultation
- Limitation of privileges
- Suspension of privileges until completion of specific conditions or requirements
- Revocation of privileges
- Other action appropriate to the facts which prompted the investigation

Nothing set forth herein shall prohibit HPN from implementing summary suspension at any time, in the exercise of its discretion.

6.6 Deferral of Action

If additional time is needed to complete the investigation process, the action may be deferred. Action must be taken within the deferred time specified, or if no time specified, within thirty (30) days of the deferral.

6.7 Procedural Rights

Any action that constitutes grounds for a hearing will entitle the practitioner to procedural rights as provided in the Judicial Review Hearing Plan. When this is the case, the practitioner will be notified in writing of the adverse action and his/her rights to request a hearing.

7 Summary Suspension

7.1 Initiation

Whenever a practitioner's conduct requires immediate action to reduce a substantial likelihood of imminent impairment of health or safety of any patient, prospective patient, employee, or other person, the Medical Director and at least two (2) other voting Credentialing Committee members shall have the authority to summarily suspend all or any portion of the practitioner's privileges.

Such summary suspension becomes effective immediately upon imposition, and the person responsible will promptly give verbal or written notice of the suspension to the practitioner. The notice of suspension will constitute a request for corrective action and the Corrective Action Procedure will be followed. Any patients whose treatment by the practitioner is terminated by the summary suspension will be assigned to another practitioner to be determined by the Medical Director.

7.2 Procedural Rights

Unless the summary suspension is terminated, it will remain in effect during the pendency and completion of the corrective action process of the hearing process. The practitioner will not be entitled to procedural rights as provided in the Judicial Review Hearing Plan until final action, and then only if the final action taken constitutes grounds for a hearing as set forth in the Judicial Review Hearing Plan.

8 Automatic Suspension

8.1 Professional Licensure

Revocation or Expiration: Automatic and immediate termination of privileges will occur upon revocation or expiration of a practitioner's license by a licensing authority, which will remain in effective for at least the term of revocation or expiration.

Restriction: Automatic and immediate limitations and restrictions will be placed upon a practitioner's privileges within the scope of limitations or restrictions by a licensing authority, which will remain in effect for at least the term of revocation or expiration.

Suspension: Automatic and immediate suspension of privileges will occur upon suspension of a practitioner's licensure by a licensing authority, which will remain in effect for at least the term of suspension.

Probation: A practitioner's privileges will be modified, as necessary, to comply with the terms and conditions of probation by a licensing authority. Modifications will remain in effective at least for the term of probation.

8.2 Drug Enforcement Administration Certificate

Revocation or Expiration: Automatic and immediate revocation of a practitioner's right to prescribe medication will occur upon revocation of a practitioner's DEA certification, which will remain in effective for at least the term of revocation or expiration.

Restriction: Automatic and immediate suspension of a practitioner's right to prescribe medication will occur upon suspension of a practitioner's DEA certificate, which will remain in effect at least for the term of suspension.

Probation: A practitioner's right to prescribe medications covered by the DEA certification will be modified as necessary, to comply with the terms and conditions of probation. Modifications will remain in effective at least for the term of probation.

8.3 Failure to Satisfy Special Appearance Requirements

A practitioner who fails, without good cause, to appear at and to satisfy the requirements of a special appearance of which that practitioner had notice will automatically be suspended from exercising all, or such portion of his/her privileges as may be suspended, until he/she appears and satisfies the requirement of that special appearance.

8.4 Further Investigation and Action

As soon as possible after automatic suspension, consideration of facts surrounding the automatic suspension will be reviewed and considered, which could initiate an investigation and/or further corrective action.

8.5 Procedural Rights

The practitioner will not be entitled to hearing rights until further action, if any, and then only if that further action constitutes grounds for a hearing as provided in the Judicial Review Hearing Plan.

9 Reinstatement of Privileges

A practitioner who has been subject to suspension or restriction will not, by the passage of time, or the curing of the event which gave rise to the automatic suspension, be automatically reinstated to his/her status and/or privileges. Instead, the practitioner must submit a written request for reinstatement along with a completed application. The practitioner will assume the burden of producing clear and convincing evidence of his/her qualifications.

10 Reporting Requirements

Any report will be filed in accordance with Division 2, Article II, Section 800 of the California Business and Professions Code by the HPN Groups Risk Management or Quality Improvement department when there are adverse decisions resulting from the peer review process. The practitioner will be advised of the report and its contents. All reports made shall be deemed

confidential. Reports will be made in writing to following entities (See Attachments E-H):

10.1 Medical Board of California

Denied Privileges: A practitioner's application is denied or rejected for medical disciplinary cause or reason.

Timeframe:An 805 and 805.01 reports will be filed within fifteen (15) days after conclusion of all proceedings.

Termination or Revoked Privileges: A practitioner's status is terminated or revoked for medical disciplinary cause or reason, fraud, or in the case of imminent harm to the member.

Timeframe:An 805 and 805.01 reports will be filed within fifteen (15) days after conclusion of all proceedings.

Restrictions on Privileges: Restriction on privileges are imposed, or voluntarily accepted for a cumulative total of thirty (30) days or more for any 12-month period for a medical disciplinary cause or reason.

Timeframe:An 805 and 805.01 reports will be filed within fifteen (15) days after conclusion of all proceedings.

Resignation or Leave of Absence: The practitioner resigns or takes a leave of absence following notice of an impending investigation based on information indicating a medical disciplinary cause or reason.

Timeframe:An 805 and 805.01 reports will be filed within fifteen (15) days after the effective date.

Summary Suspension: A summary suspension remains in effect in excess of fourteen (14) days.

Timeframe:An 805 and 805.01 reports will be filed within fifteen (15) days following the imposition of summary suspension, if the summary suspension remains in effect for a period in excess of fourteen (14) days.

Accusation of Misconduct: A physician or other healing arts licensee who is accused by a patient, in writing, of sexual abuse or sexual misconduct. Sexual misconduct is defined as "inappropriate contact or communication of a sexual nature."

Timeframe: An 805.8 report will be filed within fifteen (15) days of receipt of a written accusation to the appropriate state licensing agency. No hearing rights will be afforded prior to filing this report. A follow-up report may be filed when the investigation is completed.

Supplement Report: A supplemental report will be made within thirty (30) days following the

date the practitioner is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action.

Diversion Report: A report will be filed with the Diversion Program of the MBOC when formal investigation of a practitioner's ability to practice safely due to a disabling mental or physical condition may pose a threat to patient care.

Timeframe: A diversion report will be filed within fifteen (15) days of initiating the formal investigation. No hearing rights will be afforded prior to filing this report. A follow-up report will be filed when the investigation is completed.

10.2 805.01 Reporting Requirement

The Medical Board of California (MBOC) requires the 805.01 form 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:

a. 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.
b. 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.
c. 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
d. Sexual misconduct with one or more patients during a course of treatment or an examination.

These 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 and MBOC within 15 days after the peer review body makes the recommendation or final decision. Another change with this law is that the practitioner can submit the reports and file electronically, but it will made public for those who request it.

10.3 805.8 Reporting Requirements

California law requires any entity that makes any arrangement under which a healing arts licensee is allowed to practice or provide care for patients shall file a report of any allegation of sexual abuse or sexual misconduct made against a healing arts licensee by a patient, if the patient or the

patient's representative makes the allegation in writing, to the agency within 15 days of receiving the written allegation of sexual abuse or sexual misconduct. An oral accusation is insufficient to cause a report to be filed.

A report will be filed with the appropriate state licensing agency. The report will be kept confidential and shall not be subject to discovery, except as required by legal statute. No employee or individual contracted or subcontracted to provide health care services, a health care facility, or other entity shall not incur any civil or criminal liability as a result of making a report required by this section.

10.4 National Practitioner Data Bank

Professional Competence or Conduct: An action based on a practitioner's professional competence or conduct that adversely affects or could affect the health or welfare of a patient and remains in effect for more than thirty (30) days.

Timeframe: A NPDB report will be filed within fifteen (15) days from the date the adverse action was imposed.

Surrender or Restriction of Authority While Under Investigation: Acceptance of the practitioner's surrender or restriction of authority to provide care to patients while under investigation for possible professional incompetence, improper professional conduct, or in return for not conducting an investigation or professional review action.

Timeframe: A NPDB report will be filed within fifteen (15) days from the date the adverse action was imposed or authority to provide care to patients is voluntarily surrendered.

Supplemental Report: If necessary, a report will be filed to make revisions to a previously reported adverse action.

11 Health Plan Notification

Health Plans will be notified of final adverse actions.
Timeframe: Within fifteen (15) days of the final adverse action.

Chapter IV Judicial Review and Appeals Rights Process

1 General

Heritage Provider Network, Inc., (referred to herein as "HPN") may grant or deny Professional Services Agreement to any practitioner with or without cause. HPN may also terminate, suspend, or limit any such Agreement with or without cause, subject only to the specific terms of such Agreement. When HPN denies, suspends, limits, or terminates an Agreement without cause, the affected practitioner will not be entitled to any hearing or review under this Judicial Review Hearing Plan.

For the purpose of this Judicial Review Hearing Plan, the term "medical disciplinary cause or reason" will refer to an aspect of a practitioner's competence or professional conduct, which is reasonably likely to be detrimental to patient safety or to the delivery of patient care. The term "staff privileges" will refer to any arrangement under which a practitioner is allowed to practice or provide care for patients in a health facility.

2 Purpose

To provide intra-professional resolution of matters bearing on professional conduct or competency of any practitioner defined by the Scope of Authorization and Action.

3 Scope of Authorization and Action

Practitioners covered under the Judicial Review Hearing ("Plan") include MDs, DOs, DDSs, DPMs, and DCs. Allied health practitioners and non-physician behavioral health practitioners are not entitled to either information review or hearing rights pursuant to the Judicial Review Hearing Plan.

4 Policy

Where HPN concludes in writing that its decision to deny, suspend, limit, or terminate any Professional Services Agreement is based on a medical disciplinary cause or reason, the affected practitioner will be entitled to request a hearing (appeal) under this Judicial Review Hearing Plan.

5 Delegation of Decision-Making Authority

The Heritage Provider Network Executive Committee delegates decision-making authority to the Credentialing Committee of the Heritage Provider Network PMG/IPAs. The Credentialing Committee sub-delegates the judicial review hearing procedure to the Peer Review Committee/Quality Improvement Committee.

6 Annual Review

The HPN Credentialing Committee will annually review, revise as necessary, and approve the

Judicial Review Hearing Plan.

7 Grounds for a Hearing

Any one or more of the following actions or recommended actions will constitute grounds for a formal hearing:

- A practitioner's application for staff privileges is denied or rejected for a medical disciplinary cause or reason.
- A practitioner's staff privileges are revoked, terminated, or not renewed for a medical disciplinary cause or reason.
- Restrictions are imposed on staff privileges for a cumulative total of thirty (30) days or more in any 12-month period for a medical disciplinary cause or reason.
- The imposition of summary suspension of staff privileges for a medical disciplinary cause or reason if the summary suspension stays in effect for a period in excess of fourteen (14) days.

8 Hearing Procedure

8.1 Notice of Action or Proposed Action

Whenever there are grounds for a hearing, and such action or proposed action is specifically stated to be for a medical disciplinary cause or reason, the practitioner will be given written notice of the proposed action and of the practitioner's right to request a hearing under the Judicial Review Hearing Plan. (Appeal Rights)

The notice will include:

- Written notification indicating that a professional review action has been brought against the practitioner, including reasons for the action, and a summary of the appeal rights and process via a copy of the Judicial Review Hearing Plan. This written notification may be a certified letter to a provider.
- That the action, if adopted, must be reported to the Medical Board of California under the Business and Professions Code, Sections 805 or 805.01, and/or the National Practitioner Data Bank under 45 Code of Federal Regulations, Part 60.
- The practitioner has the right to appeal the action and request a hearing.
- That the practitioner must request the hearing within thirty (30) days of receipt of the notice and the request must be in writing to the HPN Medical Director.
- That the practitioner may be represented by an attorney or another person of the practitioner’s choice.
- That a Hearing Officer or a panel of individuals will be appointed by the HPN GROUPS to review the appeal.
- That the practitioner will be provided written notification of the appeal decision that contains the specific reasons for the decision.
- That the decision of the Judicial Hearing Committee may be more or less stringent and/or

restrictive than the proposed corrective action.

- That both the action and decision must be reported to the Medical Board of California under the Business and Professions Code, Sections 805 or 805.01, and the National Practitioner Data Bank under 45 Code of Federal Regulations, Part 60 and the health plans.

8.2 Practitioner Right To Appeal & Request For a Hearing

There is an appeals process for instances in which HPN chooses to alter the conditions of the practitioner's participation based on issues of quality of care and/or service. The practitioner will be provided their appeal rights (via letter, email, fax, or portal) and s/he has thirty (30) days following the date of receipt of a notice of an adverse action to submit a written request for a hearing to the Medical Director of HPN. If the practitioner does not request a hearing within the timeframe and in the manner described, the practitioner will be deemed to have accepted the recommendation, decision, or action involved and it may be adopted as the final action.

8.3 Time and Place

Upon receipt of the practitioner's written request for a hearing, HPN will promptly schedule and arrange for the hearing. The practitioner will be notified of the time, place, and date of the hearing. The date of commencement of the hearing will not be less than thirty (30) days and not more than sixty (60) days from receipt of the request for the hearing.

8.4 Notice of Charges and Witnesses

A notice of the charge(s) will be sent to the practitioner, either along with the notice of the hearing or separately, specifying the acts or omissions with which the practitioner is being charged. This supplemental notice will provide a list of the patient records, if any, which are to be discussed at the hearing, only if the information has not been supplied previously.

Upon the request of either party, each party, at least ten (10) days prior to the hearing, will furnish to the other a written list of names and addresses of individuals, reasonably known or anticipated, who will give testimony or evidence in support of that party at the hearing. The witness list will be amended when additional witnesses are identified. A failure to comply with this requirement is good cause to postpone the hearing.

8.5 Judicial Hearing Committee

The Medical Director will appoint a Judicial Hearing Committee consisting of at least three (3) participating HPN practitioners who are eligible for voting rights on medical interpretation and peer review activities and have the requisite expertise to ensure an efficacious and fair hearing. The majority of members of the Hearing Panel will be peers of the affected physician. The Medical Director will chair the Judicial Hearing Committee and handle all pre-hearing matters. The hearing panel members will be impartial, will not have actively participated in the formal consideration of the matter at any previous level (i.e., acted as accuser, investigator, fact finder or initial decision-maker in the same manner), will not be in direct economic competition with the affected practitioner, and will stand to gain no direct financial benefit from the outcome of the hearing.

8.6 Hearing Officer

HPN will appoint a Hearing Officer to attend the hearing. The Hearing Officer will be an attorney at law, who is qualified to preside over a formal professional peer review hearing. He/she will not be bias for or against the practitioner, will gain no financial benefit from the outcome, and must not act as a prosecuting officer or an advocate for any party. The Hearing Officer may participate in deliberations and act as a legal advisor to the Judicial Hearing Committee but will not be entitled to vote.

8.7 Presiding Officer

The Presiding Officer at the hearing will be the Hearing Officer as described above. The Presiding Officer will act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence in an efficient and expeditious manner. The Presiding Officer will assure proper decorum is maintained, and if either party is not proceeding as described, the Presiding Officer may take such discretionary action as seems warranted by the circumstances. The Presiding Officer will be entitled to determine the order of or procedure for, presenting evidence and argument during the hearing and will have the discretion, in accordance with the Judicial Review Hearing Plan provisions, to do the following:

- Grant continuances.
- Rule on disputed discovery requests.
- Decide when evidence may or may not be introduced.
- Rule on challenges to hearing committee members.
- Rule on challenges to him /her serving as the Hearing Officer.
- Rule on questions raised prior to or during the hearing pertaining to matters of law, procedure, or the admissibility of evidence.
- Exercise discretion in formulating additional procedures not consistent with these hearing policies and procedures that are deemed reasonably necessary to affect an expeditious and efficient fair hearing.

8.8 Pre-Hearing Procedure

It will be the duty of HPN and the affected practitioner to exercise reasonable diligence in notifying the Presiding Officer of any pending or anticipated procedural irregularity as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters can be made expeditiously. Objection to any such pre-hearing decisions shall be raised at the hearing, and when so raised, reflected on the record.

8.9 Discovery

Rights of Discovery and Copying - The affected practitioner may inspect and copy (at his/her own expense) any documentary information relevant to the charges that HPN has in its possession or under its control. HPN or its representative may inspect and copy (at its expense) any documentary information relevant to the charges that the affected practitioner has in his/her

possession or under his/her control. The right of inspection and copying does not create or imply an obligation to modify or create documents in order to satisfy a request for information. Requests for discovery must be fulfilled as soon as practicable. Failure to comply with reasonable discovery requests at least thirty (30) days prior to the hearing will be good cause for a continuance of the hearing.

Limits on Discovery - The Presiding Officer, upon the request of either side, may impose safeguards including, but not limited to, denial of discovery request on any of the following grounds:

- The information refers solely to individually identifiable practitioners other than the affected practitioner.
- The safeguard is warranted to protect peer review.
- The safeguard is warranted to protect justice.

Discovery Disputes - In ruling on discovery disputes, the factors that may be considered include:

- Whether the information sought may be introduced to support or defend the charges.
- Whether the information is "exculpatory" in that it would dispute or cause doubt upon the charges or "inculpatory" in that it would prove or help support the charges and/or recommendations.
- The burden on the party of producing the requested information.
- What other discovery requests the party has previously made.

8.10 Pre-Hearing Document Exchange

At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents will be made available at least thirty (30) days prior to the hearing. Failure to comply with this rule is good cause for the Presiding Officer to grant a continuance. Repeated failure to comply is good cause for the Presiding Officer to limit introduction of any documents not provided to the other side in a timely manner.

8.11 Representation

Both HPN and the practitioner have the right to be represented by an attorney or other representative; however, in no case may an attorney represent HPN if the practitioner is not otherwise represented. The foregoing will not deprive either party of their right to legal counsel for the purpose of preparing for the hearing.

8.12 Failure to Appear

Failure without good cause of a practitioner to appear and proceed at the hearing will be deemed to constitute voluntary acceptance of the recommendation or action involved, and it will become the final action of HPN.

8.13 Postponements and Extensions

Postponements and extensions of time beyond the times expressly permitted in the Judicial Review Hearing Plan may be requested by any affected person and will be permitted by the Presiding Officer on a showing of good cause. The presiding Officer will ensure that hearing proceedings are conducted in a reasonably expeditious manner under the circumstances.

8.14 Record of the Hearing

The Judicial Hearing Committee will maintain a record of the hearing by using a Certified Transcription Reporter to record the hearing or tape record the proceedings. The practitioner will be entitled to receive a copy of the transcript or recording upon paying reasonable costs for preparing the record. The Presiding Officer may, but is not required to, order that oral evidence be taken only on an oath administered by a person entitled to notarize documents in the State of California or by affirmation under penalty of perjury to the Presiding Officer that the testimony that he/she is about to give is true and correct.

8.15 Rights of Parties

Both parties have the following hearing rights to:

- Ask the Judicial Hearing Committee members and/or the Presiding Officer questions that are directly related to determining whether they meet the qualifications set forth in this Judicial Review Hearing Plan and to challenge such members or the Presiding Officer.

- Call and examine witnesses.
- Introduce relevant documents and other evidence.
- Receive all information made available to the Judicial Hearing Committee.
- Cross-examine or otherwise attempt to impeach any witness who testified orally or on any matter relevant to the issues.
- Rebut any evidence.
- Submit a written statement at the close of the hearing, which the Judicial Hearing Committee may request be filed following the conclusion of the presentation of oral testimony.

Additional Hearing Rights:

- The practitioner may be called by HPN and examined, as if under cross-examination.
- The Judicial Hearing Committee may interrogate witnesses or call additional witnesses if deemed appropriate.

8.16 Rules of Evidence

Rules of law relating to the examination of witnesses and presentation of evidence in courts of law will not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, will be admitted by the Presiding Officer if it is the sort of evidence that responsible persons are

accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

If the charges and recommendations are actions imposed by the Credentialing Committee as a result of a decision based on the initial credentialing process or recredentialing process, HPN may object to the introduction of any evidence that was requested of an applicant, but not provided, during the applicable process. The Presiding Officer will sustain such objections unless the applicant can prove that the information could not have been produced previously in the exercise of reasonable diligence.

9 Basis of Decision

The decision of the Judicial Hearing Committee will be based on the evidence produced at the hearing and any written statements submitted to the Judicial Hearing Committee. If the Judicial Hearing Committee should find the charges to be true, it will recommend such form of discipline as it finds warranted. The recommended discipline may confirm or be more or less harsh and/or restrictive than that recommended by HPN.

10 Burden of Going Forward and Burden of Proof

Initial Burden – In all cases, HPN will have the burden of initially presenting evidence to support the charges and its recommendation. Thereafter, the burden differs; depending upon whether the practitioner is applying for a Professional Services Agreement or already has a Professional Services Agreement.

Denial of Initial Agreement – At any hearing involving denial of an initial Professional Services Agreement, the practitioner has the burden of proving by a preponderance of the evidence (i.e., more likely than not) that he/she is qualified for an Agreement in accordance with the eligibility standards of HPN. The practitioner must produce information that allows for an adequate evaluation and resolution of any reasonable doubts concerning his/her current qualifications, subject to HPN's right to object to the production of certain evidence pursuant to the Rules of Evidence listed above.

Termination of Agreement or Suspension, Reduction or Limitation of Privileges – In all other cases involving a practitioner who already has a Professional Service Agreement, HPN will have the burden of proving by a preponderance of evidence that the action or recommendation 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 Judicial Hearing Committee.

11 Adjournment and Conclusion

The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. The hearing will be conducted within a reasonable amount of time. The Presiding Officer may set guidelines for introduction of evidence to achieve a timely

conclusion. Upon conclusion of the presentation of oral and written evidence and argument, the hearing will be closed. The Judicial Hearing Committee will thereupon, outside of the presence of the parties, conduct its deliberations and render a decision and an accompanying report. Final adjournment will not occur until the Judicial Hearing Committee has completed its deliberations.

12 Decision

The Judicial Hearing Committee will render a decision within thirty (30) days of the final adjournment of the hearing. A written report that contains findings of facts and conclusions that articulate the connection between the evidence produced at the hearing and the decision rendered will accompany the decision. The report will include sufficient detail to enable the affected practitioner and HPN to determine the basis for the decision of the Judicial Hearing Committee on each matter contained in the Notice of Charges. The decision and report will be delivered to the affected practitioner and HPN within 15 days of the committee decision. The decision of the Judicial Hearing Committee is the final decision.

13 Reporting

All required reports will be filed in accordance with Division 2, Article II, Section 800 of the California Business and Professions Code when there are adverse decisions resulting from the peer review process.

14 Privileges and Immunities

All activities conducted pursuant to this Judicial Review Hearing Plan are in reliance on the privileges and immunities afforded by the Federal Health Care Quality Improvement Act and applicable laws in the State of California.

Chapter V Attachments

A. **Types of Practitioners Credentialed**

B. **HPN Group Shared Credentialing**

C. **Nurse Practitioners without Standardized Procedures**

D. **Provider Site Quality Audit Tool for Complaints**

E. **Section 802.01: Physician Criminal Actions Reporting Form**

F. **Section 805: Physician Disciplinary Actions Reporting Form**

G. **Section 805.01: Physician Incompetence and Misconduct Reporting Form**

H. **Section 805.8: Facility Sexual Abuse and Misconduct Reporting Form**

I. **Ongoing Monitoring Verification Sources**

ATTACHMENT A: Types Of Practitioners Credentialed

1 Practitioners within the scope of credentialing

- Practitioners who are licensed, certified, or registered by the state to practice independently
- Practitioners who have an independent relationship with the organization.
- Practitioners in individual or group practices, facilities, telemedicine, and rental networks that are part of the primary network and the organization has members who reside in the rental network area.

2 Medical Practitioners

- Medical doctors
- Oral surgeons
- Chiropractors
- Osteopaths
- Podiatrists
- Nurse practitioners
- Other medical practitioners who may be within the scope of credentialing (e.g., certified nurse midwife)

3 Behavioral Health Practitioners

- Psychiatrists and other physicians.
- Addiction medicine specialists.
- Doctoral or master's-level psychologists.
- Master's-level clinical social workers.
- Master's-level clinical nurse specialists or psychiatric nurse practitioners.
- Other behavioral healthcare specialists who may be within the scope of credentialing (e.g., licensed professional counselor).

ATTACHMENT B: HPN Group Shared Credentialing

1 Shared Credentialed Practitioners

- Heritage Provider Network (HPN) is accredited by the National Committee for Quality Assurance (NCQA) for Credentialing and has recognized HPN affiliated medical groups as sister organizations because the groups are wholly owned by HPN. NCQA allows such entities to share practitioner credentialing with the following understanding:
- Each medical group has it's own credentialing committee.
- The primary medical group fully credentials the practitioner and takes them to committee for approval.
- The secondary medical group is not required to credential practitioners they wish to share but must take shared practitioners to their credentialing committee.
- The secondary group may share the primary groups approval dates for any shared practitioners.
- The secondary group is not required to contract with shared practitioners.

ATTACHMENT C: Nurse Practitioners w/o Standardized Procedures

California Assembly Bill 890 permits Nurse Practitioners (NPs) to practice independently after finishing a transitional oversight period. The law creates two new categories of NPs to function independently; however, NPs may continue their current arrangements if they do not meet the qualifications of those two categories or choose not to pursue independent practice.

1 Independent Nurse Practitioners under CA BPC 2837.103

- Eligibility to practice, under a defined scope of practice, without standardized procedures If they work in following requirements:
  - The NP education was consistent with already existing BRN regulations.
  - The NP has passed a supplemental examination developed by the Dept of Consumer Affairs Office of Professional Examination Services (OPES), if applicable.
  - The NP has passed a national NP board certification examination.
  - The NP has completed a transition to practice (TTP) in California of a minimum of three full-time equivalent years of practice or 4600 hours
  - The NP works in any of the following that has one or more physicians: A clinic, A health facility, A medical group practice, A home health agency, or A hospice facility.

2 Independent Nurse Practitioners under CA BPC 2837.104

- Eligibility to practice independently without standardized procedures in settings outside those listed in CA BPC 2837.103, if they meet the following criteria
  - The NP must meet all of the same requirements as the CA BPC 2837.103, including national certification, OPES exam (if applicable), BRN-approved NP education, and TTP.
  - The NP holds a valid and active RN license AND a master's degree in nursing or other clinical field related to nursing or a doctoral degree in nursing.
  - The NP has practiced as an NP in good standing for at least three years, not inclusive of the TTP.
  - An NP can open up their own practice/business pursuant to already existing laws such as, but not limited to, a nursing corporation.

3 Nurse Practitioners that do not meet the requirements under CA BPC 2837.104 or 2837.104.

- NPs who do not meet the qualifications CA BPC 2837.104 or 2837.104 or choose not to pursue independent NP practice may continue to practice under supervision with standardized procedures.

ATTACHMENT D: Office Site Quality Audit Tool for Complaints

Organizational Provider/ Facility Site Review Tool & Corrective Action Plan					Survey Date:	DD/MM/YYY
Type of Organizational Provider/HDO					**Reviewer Information**	
(Type of Facility)	**Total Number of on-site staff =**				**Reviewer Name:**	
Name of Facility:	Physician(s)		NP(s)		(Reviewer Name here)	
(Name of facility here)	RN(s)		PA(s)		**Reviewer's Organization Name:**	
Address, City, ST, ZIP:	LVN(s)		RD(s)		(Organization Name here)	
(Address here)	Clerical (s)		LCSW/SW(s)		**Reviewer Phone:**	
Phone:	Other:				(Reviewer phone here)	
(Phone number here)	**Site Visit Purpose**				**Reviewer Email:**	
Fax Number:		**Credentialing/Recredentialing Assessment (Mark X if applicable)**			(Reviewer email here)	
(Fax number here)		**Complaint Review (Mark X if applicable)**				
Administrator Name:		**CAP Follow-up 1 (Date of this Follow-up)**			**Corrective Action Plan**	
(Admin name here)		**CAP Follow-up 2 (Date of this Follow-up)**			**Scores below [enter % per your organizations policy] require a CAP.**	
Nursing Director Name:						
(Nursing Director name here)		**Other:**			**[Optional may define other CAP requirements here] Critical element deficiency requires CAP regardless of score.**	
Medical Director Name:						
(Medical Director name here)						

Assessment Summary						CAP INFORMATION	
		Points Earned	Actual Available Points*	Possible Available Points*		Next Follow-up Date:	
A.	Administrative Services	0	0	4		Next Follow-up Date:	
B.	Policies & Procedures	0	0	10		CAP Closure Date:	
C.	Personnel	0	0	4		In-person visit	
D.	Environment	0	0	9		Documentation Req'd	
E.	Environment - Emergency Plan	0	0	7	*Deduct total "N/A" from Available and overtype.	Telephone follow-up	
F.	Infection Control	0	0	11		Facility Score	
G.	QAPI	0	0	5		Total Points Earned:	0
H.	QAPI - Documents	0	0	5		Total Points Available:*	0
I.	Medical Records	0	0	6		Total Score :	#DIV/0!

Name of Facility:	Date of Survey:			Facility Audit Tool
(Name of facility here)	DD/MM/YYY			
A. Administrative Services	**YES**	**NO**	**N/A**	**COMMENTS**
1. Facility has local, state License/Certification as needed. Information is appropriately posted.				
2. There is an established organizational structure with defined functions and responsibilities. (This may be an organizational chart or other document)				
3. The OP clearly identified contracted services and temporary staff.				
4. There is access to interpreter services for patients with limited English proficiency and those with hearing impairments.				

B. Policies & Procedures	YES	NO	N/A	COMMENTS
1. Medical Record keeping				
2. Infection Control				
· Qualified Infection Control Professional				
· Vaccinations encouraged and monitored				
· Personal Protective Equipment				
· Hazardous waste				
3. Equipment Maintenance				
4. Emergency Procedures				
5. Patient Rights: The patients' rights are protected according to the regulations appropriate for the facility. This may include the right to give informed consent (in the appropriate language) ; the right to privacy and the privacy of personally identifiable healthcare information; and the right to report grievances , abuse or neglect.				
6. There is a policy & procedure regarding licensure & credentialing and privileging of staff.				
7. There is evidence that the policies & procedures have been reviewed, revised, and approved. periodically				

C. Personnel	YES	NO	N/A	COMMENTS
1. Physician(s) and other LIP(s) are credentialed and privileged according to policy and procedures.				
2. RN/ LVN have License, Training, and Education on file.				
3. There is evidence that agency/contracted staff are appropriately reviewed.				

Name of Facility:	Date of Survey:			Facility Audit Tool
(Name of facility here)	DD/MM/YYY			
4. There is documentation of staff education and training.				
D. Environment	**YES**	**NO**	**N/A**	**COMMENTS**
1. There are accessible exits which are clearly marked and emergency evacuation routes are posted.				
2. There is evidence of sufficient fire protection equipment (smoke detectors, fire extinguishers, fire blankets, etc.) and a record of fire drills.				
3. Medical equipment is clean, in good working condition and inspected according to policy and procedures to assure safety.				
4. There is sufficient handicap parking, access and accommodations within the building.				
5. Bio hazard waste is handled appropriately and there is a contract for its regular disposal.				
6. The facility is clean and the waiting area is of sufficient size to accommodate patients comfortably and to assure privacy during registration.				
7. Life Safety Code waivers (if any) no not adversely affect the operation of the facility.				
8. OP with special requirements (such as Dialysis Centers and Ambulatory surgical centers) follow established guidelines.				
9. Medication refrigerator temperature trending logs are correct and complete per policy and procedure.				

E. Environment - Emergency Plan	YES	NO	N/A	COMMENTS
1. The facility has a health care emergency plan in which staff have received training.				
2. If part of the plan, a readily accessible Crash Cart is on site that contains at least the following:				
a. Defibrillator, or AED.				
b. Suction				
c. Airway Management Devices (airways, oxygen masks/cannulas, ambu bag)				
d. Medications (per Medical Emergencies Policy)				
3. Emergency phone numbers posted at nurse's station are current.				
4. Staff with Advance Life Support (ALS) and/or Basic Life Support (BLS) are identified and their certification is current				

F. Infection Control Practices	YES	NO	N/A	COMMENTS
1. Does the facility have an infection control program based on established Policies and Procedures.				
2. Does the Infection Control program follow recognized guidelines.				

Name of Facility:	Date of Survey:			Facility Audit Tool
(Name of facility here)	DD/MM/YYY			
3. Does the facility have a licensed professional qualified to direct the program.				
4. Does the facility have a system to encourage vaccinations and prevent the spread of infections.				
5. Do staff members receive IC training.				
6. Do staff perform good hand hygiene.				
7. Do staff use good injection practices(injectable medication, saline, and other infusates)				
8. Environmental cleaning is appropriate and staff receive training				
9. Point of care devices used and cleaned appropriately.				
10. Proper use of Personal Protective Equipment observed (gloves, gowns, masks, etc.)				
11. Infection Control information is reviewed as part of Quality Assurance Performance Improvement.				

G. Quality Assurance Performance Improvement (QAPI)	YES	NO	N/A	COMMENTS
1. Is there a QAPI committee which meets regularly and keeps minutes				
2. The QAPI committee reviewed performance standards for medical records, infection control, environment, personnel and other areas of concern.				
3. The QAPI identified concerns, initiated corrective actions plans, monitored the results of the plans, and made appropriate changes based on an analysis of the data.				
4. The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches, complaints and grievances) and takes appropriate actions.				
5. The QAPI committee has reviewed surveys, inspections, and reports submitted by outside agencies. Corrective action plans are available.				

H. QAPI Documentation Which Demonstrates Compliance	YES	NO	N/A	COMMENTS
1. Designated QA&PI coordinator.				
2. The QAPI committee reviewed performance standards for medical records, infection control, environment, personnel and other areas of concern.				
3. The QAPI identified concerns, initiated corrective action plans, monitored the results of the plans and made changes on based on an analysis of the data.				
4. The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches, complaints and grievances) and takes appropriate actions.				
5. The QAPI committee has reviewed surveys, inspections, and reports from outside agencies. They have copies of the corrective action plans.				

Name of Facility:	Date of Survey:			Facility Audit Tool
(Name of facility here)	DD/MM/YYY			
I. Medical Records Review	**YES**	**NO**	**N/A**	**COMMENTS**
1. The Policies and Procedures must reflect current practices, assure privacy, and include Electronic Medical Records if used. All entries in the medical record follow established policy and procedure.				
2. Admission data is complete, informed consents, H&P and notes are signed and dated.				
3. All known Allergies are noted in the record.				
4. The medical records are uniquely identified to safeguard patient privacy.				
5. Advanced directives and surrogate healthcare decision makers are noted in the record.				
6 . Policy and procedures allow prompt retrieval and long term storage of medical records for the time required by regulation.				

Additional Information	YES	NO	N/A	COMMENTS

Organizational Provider/ Facility Site Review Tool

Corrective Action Plan (CAP) Follow-Up

Name of Facility:	Date of Survey	Reviewer Name:	
(Name of facility here)	DD/MM/YYY	(Reviewer Name here)	
Deficiency # and Description	**Date of Comment**	**Comments**	**CAP Closed**

ATTACHMENT E: Section 802.1, Physician Criminal Actions

MEDICAL BOARD OF CALIFORNIA
Central Complaint Unit

PHYSICIAN REPORTING - CRIMINAL ACTIONS

Pursuant to Section 802.1 of the California Business and Professions Code
(see reverse for specific information)

REPORTING PHYSICIAN INFORMATION

Name: _____ Medical License No. _____
Address: _____ Phone No. _____
_____ Date of Birth _____

Defense Counsel: _____ Phone No. _____
Address: _____
_____
_____

INDICTMENT OR INFORMATION FILED CHARGING A FELONY

☐ Indictment ☐ Information Filed Date of Arrest _____ Court Case No. _____

Name/Address of Arresting Agency _____ Name/Address of Court _____
_____ _____
_____ _____

Charges (Code/Section/Description) _____
_____

CRIMINAL CONVICTIONS

☐ MISDEMEANOR ☐ FELONY
☐ JURY VERDICT ☐ PLEA (☐ NOLO CONTENDERE/NO CONTEST; ☐ GUILTY)

Name/Address of Court _____ Date of Conviction _____
_____ Court Case No. _____
_____

Violations (Code/Section/Description) _____
_____
_____

SENTENCING INFORMATION Sentencing Date _____

- ☐ Prison or Jail - Length/Time Frame _____
- ☐ Probation - Length/Time Frame _____
- ☐ Special Terms/Conditions _____
- ☐ Restitution - Amount _____
- ☐ Fines/Fees - Amount _____
- ☐ Community Service _____

Additional comments _____
_____

ENF-802.1(Revised 08/11)

Section 802.1 of the California Business and Professions Code states:

(a)(1) A physician and surgeon, osteopathic physician and surgeon, and a doctor of podiatric medicine shall report either of the following to the entity that issued his or her license:

(A) The bringing of an indictment or information charging a felony against the licensee.

(B) The conviction of the licensee, including any verdict of guilty, or plea of guilty or no contest, of any felony or misdemeanor.

(2) The report required by this subdivision shall be made in writing within 30 days of the date of the bringing of the indictment or information or of the conviction.

(b) Failure to make a report required by this section shall be a public offense punishable by a fine not to exceed five thousand dollars ($5,000).

ATTACHMENT F, Section 805, Physician Disciplinary Actions

MEDICAL BOARD OF CALIFORNIA
Central Complaint Unit

HEALTH FACILITY/PEER REVIEW REPORTING FORM
(Required by Section 805 of the California Business & Professions Code)

NOTE: Certain actions, with respect to staff privileges, membership or employment of physicians and podiatrists must be reported to the Medical Board of California when they are imposed or voluntarily accepted for a medical disciplinary cause or reason. Reports on osteopathic physicians, dentists and psychologists should be directed to their respective Boards. Please see the reverse/second page of this form for further information.

******PLEASE PRINT OR TYPE******

REPORTING ENTITY

Please check type of Reporting Entity: ☐ Health Care Facility or Clinic - §805(a)(1)(A) ☐ Health Care Service Plan - §805(a)(1)(B) ☐ Professional Society - §805(a)(1)(C) ☐ Medical Group or Employer - §805(a)(1)(D) ☐ Ambulatory Surgical Center - §805(a)(1)(A)	
Reporting Entity Name	Telephone #:
Chief Executive Officer/Medical Director/Administrator	Chief of Medical Staff
Name of person preparing report:	Telephone #
Street Address City	State Zip Code

LICENTIATE

Name (Last) (First) License # _____

Physician ☐ Podiatrist ☐

ACTION TAKEN

Date(s) of Action(s) and Duration (attached additional sheets if necessary)

Type(s) of Action(s) - Check all that apply. **CHECK HERE IF THIS IS A SUPPLEMENTAL REPORT** ☐

(a) For a medical disciplinary cause or reason:
- ____ Denial/rejection of application for staff privileges
- ____ Denial/rejection of application for membership
- ____ Termination or revocation of staff privileges
- ____ Termination or revocation of membership
- ____ Termination or revocation of employment

(b) For a cumulative total of 30 days or more for any 12 month period, and for a medical disciplinary cause or reason:
- ____ Restriction(s) imposed on staff privileges
- ____ Restriction(s) imposed on membership
- ____ Restriction(s) imposed on employment
- ____ Restriction(s) voluntarily accepted on staff privileges
- ____ Restriction(s) voluntarily accepted on membership
- ____ Restriction(s) voluntarily accepted on employment

If staff privileges were restricted, list specific restrictions imposed or voluntarily accepted:

(c) Following notice of an impending investigation based on information indicating medical disciplinary cause or reason:
- ____ Licentiate resigned from staff
- ____ Licentiate resigned from membership
- ____ Licentiate resigned from employment
- ____ Licentiate took leave of absence from staff
- ____ Licentiate took leave of absence from membership
- ____ Licentiate took leave of absence from employment

(d) For a summary suspension that remains in effect for a period in excess of 14 days for a medical disciplinary cause or reason:
- ____ Imposition of summary suspension on staff privileges
- ____ Imposition of summary suspension on employment
- ____ Imposition of summary suspension on membership

DESCRIPTION OF ACTION: Attach additional sheet(s) describing the facts and circumstances of the medical disciplinary cause or reason and any other relevant information related to the action taken, including, but not limited to, the number of cases reviewed, time frame covered, any patient deaths involved, any malpractice filings as a result of the physician's actions, any expert/peer opinions obtained, etc.

_____ _____
Signature Date
Chief Executive Officer/Medical Director/Administrator

_____ _____
Signature Date
Chief of Medical Staff

ENF-805 (Revised 01/12)

ADDITIONAL INFORMATION

To complete this form, for definition of terms, when, how, and who should report, please refer to Section 805 of the California Business and Professions Code. You may access this information via www.leginfo.ca.gov under California Law, Business and Professions Code.

PLEASE NOTE: Section 805(k) of the California Business and Professions Code states: "A willful failure to file an 805 report by any person who is designated or otherwise required by law to file an 805 report is punishable by a fine not to exceed one hundred thousand dollars ($100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, 'willful' means a voluntary and intentional violation of a known legal duty."

Section 805(l) of the California Business and Professions Code states: "Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that, under no circumstances shall exceed fifty thousand dollars ($50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code."

Section 805(m) of the California Business and Professions Code states: "A health care service plan registered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that negotiates and enters into a contract with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, when determining participation with the plan or insurer, shall evaluate, on a case-by-case basis, licentiates who are the subject of an 805 report, and not automatically exclude or deselect these licentiates."

CONFIDENTIALITY

This report is not a waiver of the confidentiality of medical records and committee reports. The contents of this report may be viewed only by those persons specified in Section 800(c) of the Business and Professions Code, except as required by Section 805.5 of the Business and Professions Code.

COPY TO LICENTIATE

A copy of the 805 report, with a cover letter informing the Licentiate of his or her right to submit additional statements or other information pursuant to Section 800(c) of the Business and Professions Code, must be sent by the reporting entity to the Licentiate.

SUPPLEMENTAL REPORT

A supplemental report must be made within thirty (30) days following the date the Licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as corrective action by the reporting entity.

805 Fact Sheet

- An 805 report is the mechanism in which peer review bodies, most commonly found in hospitals, are required to report specific information regarding physicians to the Medical Board. ***It is important to note that 805 reports are not public documents and are not available to consumers.***

- SB 700 (Negrete McLeod, Chapter 505, Statutes of 2010) requires the Medical Board to post an 805 fact sheet that explains and provides information on the 805 reporting requirements. More information on the requirements related to 805 reporting can be found in Business and Professions Code Section 805: http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=00001-01000&file=800-809.9

Who must file:

Any peer review body from:

- ✓ A health care facility or clinic licensed under Division 2 of the Health and Safety Code or a facility certified to participate in the federal Medicare Program as an ambulatory surgical center
- ✓ A health care service plan licensed under Chapter 2.2 of Division 2 of the Health and Safety Code or a disability insurer that contracts with licentiates
- ✓ A medical or podiatric professional society having as members at least 25% of the eligible licentiates in the area in which it functions, which is not organized for profit and which has been determined to be exempt from taxes
- ✓ A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of care provided by members or employees

The 805 report can be signed by:

- ✓ The chief of staff of a medical or professional staff
- ✓ Other chief executive officer
- ✓ Medical director, or administrator of any peer review body
- ✓ Chief executive officer or administrator of any licensed health care facility or clinic

What must be reported:

- ✓ Name of licensee (the physician)
- ✓ Physician's license number
- ✓ Description of the facts and circumstances of the medical disciplinary cause or reason and any other relevant information deemed appropriate by the reporter

When a report must be filed:

An 805 Report must be filed within 15 days from the date:

- ✓ A peer review body denies or rejects a licensee's applications for staff privileges or membership for a medical disciplinary cause or reason
- ✓ A licensee's staff privileges, membership, or employment are revoked for a medical disciplinary cause or reason
- ✓ Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a total of 30 days or more within any 12 month period for medical disciplinary reasons
- ✓ An 805 report must be filed if the resignation, leave of absence, withdrawal or abandonment of application or for renewal of privileges occurs after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason
- ✓ A summary suspension of staff privileges, membership, or employment is imposed for a period in excess of 14 days

Failure to File:

Intentional failure to report may result in a $100,000 fine.
Any failure to report may result in a $50,000 fine.

A blank 805 report form can be obtained at the following link:

http://www.mbc.ca.gov/forms/enf-805.pdf

ATTACHMENT G: Section 805.01, Incompetence & Misconduct

MEDICAL BOARD OF CALIFORNIA
Enforcement Program

HEALTH FACILITY/PEER REVIEW REPORTING FORM
(Required by Section 805.01 of the California Business & Professions Code)

NOTE: Certain actions, with respect to staff privileges, membership or employment of physicians and podiatrists must be reported to the Medical Board of California when they are imposed or voluntarily accepted for a medical disciplinary cause or reason.

REPORTING ENTITY

Please check type of Reporting Entity	☐ Health Care Facility or Clinic – §805(a)(1)(A)	☐ Health Care Service Plan - §805(a)(1)(B)
	☐ Professional Society - §805(a)(1)(c)	☐ Medical Group or Employer - §805(a)(1)(D)
	☐ Ambulatory Surgical Center - §805(a)(1)(A)	

Name	Telephone #:
Chief Executive Officer/Medical Director/Administrator	Chief of Medical Staff
Name of person preparing report:	Telephone #
Street address City	State Zip code

LICENTIATE

Name:	License #
☐ Physician	☐ Podiatrist

REASON FOR FORMAL INVESTIGATION

Reason for formal investigation that resulted in recommended action:	
☐	Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public.
☐	The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
☐	Repeated acts of clearly excessive prescribing, furnishing or administering 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 medical reason therefor.
☐	Sexual misconduct with one or more patients during a course of treatment or an examination.

RECOMMENDED ACTION

☐	Termination or revocation of staff privileges, membership or employment
☐	Summary suspension of staff privileges, membership or employment
☐	Restriction of staff privileges, membership or employment
List proposed specific restrictions:	
Date final decision/recommendation made:	

Signature Date
Chief Executive Officer/Medical Director/Administrator

Signature Date
Chief of Medical Staff

California Business and Professions Code Section 805.01

(a) As used in this section, the following terms have the following definitions:

(1) "Agency" has the same meaning as defined in Section 805.

(2) "Formal investigation" means an investigation performed by a peer review body based on an allegation that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) occurred.

(3) "Licentiate" has the same meaning as defined in Section 805.

(4) "Peer review body" has the same meaning as defined in Section 805.

(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file a report with the relevant agency within 15 days after a peer review body makes a final decision or recommendation regarding the disciplinary action, as specified in subdivision (b) of Section 805, resulting in a final proposed action to be taken against a licentiate based on the peer review body's determination, following formal investigation of the licentiate, that any of the acts listed in paragraphs (1) to (4), inclusive, may have occurred, regardless of whether a hearing is held pursuant to Section 809.2. The licentiate shall receive a notice of the proposed action as set forth in Section 809.1, which shall also include a notice advising the licentiate of the right to submit additional explanatory or exculpatory statements electronically or otherwise.

(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. This paragraph shall not be construed to affect or require the imposition of immediate suspension pursuant to Section 809.5.

(2) The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.

(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 medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Sexual misconduct with one or more patients during a course of treatment or an examination.

(c) The relevant agency shall be entitled to inspect and copy the following documents in the record of any formal investigation required to be reported pursuant to subdivision (b):

(1) Any statement of charges.

(2) Any document, medical chart, or exhibit.

(3) Any opinions, findings, or conclusions.

(4) Any certified copy of medical records, as permitted by other applicable law.

(d) The report provided pursuant to subdivision (b) and the information disclosed pursuant to subdivision (c) shall be kept confidential and shall not be subject to discovery, except that the information may be reviewed as provided in subdivision (c) of Section 800 and may be disclosed in any subsequent disciplinary hearing conducted pursuant to the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) The report required under this section shall be in addition to any report required under Section 805.

(f) A peer review body shall not be required to make a report pursuant to this section if that body does not make a final decision or recommendation regarding the disciplinary action to be taken against a licentiate based on the body's determination that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) may have occurred.

ATTACHMENT H: Section 805.8, Facility Sexual Abuse & Misconduct

Medical Board of California

Health Facility Reporting Form (805.8)

Required by Section (§) 805.8 of the California Business & Professions Code

Enforcement Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2528
Fax: (916) 263-2435
complaint@mbc.ca.gov

NOTE: Certain actions, with respect to staff privileges, membership or employment of physicians, podiatrists, licensed midwifes and physician assistants must be reported to the Medical Board of California. Reports on osteopathic physicians, dentists and psychologists should be directed to their respective Boards. Please see the reverse/second page of this form for further information

REPORTING ENTITY (Check One)

☐ Ambulatory Surgical Center – §805.8(a)(3) ☐ Health Care Facility or Clinic – §805.8(a)(3)

☐ Other Entity (Including, but not limited to, a postsecondary educational institution) – §805.8(a)(4)

If other, please describe:

Name of Person Preparing Report	Phone Number	Email Address
Chief Executive Officer/Medical Director/Administrator	Phone Number	Email Address

Facility Name and Address	City	State	Zip Code

LICENTIATE (Check One)

☐ Physician ☐ Podiatrist ☐ Licensed Midwife ☐ Physician Assistant

Name	License Number

PATIENT & INCIDENT INFORMATION

Patient Name ○Female ○Male	Phone Number	Email Address
Patient Address	City	State / Zip Code

Date that the allegations of sexual abuse and/or sexual misconduct were reported by patient/patient's legal representative in writing to reporting entity. Date (mm/dd/yyyy)

Details of the reported incident. (Attach additional pages if necessary)

ATTACH COPY OF PATIENT REPORTED ALLEGATION!

Signature of Person Preparing Report Date (mm/dd/yyyy)

***Return completed form by fax: (916) 263-2435, email: complaint@mbc.ca.gov, or mail to the address above.**

California Business and Professions Code §805.8

(a) As used in this section, the following terms shall have the following meanings:

(1) “Agency” means the relevant state licensing agency with regulatory jurisdiction over a healing arts licensee listed in paragraph (2).

(2) “Healing arts licensee” or “licensee” means a licensee licensed under Division 2 (commencing with Section 500) or any initiative act referred to in that division. “Healing arts licensee” or “licensee” also includes a person authorized to practice medicine pursuant to Sections 2064.5, 2113, and 2168.

(3) “Health care facility” means a clinic or health facility licensed or exempt from licensure pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(4) “Other entity” includes, but is not limited to, a postsecondary educational institution as defined in Section 66261.5 of the Education Code.

(5) “Sexual misconduct” means inappropriate contact or communication of a sexual nature.

(b) A health care facility or other entity that makes any arrangement under which a healing arts licensee is allowed to practice or provide care for patients shall file a report of any allegation of sexual abuse or sexual misconduct made against a healing arts licensee by a patient, if the patient or the patient’s representative makes the allegation in writing, to the agency within 15 days of receiving the written allegation of sexual abuse or sexual misconduct. An arrangement under which a licensee is allowed to practice or provide care for patients includes, but is not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

(c) The report provided pursuant to subdivision (b) shall be kept confidential and shall not be subject to discovery, except that the information may be reviewed as provided in subdivision (c) of Section 800 and may be disclosed in any subsequent disciplinary hearing conducted pursuant to the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

(d) A willful failure to file the report described in subdivision (b) shall be punishable by a fine, not to exceed one hundred thousand dollars ($100,000) per violation, that shall be paid by the health care facility or other entity subject to subdivision (b). The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the licensee regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file the report under this section is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. If the person who is designated or otherwise required to file the report required under this section is a licensed doctor of podiatric medicine, the action or proceeding shall be brought by the Podiatric Medical Board of California. The fine shall be paid to that agency, but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licensee. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, “willful” means a voluntary and intentional violation of a known legal duty.

(e) Except as provided in subdivision (c), any failure to file the report described in subdivision (b) shall be punishable by a fine, not to exceed fifty thousand dollars ($50,000) per violation, that shall be paid by the health care facility or other entity subject to subdivision (b). The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file the report required under this section is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. If the person who is designated or otherwise required to file the report required under this section is a licensed doctor of podiatric medicine, the action or proceeding shall be brought by the Podiatric Medical Board of California. The fine shall be paid to that agency, but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether any person who is designated or otherwise required by law to file the report required under this section exercised due diligence despite the failure to file or whether the person knew or should have known that a report required under this section would not be filed; whether there has been a prior failure to file a report required under this section; and whether a report was filed with another state agency or law enforcement. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital, as defined in Section 124840 of the Health and Safety Code.

(f) A person, including an employee or individual contracted or subcontracted to provide health care services, a health care facility, or other entity shall not incur any civil or criminal liability as a result of making a report required by this section.

(g) The agency shall investigate the circumstances underlying a report received pursuant to this section.

ATTACHMENT I: Ongoing Monitoring Verification Sources

VERIFICATION SOURCES

	SERVICE	SITE NAME	WEBSITE
1.	OIG - List of Excluded Individuals and Entities excluded from Federal Health Care Programs: Medicare /Medicaid sanction & exclusions	HHS Officer of Inspector General	**www.oig.hhs.gov**
2.	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	**https://www.sam.gov/portal/SAM/#1**
3.	Medicare Opt-Out	Centers for Medicare & Medicaid Services (CMS)	**https://data.cms.gov/**
4.	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	Department of Health Care Services (DHCS) Medi-Cal Provider Suspended and Ineligible List	**www.medi-cal.ca.gov**
5.	Osteopathic Board of California Enforcement Actions	Osteopathic Board of California	**https://www.ombc.ca.gov/consumers/enforce_action.shtml** **Actions may also be emailed from Corey.sparks@dca.ca.gov**

VERIFICATION SOURCES

6.	Board of Podiatric Medicine Recent Disciplinary Actions	Board of Podiatric Medicine	**https://pmbc.ca.gov /consumers/dispsumm.shtml**
7.	California Board of Chiropractic Examiners Disciplinary Actions	California Board of Chiropractic Examiners	**https://www.chiro.ca.gov/ enforcement/actions.shtml**
8.	Acupuncture Board Disciplinary Actions Board Actions	Acupuncture Board Disciplinary Actions	**https://www.acupuncture.ca.gov/ consumers/board_actions.shtml**
9.	Dental Board of California Enforcement Program	Dental Board of California	**https://www.dbc.ca.gov/ consumers/hotsheets.shtml**
10.	California Board of Optometry Citations & Disciplinary Actions	California Board of Optometry	**https://www.optometry.ca.gov/ consumers/disciplinary.shtml**

VERIFICATION SOURCES

11.	Physician Assistant Committee Disciplinary Actions	Physician Assistant Committee	**https://www.pab.ca.gov/forms_pubs/disciplinaryactions.shtml**
12.	Speech Language Pathology and Audiology Board Disciplinary Actions	Speech Language Pathology and Audiology Board	**https://www.speechandhearing.ca.gov/consumers/disciplinary_actions.shtml**
13.	Physical Therapy Board of California Citations & Disciplinary Actions	Physical Therapy Board	**Does not publish disciplinary actions. the organization will conduct individual queries every 12- 18 months on credentialed providers.**