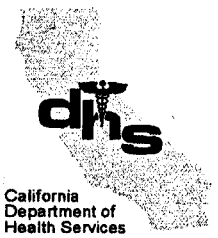
MMCD

State of California—Health and Human Services Agency
Department of Health Services



DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

May 16, 2002

MMCD Policy Letter 02-03

TO:
[X] County Organized Health Systems
[X] Local Initiative Plans
[X] Geographic Managed Care Plan
[X] Prepaid Health Plans
[X] Two Plan Model Plans

SUBJECT: CREDENTIALING & RECREDENTIALING: TIME LINE CHANGE, NEW PRIMARY SOURCE VERIFICATION REQUIREMENTS AND VERIFICATION OF CREDENTIALS OF NON-PHYSICIAN MEDICAL PRACTITIONERS

PURPOSE

The purpose of this Policy Letter is to inform Medi-Cal managed care plans (plans) of changes to Department of Health Services (DHS) credentialing requirements for plan physicians and non-physician medical practitioners. These changes and clarifications are designed to simplify administrative requirements by aligning DHS policy with those of the Centers for Medicare and Medicaid Services (CMS) and private accrediting organizations.

BACKGROUND

Credentialing is part of the comprehensive quality improvement system included in all Medi-Cal managed care contracts as mandated by the California Code of Regulations (CCR) Title 22, sections 53100 and 53280 and Title 10 of the California Administrative Code, beginning with section 1300.43. As one element of the QI process, credentialing ensures that physician and non-physician medical practitioners are licensed and certified in accordance with State and Federal requirements.

Do your part to help California save energy. To learn more about saving energy, visit the following web site:
www.consumerenergycenter.org/flex/index.html

714 P Street, Room 650 Sacramento, CA 95814
916-654-8076
Internet Address: www.dhs.ca.gov

I. Initial Credentialing of Physicians

The most significant change to initial credentialing of physicians (including specialists) is that some information must be verified from primary sources. "Primary source" refers to an entity with legal responsibility for originating a document and ensuring the accuracy of the information, such as a state licensing agency.

A. The following information must be verified from primary sources:

1. License to practice;
2. Education and training, including evidence of graduation from the appropriate professional school and completion of a residency or specialty training; and
3. Board certification, if claimed at time of application.

B. The following information is required but does not require primary source verification:

1. Work history;
2. Clinical privileges in good standing (if applicable), including review of past history of curtailment or suspension of medical staff privileges;
3. Valid Drug Enforcement Administration (DEA) number;
4. Current, adequate malpractice insurance;
5. Professional liability claims history;
6. Information from the National Practitioner Data Bank;
7. Medicare and Medi-Cal/Medicaid sanctions, and
8. Sanctions or limitations on licensure from State agencies or licensing boards.

The physician signs a statement indicating any limitations or inability to perform the essential functions of the position, with or without accommodation. The signed and dated application includes an attestation as to the correctness and completeness of the information.

II. Recredentialing Cycle Change and Requirements

A. Cycle Change

Effective October 12, 2001, DHS will require recredentialing of plan physicians every three years, as a minimum. This was previously a two year requirement. The change was prompted by the adoption of a three year recredentialing cycle by CMS and by private accrediting organizations. Plans may implement the three-year cycle as of the effective date. That is, physicians whose recredentialing was due on or after October 12, 2001 do not need to be recredentialed until three years have elapsed from their last credentialing date.

B. Requirements

1. The plan or entity performing credentialing shall ensure that the recredentialing process occurs, at a minimum, every three years. The process shall include reverification of the following from primary sources:

   (a) Licensure;
   (b) Board certification.

2. Re-verification of the following must also be included (primary source verification not required):

   (a) Admitting privileges if applicable;
   (b) Malpractice insurance;
   (c) Valid DEA certificate;
   (d) National Practitioner Data Bank information;
   (e) Medi-Cal, Medicaid, and Medicare sanctions; and
   (f) Sanctions or limitations on licensure from State agencies/licensing boards.

The recredentialing process includes a signed and dated application that includes an attestation as to the correctness and completeness of the information.

Recredentialing should also include documentation that the entity has considered information from other sources pertinent to the credentialing process such as quality improvement activities, member complaints and medical record reviews.

III. Non-Physician Medical Practitioner Credentialing

Plans must develop policies and procedures to ensure that the credentials of Nurse Practitioners, Certified Nurse Specialists, Certified Nurse Midwives and Physician Assistants have been properly verified. Plans may credential these providers themselves if this is their policy, or this may be a delegated activity. These providers generally are credentialed at the practice site rather than by plans directly. The plan bears overall responsibility for ensuring that non-physician medical practitioners meet the State requirements to practice, as described below.

A. Nurse Practitioners (Title 16, CCR; Business and Professions [B & P] Code Sections 2834 – 2837):

   1. California Registered Nursing license;
   2. Nurse Practitioner number, issued by the Board of Registered Nursing (BRN);
   3. Nurse Practitioner Furnishing number issued by the BRN; and
   4. DEA number if prescribing controlled substances.

B. Certified Nurse Midwives (Title 16, CCR; B & P Code Sections 2505 - 2521; and 2746 – 2746.8)

1. California Registered Nursing license;
2. Nurse Midwife certification from the BRN or Medical Board of California (as applicable).
3. Furnishing number issued by the BRN; and
4. DEA number if prescribing controlled substances.

C. Clinical Nurse Specialist (Title16, CCR; B & P Code Sections 2838-2838.4)

1. California Registered Nursing license;
2. Clinical Nurse Specialist certification number from the BRN.

D. Physician Assistant (Division 2, Chapter 7.7, B & P Code; Title 16, Division 13.8 CCR)

1. Physician Assistant license issued by the Medical Board of California;
2. DEA number.

IV. Attestation

The credentialing and recredentialing process includes completion of an application form by the provider. The provider is required to sign the application and attest to the following:

- any limitations in ability to perform the essential functions of the position with or without accommodation;
- history of loss of license or felony convictions;
- history of loss or limitation of privileges or disciplinary activity;
- lack of present illegal drug use; and
- correctness and completeness of the application.

Medi-Cal managed care plans must comply with the requirements of the Americans with Disabilities Act (ADA). Plans must ensure that the attestation statement language developed by the plan and incorporated in the credentialing application conforms to the requirements of the ADA. A discussion of the changes to credentialing language required for ADA conformance is contained in an information bulletin from the California Medical Association (see attachment 1 to this letter).

V. Site Reviews

Site reviews shall be conducted on all primary care provider sites, according to the provisions of Title 22, CCR, Section 53856. For site review guidance, please see the current DHS policy letter on site reviews. Site reviews are required as part of the initial

credentialing process when both the site and the provider have been added to the provider network. In this situation, initial credentialing and the site review will coincide. A site review is not required automatically as part of the recredentialing process. The addition of new providers will not trigger a site review if the previous site review score is still current (within three years) and the site received a passing score.

VI. Delegation of Credentialing

Delegation occurs when a plan gives another entity the authority to perform a function that otherwise would be carried out by the plan. Plans may delegate credentialing to a professional credentialing verification organization. The plan remains accountable for credentialing and recredentialing its practitioners, even if it delegates all or part of these activities.

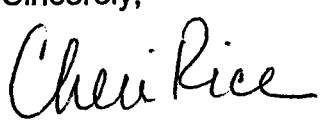
Entities conducting delegated credentialing activities, such as physician groups, may obtain Provider Organization Certification from the National Committee on Quality Assurance (NCQA), at their own discretion. Provider Organization Certification focuses on the entity's role as the agent performing the credentialing functions on behalf of a plan. This certification will be deemed by DHS as meeting a plan's credentialing requirement and relieves the plan from having to credential providers itself. Delegation agreements should be detailed mutually agreed upon documents developed by the plan and the credentialing entity. Delegation agreement documents do not need revision until and unless the conditions of the delegation agreement change.

Health Plan Accreditation

Plans that have received a rating of "excellent," "commendable," or "accredited" from NCQA will be deemed to meet the DHS requirements for credentialing. These plans will be exempt from the DHS medical review audit of credentialing. Plans, however, retain overall responsibility for ensuring that credentialing requirements are met. Deeming of credentialing from entities other than NCQA will be considered by DHS upon request from a plan.

If you have any question regarding this information, please contact your DHS plan Contract Manager.

Sincerely,



Cheri Rice, Chief
Medi-Cal Managed Care Division

Enclosure

Attachmer

California Medical Association

221 Main Street, P.O. Box 7690, San Francisco, CA 94120-7690 • (415) 541-0900

Physicians dedicated to the health of Californians

March 8, 2000

Sally Marcus
Blue Cross of California
2121 N. California blvd., 7th Floor
Walnut Creek, CA 94596

Dear Sally:

Per your request, enclosed are two documents I hope you find useful in supporting your institution's use of the California Participating Physician Application (CPPA) with respect to health status credentialing questions.

You will note that both CMA Legal Counsel and NCQA surveyor Guidelines for the year 2000 support health status attestations as they currently appear in the CPPA to address legal requirements of the Americans with Disabilities Act (ADA).

Should you wish our assistance in contacting the California Department of Health Services to achieve acceptance of the CPPA language for purposes of its credentialing audits, please let me know. We would be happy to seek clarification of this matter with department officials if individual auditors are questioning this approach.

Sincerely,

original signed

Sandra E. Bressler
Director, Professional Standards and Quality of Care

Enclosure

cc: Catherine Hanson
CMA Legal Counsel

Health Care Credentialing and the ADA
California Medical Association Legal Counsel
January 2000

The Americans With Disabilities Act (42 U.S.C. §§12101 *et seq.*, hereafter "ADA" or "the Act") is a comprehensive legislative scheme designed to prevent and punish discrimination against persons with disabilities, in a variety of settings. The scope of the ADA is very broad. Specifically, the Act addresses discrimination on the basis of disability in each of the following areas: (Title I) employment, (Title II) state and local governmental services (including public transportation), (Title III) public accommodations, and (Title IV) telecommunications.
To the extent it applies, the ADA provides numerous detailed requirements and prohibitions concerning employment practices, from the initial application process to medical testing, training, promotion, and related issues concerning existing employees. It is clear that the ADA applies to most traditional relationships of employment. Thus, any entity which employs at least 15 people should carefully review its policies and procedures to ensure compliance. For more information, order CMA ON-CALL document #0812. It is not clear, however, whether the Act will be deemed to apply in the non-employee medical credentialing and staff appointment/reappointment context and, if it does apply, how this will affect considerations of an applicant's, staff member's, or contracting physician's health status. With respect to the credentialing activities of most hospital medical staffs, medical groups, IPAs, health maintenance organizations ("HMOs"), and other health care organizations, Title I (respecting relationships of employment) and Title III (respecting places of public accommodation) are of greatest concern.[1]

The major medical credentialing dilemma presented by the ADA is as follows: under hospital accreditation standards and most states' laws, hospital medical staffs are required to inquire regarding the health status or ability of prospective medical staff members to practice medicine (at the time of application) and existing medical staff members every two years (upon reapplication), in order that any health conditions of concern (e.g. debilitating medical conditions or drug or alcohol abuse problems) may be noted by the medical staff and handled appropriately to ensure patient safety. Increasingly, HMOs, large medical groups, and managed care networks of all varieties are also engaging in rigorous credentialing of physicians and other health care practitioners, either for their own risk management purposes or pursuant to statutory or contractual mandates.[2] Where applicable, however, the ADA expressly **prohibits** application questions which are designed to elicit information regarding a condition which is deemed to be a "disability" under the Act. Thus, if the ADA applies in the non-employee medical staff or other

---

[1]Regardless of whether Title I or III also applies, however, Title II will apply to all state and local health care entities.

[2]In most states, for example, HMOs are mandated to engage in rigorous quality assurance activities. (*See e.g.*, California Health & Safety Code §1351(m) (application for HMO licensure must include description of procedures and programs for internal review of the quality of care pursuant to all requirements), Health & Safety Code §1370 (every HMO must establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs). All federally-qualified HMOs must similarly have arrangements in accordance with federal regulations for an ongoing quality assurance program for health services. Although the HMO requirements appear to stress ongoing quality assurance rather than specifically targeting credentialing activities, credentialing is a vital part of ongoing quality assurance. Moreover, courts around the country are extending principles of negligent credentialing (as initially applied to hospitals) to HMO entities. *See e.g.*, Harrell v. Total Health Care, Inc., 781 S.W.2d 58 (Mo. 1989).

© California Medical Association 2000

medical services arrangement context, then most, if not all, of the health status questions traditionally contained on medical credentialing application forms will be prohibited by the Act.[3]

As is further discussed below, unless and until there is definitive court interpretation indicating that the ADA is not intended to apply to arrangements for the provision of medical services which are not ones of traditional "employment," then medical staffs, as well as HMOs and any other entities for which its applicability is uncertain, would be well-advised to assume that the ADA does apply and act accordingly. In order to avoid substantial monetary liability under the Act, medical staffs and others should evaluate and modify health status questions to the extent necessary to ensure compliance with the Act.

TOP QUESTIONS ON CREDENTIALING AND THE ADA

The following represent the most common questions which CMA has received regarding health care credentialing and the ADA. All of these issues and more are discussed in much greater detail in CMA's publication entitled ***Health Care Credentialing and the Americans with Disabilities Act*** (with 1997 update), available from CMA at (415) 882-1CMA (882-1262).

1. What health status questions may we ask on our application/reapplication forms?

In general, an entity subject to Title I of the ADA is prohibited from making job applicant inquiries which will identify persons with disabilities or solicit information regarding the nature or severity of a disability. Thus, an employer may not use an application form that lists a number of potentially disabling impairments and ask the applicant to check any of the impairments that he or she may have. The Equal Employment Opportunity Commission (E.E.O.C.) has regulatory authority over Title I of the ADA. E.E.O.C.'s interpretive guidance with respect to these prohibitions makes clear that no question should be phrased in terms of a disability. Rather, questions must be phrased in terms of an applicant's **ability** to perform a particular job function.

Questions may be asked regarding conditions which are **not** defined to be "disabilities" under the Act (such as current drug use). Moreover, the interpretive guidance states that disability-related questions **may** be asked of a particular applicant who has a known disability that may interfere with or prevent performance of a job-related function. Where the disability is obvious or has been divulged voluntarily (without solicitation) by the applicant, an employer may ask whether or not an accommodation is required and, if the answer is "yes", what accommodation is needed. The employer or entity may also ask the applicant to demonstrate how he or she will perform the essential job functions, with or without reasonable accommodation.

Given remaining uncertainties with respect to this issue, however, and the potentially large monetary penalties which may be assessed for breach of the law, medical staffs and other entities which are potentially subject to the ADA are advised to err on the side of caution. CMA has developed a generic application question which we believe to be consistent with the provisions of the ADA as follows:

> Are you able to perform all of the procedures for which you have requested privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients?

---

[3]As noted, there is no question that the ADA does apply wherever medical practitioners are bona fide employees (e.g. in some state-owned hospitals, medical groups, or HMOs). The issue of concern is whether the ADA might also be deemed to apply to physicians who are non-employee medical staff members or contractors, as is the case in most California hospitals, as well as in HMO and PPO contracting.

2. Is alcoholism a disability?

Yes. For this reason, a medical staff or other entity covered by Title I of the ADA may not include a question on its application forms asking whether the applicant/reapplicant is either suffering from or has a history of alcoholism. Moreover, case law suggests that the employer may have a duty to accommodate a person suffering from alcoholism (e.g. by allowing an unpaid leave of absence for purposes of obtaining rehabilitative treatment). However, the law does allow an employer to prohibit the use of alcohol at the workplace, require that an employee not be under the influence of alcohol at the workplace, and hold an employee who is an alcoholic to the same qualification standards for employment or job-performance and behavior that is applicable to other employees.

3. Is drug addiction a disability?

The current illegal use of drugs (i.e. the use, possession or distribution of drugs that are unlawful under the Controlled Substances Act or the illegal use of prescription drugs that are "controlled substances") **is not** a disability under the ADA. However, the illegal use of drugs does not include drugs taken under the supervision of a licensed health care professional. Moreover, an individual with a disability under the ADA expressly **includes** any individual who

- has successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs, or has otherwise been rehabilitated successfully and is no longer engaging in such use;
- is participating in a supervised rehabilitation program and is no longer engaging in such use; or
- is erroneously regarded as engaging in such use, but is not engaging in such use.

Thus, a medical staff **may** include a question concerning **current** illegal use of drugs on its application/reapplication forms. However, it may **not** include a question at the pre-offer stage regarding whether the applicant has a history of past drug abuse or rehabilitation.

Although the law does not require an entity covered by Title I to provide accommodation for the current illegal use of drugs, it is unclear the extent to which such accommodation may be required for an applicant or employee who is either currently in a supervised program of rehabilitation or who has completed such a program.

CREDENTIALING

4. How should we credential applicants in conformance with the ADA?

For initial credentialing, three options are described in CMA's *Health Care Credentialing and the ADA* (for ordering information, *see* end of document). Some medical staffs/others may choose to rely upon ADA-acceptable health status questions, along with a period of heightened scrutiny for newly appointed members. Alternatively, medical staffs/others who desire more information from initial applicants may, in addition to the use of ADA-acceptable questions on the application, recommend that the governing body make initial offers of medical staff or panel membership or clinical privileges **contingent** upon satisfactory completion of a post-appointment, pre-privileging medical inquiry or examination, so long as such inquiry/examination is required for all applicants in the same category. Disability-related questions **may** be asked once a contingent offer has been given. This approach is expressly permitted by the Act, so long as the results of the inquiry/examination are not used in an impermissibly discriminatory manner and the confidentiality of the medical information is safeguarded.

Finally, some advocate a "closed envelope" mechanism which combines elements of the first and second options. Under this approach, the applicant is given a health status questionnaire with the initial application form, but is asked to return it in a separate "closed envelope." The medical staff would open the envelope only **after** the Board

has accepted the applicant on a contingent basis, having found the applicant to be qualified based upon all qualifications other than those related to health status. This method is risky and, in our view should not be pursued. The E.E.O.C. recently issued guidance stating that:

> An employer may not ask disability-related questions or require a medical examination pre- offer even if it intends to look at the results only at the post-offer stage." (E.E.O.C.'s "Enforcement Guidance: Pre-Employment Disability-Related Questions and Medical Examinations," Notice #915.002,10/10/95. p.1.)

EXISTING RELATIONSHIPS

5. How should we re-credential in conformance with the ADA?

With respect to existing members/panel participants who are reapplying for privileges or are subject to routine credentialing, the use of ADA-acceptable application questions, in conjunction with a review of the results of ongoing peer review and quality assessment activities, generally should be sufficient for credentialing purposes. Where a credible health concern exists regarding an existing staff member or panel participant, the entity may ask for specific information or a medical evaluation (which is not generally asked or required of all members or reapplicants) so long as the inquiries/evaluations are job-related, consistent with business necessity and otherwise in compliance with the Act.

CONCLUSION

Regardless of the approach utilized, medical staffs and others involved in health care credentialing are urged to proceed with caution in the application and evaluation process. Moreover, great care must be utilized whenever an applicant or existing staff member or panel provider has a disability which raises quality of care concerns, in order to ensure that any action taken is not only protective of patients, but also in compliance with the ADA.

We hope this information is helpful to you. CMA is unable to provide specific legal advice to each of its more than 30,000 members. For a legal opinion concerning a specific situation, consult your personal attorney.

For further information, *see* CMA's new publication, ***Health Care Credentialing and the Americans with Disabilities Act*** (with 1997 update). For information on other legal issues, use CMA ON-CALL, or refer to CMA's *California Physician's Legal Handbook.* This book contains legal information on a variety of subjects of everyday importance to practicing physicians. Written by CMA's Legal Department, the book is available in an easy-to-update binder format. Also, CMA attorneys have published the *Physician's Managed Care Manual—Second Edition,* which provides practical, business, and legal information regarding managed care contracts. To order your copies, call (800) 882-1CMA.

Credentialing FAQ

DHS has received the following questions about specific elements of the Credentialing & Recredentialing Policy Letter 02-03 dated May 16, 2002. Responses have been researched and verified for consistency with other accrediting organizations, both governmental and private. Similar questions have been grouped, if the answer applies to both questions.

Does completion of residency or specialty training need to be primary source verified if board certification is primary source verified? It's my understanding that completion of residency or specialty training is required to become board certified, therefore, it wouldn't make sense to require the plan to verify both.
DHS response: If board certification is verified from primary sources, additional primary source verification of specialty training and residency is not required. If the highest credential attained is verified from primary sources, then the prerequisite education and training that a provider attained in order to receive that credential (and could not receive without that training) does not have to be separately verified.#

For primary source verification of education, must plans verify education with the university or institution or is the Internet web service PrimeSource Web adequate?

For primary source verification of board certification can plans use Certifacts, the online service developed by the American Board of Medical Specialties (ABMS)?
DHS response: We do not screen online credentialing services or make specific recommendations for particular web sites or online services. The nationally recognized commercial accrediting organizations specify which sources they consider appropriate. If a Medi-Cal plan uses one of the sources accepted by the nationally recognized organizations, DHS will consider that source acceptable. For example, board certification for physicians may be verified in the ABMS Official Directory of Board Certified Medical Specialists, which is available in hard copy, on CD-ROM and through online sites Certifax and CertiFACTS. This source is recognized by the National Committee on Quality Assurance (NCQA) as an acceptable source for verification of board certification. State web sites, in which the State controls and updates the content (such as licensure information), are considered primary source verification. If a primary source on the Internet redirects the plan to a secondary source (a web site that is not controlled by the original site), the plan must obtain a letter directly from the secondary source that attests to the accuracy and timeliness of the information on the web site.#

What should plans do about "Addendum C," of the credentialing application? Should they still send this out?
DHS response: Addendum C contains questions that are not in compliance with the requirements of the American with Disabilities Act. If plans wish to use this Addendum, they must ensure that the questions do not violate the ADA. For example, questions that ask about a history of alcoholism and subsequent rehabilitation programs are not allowed under the ADA. We question the added value of Addendum C.

If the health plan is not required to credential "midlevel" providers directly but retains oversight responsibility to ensure that verification of credentials is performed, what constitutes adequate oversight?

If a plan contracts with physicians in an IPA, and the physicians, in turn, employ "midlevel" providers, what is the plan's responsibility to credential the "midlevel"s, or to ensure that their credentials are verified?

If a "midlevel" is employed directly by an IPA, what is the plans' level of credentialing oversight in this case?

DHS requires health plans to have policies and procedures that require that the licensure of ""midlevel"" providers be checked. DHS does not require the full credentialing process that physicians undergo, however their credentials (licenses, certifications) that allow them to function and NPs, PAs, CNMs and CNSs must be checked. The exact requirements are listed in the policy letter. Usually this verification is accomplished at the site where these providers are employed. Plans do not have to maintain these files, or check them. "File pulls" and checking of these provider files is done during the site review process. If the plan can show that the site where the "midlevel" practices has received a passing score, this will constitute adequate oversight of the verification process for "midlevel" providers.

Does a physician have to be recredentialed if he changes locations within a group (moves to another office location)?
No. If the site review score (from the provider's previous location) is current, and the site received a passing score on the facility site review, the provider does not have to be recredentialed until the next time he is due.