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MEMORANDUM


To: Alliance Providers
From: Ann Kern, Provider Services Network Manager
Date: 03/18/2013
Subject: Clarification of Complaint Procedure

The Central California Alliance for Health (the Alliance) has reviewed and clarified its policy regarding member complaints which require Peer Review and Credentialing Committee (PRCC) review. A copy of the revised policy is available for your review on the “What’s New” section of the Provider page of the Alliance website (<http://www.ccah-alliance.org/Providers.html>) and can be provided to you by your Provider Services Representative on your request.

As described in the Provider Manual, providers must cooperate with the Alliance in identifying, processing and resolving member complaints. This includes providing the Plan with pertinent information to the complaint when requested by the Plan, as is further described in the Provider Manual. Provider participation in the resolution of member complaints is required for complaints which cannot be resolved within 24 hours. The Plan has 30 days to resolve such complaints. Complaints which can be resolved in 24 hours are usually resolved by a member changing their PCP, and the resolution requires no participation by the provider. As these complaints are resolved without participation of the provider, providers are often unaware of the issues raised by such complaints.

Beginning Quarter 2 2013, the Alliance will begin to share with providers, on a calendar quarter, a summary of complaints received (if any are brought) during the quarter. The report will include both the 24-hour and 30-day complaints resolved during the quarter. In sending you the quarterly report regarding complaints, the Alliance is **not** asking for your feedback or follow-up on the specific complaint(s). This information is provided to better inform your practice about concerns expressed by members and any trends in complaints the Plan has identified. We believe that sharing this information gives your practice a more complete customer service picture. You will see the first report shortly after the close of each calendar quarter.

Should you have any questions regarding the clarified policy, or any quarterly complaint report, please contact your Provider Services Representative at (831) 430-5504 or 1-800-700-3874, ext. 5504.

 <p style="text-align: center;">LA ALIANZA • THE ALLIANCE CENTRAL CALIFORNIA ALLIANCE FOR HEALTH</p>	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 300-4030</p>	<p>Lead Department: Provider Services</p>
<p>Title: Credentialing Criteria and Identified Issues</p>	
<p>Original Date: 10/01/2007</p>	<p>Last Revision Date: 12/12/2012</p>
<p>Approved by: Peer Review and Credentialing Committee</p>	
<p>Effective Date: 12/12/2012</p>	

Purpose:

To establish criteria for the review and approval of provider credentials based on verified credentialing information and identified issues.

Policy:

The Peer Review and Credentialing Committee (PRCC) is responsible for reviewing and approving, deferring, or denying Central California Alliance for Health (the Alliance) provider network participation based on established credentialing criteria and adverse findings.

Definitions:

Attestation: A signed statement indicating that a provider personally confirms the validity, correctness and completeness of the credentialing applications at the time of application to the Plan.


Conditional Credentialing: Network approval by the PRCC with special conditions of participation rendered as a result of recommended focused monitoring, typically resulting from identified issues during the credentialing or ongoing monitoring processes.

Provisional Credentialing: A process by which a new practitioner, who meets credentialing criteria, is approved to participate in the network in advance of a PRCC meeting to meet a specific access need.


Service Area: Santa Cruz, Monterey, and Merced Counties.

Procedures:

1. Verified Credentialing Criteria
 - 1.a. Provider credentials are collected, verified, and reviewed in line with parameters set in Policies 300-4040 – Professional Providers Credentialing Guidelines, 300-4110 – Organizational Providers Credentialing Guidelines, and 300-4090 – Ongoing Monitoring of Provider Credentials and Issues.
 - 1.b. The PRCC approves, defers, or denies providers’ network participation status, based on established credentialing criteria for network providers.

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- 1.c. The PRCC renders non-discriminatory, confidential credentialing decisions and/or recommendations, as defined in Policy 300-4020 – Peer Review and Credentialing Committee – Authority, Roles and Responsibilities, based on review of providers’ verified credentialing file obtained during initial credentialing, recredentialing and ongoing monitoring processes.
 - 1.d. Credentialing decisions and/or recommendations are signed off by each PRCC member and reflected in the meeting minutes.
 - 1.e. Notification of PRCC decision will be sent to the provider in writing within sixty (60) calendar days of the PRCC decision.
 - 1.f. After final approval by the PRCC, provider qualification information is listed in the Alliance provider directory consistent with information gathered and verified during the credentialing process.
2. Clean Credentialing Status
- Clean Credentialing refers to files that meet the established credentialing criteria with no issues identified that would require PRCC review. Clean files are reviewed, signed and dated by the Medical Director, or designee, prior to presentation to the PRCC for final approval.
- 2.a. Provisional Credentialing
 - i. Providers applying for participation in the Alliance network for the first time who meet all of the credentialing criteria standards and having “clean” credentialing files may be recommended by the Provider Services Network Manager or Provider Services Director for Provisional credentialing approval.
 - ii. The Medical Director will review and may approve such “clean” credentialing files for new providers on a provisional basis, pending final PRCC approval, as needed to meet specific access needs within the network between quarterly PRCC meetings.
 - iii. Provisional status will not exceed sixty (60) calendar days.

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3. Identified Issues

Provider files not meeting established credentialing criteria resulting from verified or potential issues, are reviewed by the PRCC.

3.a. Conditional Credentialing

- i. When appropriate, the PRCC members may approve a provider's credentials conditionally pending possible follow-up and further review. A timeframe is set by the PRCC to allow for the conditions of approval to be met. Upon fulfillment of the conditions, a provider may be approved for active network participation.
- ii. Notification is sent to the provider to inform them of the Committee's decision and the special condition(s) attached to the approval as recommended by the PRCC.

3.b. Unfavorable recommendations and decisions are made in accordance with Policy 300-4102 – Reporting to the Medical Board of California and National Practitioner Data Bank.

3.c. Notice of the PRCC's final decision does not entitle the provider to any procedural hearing rights, except for specific providers, as defined in Policy 300-4103 - Fair Hearing Process for Adverse Decisions.


3.d. Identified issues, issues not meeting credentialing criteria and requiring PRCC review include:

- i. Attestation

Attestation information disclosing health status and any history or limitations of licensure or privileges that could adversely affect the provider's ability to deliver care to members.
- ii. Sanctions and Limitations

Any denial, limitation, restriction, suspension, revocation, forfeiture, subjection to probationary conditions, disciplinary action, or voluntary relinquishment as applicable to the provider of the following:

 - Professional state license
 - Drug Enforcement Agency (DEA) registration

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- Hospital clinical privileges
- Professional organization membership

iii. Professional Liability Claims History


- Two or more malpractice cases of any amount that have settlement dates within the past seven (7) consecutive years, and not reviewed during a previous credentialing cycle.
- Malpractice case(s) settled for an amount greater than \$30,000 within the last seven (7) years, and not reviewed during a previous credentialing cycle.
- Any reports that do not meet established criteria through the National Practitioner Data Bank/Health Integrity Data Bank (NPDB/HIPDB) query, and not reviewed during a previous credentialing cycle.

iv. Medicare/Medicaid Program Participation and Eligibility

- Provider must not be ineligible, excluded or debarred from participation in the Medicare/Medicaid program and related state and federal programs; and
- Provider must be free from restrictions or sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or disciplinary action by other federal or state entities.

v. Member Complaints and Grievances

- Any pattern of member complaints or grievances, including 24 hour complaints as well as 30 day complaints, filed against a provider according to the following schedule:
 - Primary care practices with between 0 and 1,000 linked members and all specialist physicians: Two (2) or more complaints filed in any given quarter, four (4) or more in any given year; and six (6) or more during the three-year period since the prior credentialing review.
 - Primary care practices with >1000 linked members: Three or more complaints filed in any given quarter; six (6) or more in any given year; and nine (9) or more

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during the three-year period since the prior credentialing review.

vi. Quality Issues

- Any one (1) Verified Quality Issue (VQI) or three (3) or more Potential Quality Issues (PQI), as defined in Health Services Policy 401-1301 - Potential Quality Issue Review – General, since the last credentialing cycle, will be reviewed during recredentialing, or sooner if indicated.

vii. Site Review

- Any facility site or medical record review issues, based on Quality Improvement reports, including unresolved Critical Element Corrective Action Plans (CAP) since the last site review cycle.
- Site review must be current at time of PRCC review.

viii. Criminal Charges

- The following criteria will be reviewed as part of the provider’s file:
 - Providers with a pending felony charge;
 - Providers with a pending criminal charge involving any criminal activity related to the professional practice of medicine;
 - Providers involved in any open civil suit related to the practice of medicine;
 - Providers registered as a sex offender, if pertinent.

References:

Alliance Policies: 300-4020 –PRCC Authority, Roles and Responsibilities; 300-4040 – Professional Provider Credentialing Guidelines, 300-4110 – Organizational Providers Credentialing Guidelines; 401-1301 – Potential Quality Issue Review – General; Policy 300-4102 – Reporting to the MBC and NPDB; 300-4103 – Fair Hearing Process for Adverse Decisions
Regulatory: NA



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Contractual: Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12; Exhibit E, Attachment 2, Provision 24.B.2

Legislative: NA

MMCD: Policy Letter 02-03

Supersedes: 300-4022 - Peer Review and Credentialing Committee – Review of Credentials and Issues (retired)

Lines of Business This Policy Applies To:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Medi-Cal | <input checked="" type="checkbox"/> Access for Infants and Mothers |
| <input checked="" type="checkbox"/> Healthy Families | <input checked="" type="checkbox"/> Individual Conversion Form |
| <input checked="" type="checkbox"/> Healthy Kids Santa Cruz | <input checked="" type="checkbox"/> Santa Cruz County LIHP |
| <input checked="" type="checkbox"/> Healthy Kids Merced | <input checked="" type="checkbox"/> Monterey County LIHP |
| <input checked="" type="checkbox"/> Alliance Care IHSS | |

Revision History:

Review Date	Revised Date	Changes Made By	Approved By
12/12/2007			PRCC
12/10/2008	12/10/2008		PRCC
03/10/2010	02/24/2010		PRCC
12/14/2011	12/06/2011	Sierra Brode	PRCC
12/12/2012	12/12/2012	Sitara Cavanagh	PRCC