

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/ PROCEDURE**

Policy/Procedure Number: MPCR100			Lead Department: Network Services Business Unit: Credentialing		
Policy/Procedure Title: Credential and Re-credential Decision Making Process			<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy		
Original Date: 04/23/2018		Next Review Date: 02/11/2027 Last Review Date: 02/11/2026			
Applies to:	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees			
Reviewing Entities:	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input type="checkbox"/> QUAC		
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> DEPARTMENT	
Approving Entities:	<input type="checkbox"/> BOARD		<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE	<input type="checkbox"/> PAC
	<input type="checkbox"/> CEO	<input type="checkbox"/> COO	<input checked="" type="checkbox"/> CREDENTIALS	<input type="checkbox"/> DEPT. DIRECTOR/OFFICER	
Approval Signature: <i>Mark Netherda, MD</i>			Approval Date: 02/11/2026		

I. RELATED POLICIES:

- A. MPCR300 - Physician Credentialing and Re-Credentialing Requirements
- B. MPCR601 - Fair Hearing Process for Adverse Decisions
- C. MPCR700 - Assessment of Organizational Providers
- D. MPUP3006 - Appropriate Service and Coverage Policy

II. IMPACTED DEPTS:

- A. Health Services

III. DEFINITIONS:

- A. N/A

IV. ATTACHMENTS:

- A. [Routine Practitioners List](#)
- B. CMO Profile Review Sign Off Sheet (example)

V. PURPOSE:

To define the process for making credentialing and re-credentialing decisions, including the procedures for managing credentialing files that meet and do not meet Partnership HealthPlan of California's (Partnership's) credentialing criteria identified during the credentialing or re-credentialing of a practitioner or an organizational provider.

VI. POLICY / PROCEDURE:

- A. Partnership HealthPlan credentials practitioners before they provide care to members.
- B. Each individual practitioner or organizational provider credentialing or re-credentialing file is reviewed and verified by the Partnership Provider Relations Department for completion and accuracy based on Partnership's established credentialing criteria (Policy MPCR300 or MPCR700) prior to presentation to the Partnership Credentials Committee.
- C. Practitioners who meet Partnership credentialing criteria are considered to be clean files and are included on a "Routine Practitioners" list (Attachment A) and presented to the Credentials Committee for approval.
 - 1. The Routine Practitioners list includes the following information:
 - a. Initial or Re-credential Application from Practitioner
 - b. Practitioner Name
 - c. Practice Name(s) where the Practitioner Practices
 - d. County(ies) where the Practitioner Practices

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- e. Practice Specialty
- f. Board Certification and Status
- g. Name of Hospital where Practitioner has Privileges and Admitting Status
- h. Malpractice Claims and Payments within seven years of Application Date
- 2. Individual Credentialing Files for all practitioners on the Routine Practitioner’s list are available during the meeting for the Committee to access credentialing information required to make decisions.
- D. Organization providers that meet Partnership credentialing criteria are included on a consent calendar for committee review. Credentialing Files for all organizational providers on the consent calendar are available during the meeting for the Committee to access information required to make decisions.
- E. Any provider file identified as not meeting Partnership credentialing criteria with exceptions or potential exceptions is referred to the Chief Medical Officer (CMO) or Designated Medical Director(DMD) for review.
 - 1. The CMO/DMD will review each file for providers who do not meet credentialing criteria and make recommendations regarding approving or denying credentialing of the practitioner to the Credentials Committee. In some cases the CMO/DMD will request staff obtain additional information for review prior to presenting to the Committee.
 - 2. Credentialing criteria for practitioners that do not meet the requirement for a clean file and trigger a CMO/DMD file review include:
 - a. A “yes” answer on the credentialing application indicating a history of
 - b. an adverse issue with any of the following:
 - 1) The ability to perform with or without accommodation.
 - 2) Illicit drug use
 - 3) DEA or State Controlled Substance Registration
 - 4) Felony convictions
 - 5) Licensing
 - 6) Hospital privileges or other affiliations
 - 7) Education, Training, and Board Certification
 - 8) Sanctions or Investigations
 - 9) Malpractice coverage
 - 10) Completeness of application
 - c. Cases found through inquiry of the National Provider Data Base (NPDB)/Healthcare Integrity and Protection Data Bank (HIPD) not reviewed during a previous credentialing cycle.
 - d. Refusal to comply with a Corrective Action Plan based on a facility site or medical chart audit, or non-compliance with Peer Review Committee recommendations.
 - e. Appearance on the Medi-Cal Sanction Report, lists of parties Excluded from Federal Procurement and Non-procurement program, Medi-Cal Participation Exclusion Report, the Medical Board License Alert Report, or the Medicare Opt-Out Report.
 - f. Member complaints exceeding the threshold
 - g. Relevant practitioner-specific data as compared to aggregate data, when provided by the Over/Under Utilization Workgroup (as defined in policy MPUP3006).
 - 3. Credentialing criteria for organizational providers that do not meet the requirement for a clean file and trigger a CMO/ DMD file review include:
 - a. A “yes” answer on the credentialing application indicating a history of:
 - 1) denied, revoked, limited, or suspended DHCS or Business License

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- 2) denied, revoked, limited, or suspended Medi-Cal License
- 3) denied, revoked, limited, or suspended Medicare License
- 4) any type of AA, A, or Category 3 State citations within the last 24 months
- b. Member complaints exceeding the threshold
- c. Appearance on the Medi-Cal Sanction Report, lists of parties Excluded from Federal Procurement and Non-procurement program, Medi-Cal Participation Exclusion Report, the Medical Board License Alert Report, or the Medicare Opt-Out Report.
4. Upon reviewing the requirements for a “clean file”, the CMO/DMD may take one of several actions:
 - a. Request additional and specific information to clarify any concerns and reevaluate the file
 - b. Determine that the reported issue(s) is/are satisfactorily resolved, meaning the applicant’s current status meets criteria for credentialing, and approve the file to move forward as “Committee Routine”.
 - c. Determine the reported issue(s), while not resolved, is/are under appropriate monitoring by the applicant’s licensing or regulatory authority, and is permitting the applicant to practice during this monitoring period, and approve the file to move forward as “Committee Routine with Monitoring”.
 - d. Determine the reported issue(s) is/are of significant concern and require discussion, adding the applicant to the “Exception Report” for committee discussion and resolution of the application.
- F. The Credentials Committee approves, pends, or denies providers based on its review of credentialing information, documents, and information presented by the Partnership staff. All decisions are reflected in the minutes.
 1. The Committee reviews a list of providers that meet Partnership credentialing standards as delineated in credentialing criteria policies, including providers that have been approved by the CMO or the DMD.
 2. The CMO/DMD presents findings and makes recommendations to the Committee for the providers that do not meet credentialing standards.
 3. The Committee may request additional information, which is documented in the minutes and the file is pended for further action. Requested information is presented to the Committee when it is available.
- G. Providers who are approved by the Committee are notified in writing within ten (10) business days from the date of approval. This time period is a guideline and does not create any rights for an applicant. A decision notice to accept a provider for participating provider status includes any special condition attached to the approval as recommended by the Credentials Committee. Providers who are denied or receive an unfavorable recommendation by the Committee are notified in writing within ten (10) business days from the date of the Committee’s decision.
- H. Providers who are denied or receive an unfavorable recommendation by the Committee are notified in writing within ten (10) business days from the date of the Committee’s decision.
- I. Denial notices to practitioners include the practitioner’s right to appeal the Credentials Committee decision through Partnership’s Fair Hearing Process for Adverse Decisions.
 1. The final denial does not entitle the practitioner to any procedural hearing rights except to the extent to those outlined in Partnership Policy MPCR601, Fair Hearing Process for Adverse Decisions.

VII. REFERENCES:

NCQA 2026 Standards CR 1 A Factors 3, 4, 5, 7, 8 and 10

VIII. DISTRIBUTION:

Partnership Provider Manual

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IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

Director, Network Services

X. REVISION DATES: 05/09/2018, 04/10/2019, 11/13/2019, 04/08/2020, 04/14/2021, 04/13/2022, 04/12/2023, 04/10/2024; 11/13/24, 02/11/26

XI. DHCS APPROVAL DATES: 05/30/2023

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PREVIOUSLY APPLIED TO:

This Policy supersedes

- A. MPCR1 (Archive date 07/01/2018)
- B. MPCR2 (Archive date 07/01/2018)
- C. MPCR5 (Archive date 07/01/2018)
- D. MPPRPLCR201 (Archive date 07/01/2018)