Policy:	GG.1657
Title:	**State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/ Michael Hunn 10/31/2024*
Effective Date:	03/07/2019
Revised Date:	10/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

The State Licensing Board and the National Practitioner Data Bank (NPDB) have imposed legal requirements for reporting certain actions related to the credentialing and peer review processes. This policy is to comply with the State Licensing Board and the NPDB requirements for reporting adverse actions against a CalOptima Health Practitioner.

II. POLICY

A. CalOptima Health and its delegated Health Networks shall comply with State Licensing and NPDB requirements for reporting certain actions related to CalOptima Health Practitioner and Organizational Provider credentialing and peer review activities, as applicable.

B. If a reportable action is taken by CalOptima Health against a Practitioner and Organizational Provider, then CalOptima Health is the entity responsible for making the report(s) required by this Policy unless such reports are not required by applicable law.

C. Health Networks shall have policies and procedures that address credentialing and peer review reporting requirements. If a reportable action is taken by a Health Network against a Practitioner, then the Health Network is the entity responsible to make the report(s) unless such reports are not required by applicable law.

1. If a reportable action is taken by a Health Network, the Health Network shall report the reportable action, via mail or electronically, to the CalOptima Health Quality Improvement Department Director within thirty (30) calendar days from the date the action was reported.

III. PROCEDURE

A. Reports to the State Licensing Board Based on Business and Professions Code § 805

1. Entity Required to Report

    a. Only one peer review body is required to file an 805 Report for a Practitioner's Medical or Disciplinary Cause or Reason. If another peer review entity reports a Practitioner, CalOptima Health is not required to file a separate 805 Report attributable to the same conduct by the Practitioner.

2. Actions Requiring Reports

    a. An 805 Report is filed with the State Licensing Board whenever any of the following actions become final:

        i. Denial of a Practitioner's application for CalOptima Health participation or Health Network participation in CalOptima Health programs for a Medical or Disciplinary Cause or Reason;

        ii. Non-renewal of a Practitioner's CalOptima Health participation or Health Network participation in CalOptima Health programs for a Medical or Disciplinary Cause or Reason;

        iii. Restriction on a Practitioner's CalOptima Health participation or Health Network participation in CalOptima Health programs for a Medical or Disciplinary Cause or Reason;

        iv. Termination of a Practitioner's CalOptima Health participation or Health Network participation in CalOptima Health programs for a Medical or Disciplinary Cause or Reason; or

        v. Restriction on a Practitioner's CalOptima Health participation or Health Network participation in CalOptima Health programs for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a Medical or Disciplinary Cause or Reason;

        vi. Imposition of summary suspension of a Practitioner's CalOptima Health participation or Health Network participation in CalOptima Health programs for a Medical or Disciplinary Cause or Reason if the summary suspension remains in effect for more than fourteen (14) calendar days.

    b. An 805 Report is filed with the State Licensing Board if the Practitioner takes any of the following actions listed below:

        i. Resignation or leave of absence by a Practitioner from CalOptima Health participation or Health Network participation in CalOptima Health programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that their application is denied or will be denied for a Medical or Disciplinary Cause or Reason;

        ii. Withdrawal or abandonment of a Practitioner's application for CalOptima Health participation or Health Network participation in CalOptima Health programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause

or Reason; or (2) notice that their application is denied or will be denied for a Medical or Disciplinary Cause or Reason; or

iii. Withdrawal or abandonment of a Practitioner's request for renewal of CalOptima Health participation or Health Network participation in CalOptima Health programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that their application is denied or will be denied for a Medical or Disciplinary Cause or Reason.

3. Timeframe for filing an 805 Report

   a. Denial, Non-Renewal, Restriction or Termination

      i. CalOptima Health shall file an 805 Report within fifteen (15) calendar days after the conclusion of all of the proceedings under CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, if a denial, non-renewal, restriction or termination results from such proceedings;

      ii. CalOptima Health shall file an 805 Report within fifteen (15) calendar days if the Practitioner's participation is restricted for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a Medical or Disciplinary Cause or Reason.

   b. Summary Suspension

      i. CalOptima Health shall file an 805 Report within fifteen (15) calendar days following the imposition of summary suspension, if the summary suspension remains in effect for a period in excess of fourteen (14) consecutive days.

         a) CalOptima Health will also file an additional 805 Report with the State Licensing Board about the same Practitioner following conclusion of all proceedings under CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, or after the effective date of resignation or leave of absence by a Practitioner related to such summary suspension/investigation, within the timeframes provided in Section III.A.3.a.i. and Section III.A.3.c.i.

   c. Resignation, Withdrawal or Leave of Absence

      i. CalOptima Health shall file an 805 Report within fifteen (15) calendar days after the effective date of resignation or leave of absence by a Practitioner.

4. Exhaustion of Fair Hearing Rights

   a. For any action taken by CalOptima Health pursuant to Section III.A.2.a.i. through Section III.A.2.a.iv., CalOptima Health shall not file an 805 Report until the Practitioner has had the opportunity to either waive or exhaust their Fair Hearing rights in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners.

5. Notification to the Practitioner

a. CalOptima Health shall provide the Practitioner with a copy of the 805 Report and notice advising the Practitioner of their right to submit additional statements or other information, electronically or otherwise to the State Licensing Board and that information submitted electronically will be disclosed to those who request it, pursuant to Section 800(c) of the Business and Professions Code.

B. Reports to the State Licensing Board Based on Business and Professions Code §805.01

1. Actions Requiring Reports

a. An 805.01 Report is filed with the State Licensing Board whenever a peer review body (e.g., the Credentialing and Peer Review Committee) makes a final decision or recommendation, as specified in Section III.A.2.a.i. through Section III.A.2.a.iv. above, resulting in a final proposed action to be taken against a Practitioner based on the peer review body's determination, following formal investigation of Practitioner, that any of the acts listed below, may have occurred:

i. Incompetence, gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a matter as to be dangerous or injurious to any person or the public;

ii. The use of, or prescribing for or administering to themselves, any controlled substance; or use of any dangerous drug, as defined in Business and Professions Code Section 4022, or of alcoholic beverages, that is dangerous or injurious to the Practitioner, any other person, or the public, or to the extent that such use impairs the ability of the Practitioner to practice safely;

iii. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or related 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 Practitioner who is lawfully treating intractable pain be reported for excessive prescribing); or

iv. Sexual misconduct with one or more patients during a course of treatment or examination.

2. Timeframe for filing an 805.01 Report

a. CalOptima Health shall file an 805.01 Report within fifteen (15) calendar days after a final decision or recommendation regarding disciplinary action based upon a formal investigation that concludes that based on an allegation that any of the acts listed in Section III.B.1. of this Policy have occurred.

3. Fair Hearing Rights

a. CalOptima Health shall file an 805.01 Report (distinct from an 805 Report) regardless of whether the Practitioner is afforded their Fair Hearing Rights in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners.

4. Notification to the Practitioner

a. CalOptima Health shall provide the Practitioner with a copy of the 805.01 report and notice advising the Practitioner of their right to submit additional statements or other information, electronically or otherwise to the Medical Board and that information submitted electronically will be disclosed to those who request it, pursuant to Section 800(c) of the Business and Professions Code.

C. Reports to the National Practitioner Data Bank

1. Actions Requiring Reports

a. An NPDB Report is filed whenever any of the following actions become final:

i. An adverse Clinical Privileges action that is based on the Practitioner's and Organizational Provider's professional competence or professional conduct which adversely affects or could adversely affect the health or welfare of a patient when that action adversely affects the Practitioner's authority to provide care to CalOptima Health patients for more than thirty (30) calendar days. This includes actions taken against a Practitioner's privileges including reducing, restricting, suspending, revoking, denying or not renewing privileges;

ii. Acceptance of the Practitioner's and Organizational Provider's surrender of Clinical Privileges, or any restriction of such privileges by a Practitioner:

a) While the Practitioner and Organizational Provider's is under investigation relating to possible incompetence or improper professional conduct; or

b) In return for not conducting such an investigation or proceeding.

iii. Withdrawal of an initial application by Practitioner and Organizational Provider for Clinical Privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action;

iv. Practitioner and Organizational Provider does not apply for renewal of Clinical Privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action; or

v. Summary suspension imposed for more than thirty (30) days based on the Practitioner's and Organizational Provider's professional competence or professional conduct of the Practitioner that adversely affects, or could adversely affect the health and welfare of a patient and is the result of a professional review action.

2. Timeframe for filing an NPDB Report

a. CalOptima Health shall file an NPDB Report within thirty (30) calendar days from the date the adverse action was taken or authority to provide care to CalOptima Health patients is voluntarily surrendered.

3. Fair Hearing Rights

    a. Except in the event of a summary suspension in effect less than thirty-one (31) consecutive days or a surrender or restriction of authority to provide care to CalOptima Health patients, CalOptima Health shall file a NPDB Report after the Practitioner has had the opportunity to either waive or exhaust his/her fair hearing rights in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners.

4. Notification to the Practitioner and Organizational Provider

    a. The NPDB will mail a copy of the submitted report to the Practitioner and Organizational Provider named in the report. The Practitioner and Organizational Provider will have the opportunity to review the report for accuracy, and may add a statement to the report, or may dispute the report directly with the NPDB.

5. Additional Reports

    a. CalOptima Health shall file a Revision-to-Action report to supplement an initial report to the NPDB if the summary suspension of a Practitioner is modified or revised as part of CalOptima Health's final decision in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners.

D. Persons at CalOptima Health Required to Report

1. Reports to the Medical Board Based on Business and Professions Code § 805

    a. If CalOptima Health or the CalOptima Health Credentialing and Peer Review Committee take any action as described in Section III.A.2. of this Policy, the Chief Medical Officer or Physician Designee who participates on CPRC, shall file an 805 Report with the Medical Board in the appropriate time required in Section III.A.3. of this Policy.

2. Reports to the Medical Board Based on Business and Professions Code § 805.01

    a. If CalOptima Health or the CalOptima Health Credentialing and Peer Review Committee take any action as described in Section III.B.2. of this Policy, the Chief Medical Officer or Physician Designee who participates on CPRC, shall file an 805.01 Report with the Medical Board in the appropriate time required in Section III.B.3. of this Policy.

3. Reports to the National Practitioner Data Bank

    a. If CalOptima Health or the CalOptima Health Credentialing and Peer Review Committee take any action as described in Section III.C.2. of this Policy, Quality Improvement Credentialing Manager, shall file a report with the NPDB in the appropriate time required in Section III.C.3. of this Policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract for Health Care Services
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners
F. California Welfare and Institutions Code, §14087.58(b)
G. California Business and Professions Code, §§805, 805.01 and 809
H. California Health and Safety Code §1370
I. Health Care Quality Improvement Act of 1986 (HCQIA), 42 U.S.C. §11101 *et seq*.
J. National Practitioner Data Bank Regulations, 45 CFR, Part 60
K. National Practitioner Data Bank Guidebook (2018 Edition)
L. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing Standards
M. Medical Board of California 805, 805.1: https://www.mbc.ca.gov/Download/Forms/enf-805.pdf & https://www.mbc.ca.gov/Download/Forms/enf-805-01.pdf
N. National Practitioner Data Bank: https://www.npdb.hrsa.gov/

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/07/2019	GG.1657	Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting	Med-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1657	Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting	Med-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1657	State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting	Med-Cal OneCare PACE
Revised	10/01/2023	GG.1657	State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting	Med-Cal OneCare PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2024	GG.1657	State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting	Med-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Clinical Privileges	Defined in NPDB regulations as "the authorization by a health care entity to a health care practitioner for the provision of health care services, including privileges and membership on the medical staff." The term "medical staff" also includes network participation and panel membership.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medical or Disciplinary Cause or Reason	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.
Organizational Provider	For purposes of this Policy, Organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Practitioner	For purposes of this Policy, Practitioner means a "Licentiate" as that term is defined in Business and Professions Code Section 805 and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168. Practitioner also means an individual who is licensed or otherwise authorized by a State to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized as that term is defined in the Health Care Quality Improvement Act of 1986 (HCQIA) and its implementing regulations.