

## **Table of Contents**

### **QM - CREDENTIALING SERVICES**

### **POLICIES AND PROCEDURES**

CR 1.0	Credentials and Quality Committee
	<ul style="list-style-type: none"><li>I. Oversight</li><li>II. Committee Members</li><li>III. Responsibilities</li><li>IV. Non-discrimination</li></ul>
CR 2.0	Practitioner Credentialing
	<ul style="list-style-type: none"><li>I. Credentialing Procedure</li><li>II. Primary Care Practitioners</li><li>III. Recredentialing Procedure</li><li>IV. Nonresponsive to Credentialing Requests</li><li>V. Termination and Reinstatement</li><li>VI. Primary Source Verification Procedure</li><li>VII. Electronic Credentialing Process</li><li>VIII. Storage</li><li>IX. Quality Assurance and Performance Improvement</li><li>X. Residents</li><li>XI. Practitioners Who Do Not Need To Be Credentialed</li><li>XII. Auditing Process</li><li>XIII. Directory Maintenance</li></ul>
CR 3.0	Chief Medical Officer – Role and Responsibilities
CR 4.0	Practitioners Rights and Confidentiality
	<ul style="list-style-type: none"><li>I. Right to Review Credentialing Information</li><li>II. Notification of Erroneous or Varying Information</li><li>III. Right to Know Status of Application</li><li>IV. Confidentiality</li></ul>
CR 6.0	Delegated Credentialing
	<ul style="list-style-type: none"><li>I. Pre-delegation Evaluation</li><li>II. Pre-delegation Audit Results</li><li>III. Delegation Agreement</li><li>IV. Oversight of Delegation</li><li>V. Annual Audit</li><li>VI. Reporting</li><li>VII. Auto-Credit</li><li>VIII. Delegated Practitioner Additions</li></ul>
CR 9.0	Ongoing Monitoring, Corrective Action, and Intervention
	<ul style="list-style-type: none"><li>I. Ongoing Monitoring Activities</li></ul>

- II. Implementing Interventions
  - III. Reporting Process
- CR 10.0      Actions and Appeals Process
- I. Actionable Issues
  - II. Medical Director and CQC Review
  - III. Appeal Process
  - IV. Summary Suspension
  - V. Member Notification
- CR 11.0      Organizational Providers Credentialing
- I. Credentialing Procedure
  - II. Recredentialing Process
  - III. CQC Oversight
  - IV. Organizational Providers Primary Source Verification Procedure
- CR 16.0      Exceptions Policy
- I. Types of Credentialing Exceptions
  - II. Network Need Exceptions
  - III. Exception Review
  - IV. Temporary Emergency Provisions to Exceptions Policy
- CR 17.0      System Controls, Maintenance and Storage of Credentialing Information
- I. Securing Information
  - II. Modifications and Authorizations of Staff
  - III. Auditing Process
  - IV. Directory Maintenance
- CR 21.0      Annual Review & Development of Policies and Procedures
- CR 23.0      Credentialing Definitions and Acronyms

Credentials and Quality Committee Charter

# NCQA Credentialing Crosswalk

NCQA Element/Factor	Internal materials	Status
<b>CR 1: Policies and Procedures</b>		
<b>Element A - Practitioner Credentialing Guidelines</b>		
Factor 1: Types of practitioners it credentials and recredentials	CR 2.0, pg 2-3 section Policy	X
Factor 2: The verification sources it uses	CR 2.0 pg 26-30 section V Primary Source Verification Procedure	X
Factor 3: The criteria for credentialing and recredentialing	CR 2.0 pg 1 section Policy CR 2.0 pg 5-24 Criteria Grid, sections I Credentialing procedure, section II Recredentialing procedure includes the following: and section III Nonresponsive to Credentialing Requests	X
Factor 4: The process for making credentialing and recredentialing decisions	CR 2.0 pg 1 section Policy CR 2.0 pg 5-24 Criteria Grid, sections I Credentialing procedure, section II Recredentialing procedure includes the following: and section III Nonresponsive to Credentialing Requests	X
Factor 5: The process for managing credentialing files that meet the organization's established criteria	CR 1.0 pg 4 section III Responsibilities G CR 3.0 pg 2 section Procedure sub-section E	X
Factor 6: The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner	CR 1.0 pg 5 section-IV Non-discrimination letter A CR 1.0 pg 5 Section IV Non-discrimination letter B sub-section 2 CR 1.0 pg 5 section-IV Non-discrimination letter B sub-section 3	X
Factor 7: The process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information, they provided to the organization	CR 4.0 pg 3 section II Notification of Erroneous or Varying Information sub-section B	X
Factor 8: The process for ensuring that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee decision	CR 2.0 pg 1 section Policy paragraph 3	X
Factor 9: The medical director or other designated physicians' direct responsibility and participation in the credentialing program	CR 3.0 pg 1-2 section Policy and Procedure sub-section A-E	X
Factor 10: The process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law	CR 1.0 pg 4, section Responsibilities sub-section J-K CR 4.0 pg 5-6 section IV Confidentiality sub-section A-B Confidentiality Agreement	X
Factor 11: The process for ensuring listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty	CR 2.0 pg 36 section XII Directory Maintenance	X
<b>Element B – Practitioner Rights</b>		

NCQA Element/Factor	Internal materials	Status
Factor 1: Review information submitted to support their credentialing application	CR 4.0 pg 2-3 section I Right to Review Credentialing Information	X
Factor 2: Correct erroneous information	CR 4.0 pg 3-4 section II Notification of Erroneous or Varying Information A-G	X
Factor 3: Receive the status of their credentialing or recredentialing application, upon request	CR 4.0 pg 4-5 section III Right to Know Status of Application sub-sections A-C	X
<b>Element C – Credentialing System Controls</b>		
Factor 1: How primary source verification information is received, dated and stored.	CR 2.0 pg 25-29 section V Primary Source Verification Procedure, column “Methods of receipt”  CR 2.0 pg 30- 32 section VI Electronic Credentialing Process B Primary Source Verification Process, C Electronic Verification Workflow and section VII Storage	X
Factor 2: How modified information is tracked and dated from its initial verification.	CR 17, page 4-5 section III Tracking Modifications B	X
Factor 3: Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.	CR 17 pg 3-4 section II Authorization to Modify Information section A and section III Tracking Modifications section A	X
Factor 4: The security controls in place to protect the information from unauthorized modification.	CR 17 pg 2- section I Securing Information A-C	X
Factor 5: Annually monitoring the credentialing process	CR 17 pg 5-7 section IV System Controls Monitoring and Oversight Process A-E	X
<b>Element D Credentialing System Controls Oversight</b>		
Factor 1: Identifying all modifications to credentialing and recredentialing information that did not meet the organization’s policies and procedures for modifications.	CR 17 pg 5 section IV System Controls Monitoring and Oversight Process A- C  Evidence from Ongoing Monitoring Log	X
Factor 2: Analyzing all instances of modifications that did not meet the organization’s policies and procedures for modifications.	CR 17 pg 5 section IV System Controls Monitoring and Oversight Process A-C  Evidence from Ongoing Monitoring Log	X
Factor 3: Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.	CR 17 pg 7 section IV System Controls Monitoring and Oversight Process D  Evidence from Ongoing Monitoring Log	X
<b>CR2: Credentialing Committee</b>		
<b>Element A Credentialing Committee</b>		
Factor 1: Uses participating practitioners to provide advice and expertise for credentialing decisions.	CR 1.0 pg 2 Section II Committee Member sub-section B	X
Factor 2: Reviews credentials for practitioners who do not meet established thresholds.	CR 1.0 pg 3 Section III Responsibilities sub-section B, C and F  CR 1.0 pg 2 Section I Oversight sub-section A second paragraph  CR 1.0 pg 2 Section I Oversight sub-section A second paragraph	X
Factor 3: Ensures that files that meet established criteria are reviewed and approved by a medical director or designated physician.	CR 1.0 pg 3 Section III Responsibilities sub-section G  CR 3.0 pg 2 section Procedure sub-section E	X

NCQA Element/Factor	Internal materials	Status
*All meeting minutes and clean file lists are located in the T drive		
<b>CR3: Credentialing Verification</b>		
<b>Element A Verification of Credentials</b>		
Factor 1 A current and valid license to practice.	Verification conducted during credentialing file audit	
Factor 2 A valid DEA or CDS certificate, if applicable.		
Factor 3 Education and training as specified in the explanation.		
Factor 4 Board certification status, if applicable.		
Factor 5 Work history.		
Factor 6 A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner.		
<b>Element B Sanction Information</b>		
Factor 1 State sanctions, restrictions on licensure or limitations on scope of practice.	Verification conducted during credentialing file audit	
Factor 2 Medicare and Medicaid sanctions.		
<b>Element C Credentialing Application</b>		
Factor 1 Reasons for inability to perform the essential functions of the position	Verification conducted during credentialing file audit – All factors in Element C are found on the OPCA & OPRA attestation	
Factor 2 Lack of present illegal drug use.		
Factor 3 History of loss of license and felony convictions.		
Factor 4 History of loss or limitation of privileges or disciplinary actions.		
Factor 5 Current malpractice insurance coverage.		
Factor 6 Current and signed attestation confirming the correctness and completeness of the application.		
<b>CR4: Recredentialing Cycle Length</b>		
<b>Element A – Recredentialing Cycle Length</b>		
The length of the recredentialing cycle is within the required 36-month time frame.	Verification conducted during on-site credentialing file audit	
<b>CR5: Ongoing Monitoring and Interventions</b>		
<b>Element A - Ongoing Monitoring and Interventions</b>		
Factor 1: Collecting and reviewing Medicare and Medicaid sanctions	CR 9.0 pg 2-3 section I Ongoing Monitoring Activities sub-section A	X
Factor 2: Collecting and reviewing sanctions or limitations on licensure	CR 9.0 pg 3-4 section I Ongoing Monitoring Activities sub-section B	X
Factor 3: Collecting and reviewing complaints	CR 9.0 pg 4 section I Ongoing Monitoring Activities sub-section C  QM 213 pg 2 and pg 4-8 sections I.A Quality of Care Review and II Ongoing Monitoring	X
Factor 4: Collecting and reviewing information from identified adverse events	CR 9.0 pg 4 section I Ongoing Monitoring Activities sub-section C  QM 213 pg 2 and pg 4-8 sections I.A Quality of Care Review and II Ongoing Monitoring	X
Factor 5: Implementing appropriate interventions when it identifies instances of poor quality related to factors 1-4	CR 9.0 pg 5 section II Implementing Interventions sub-section A	X

NCQA Element/Factor	Internal materials	Status
<b>CR6: Notification to Authorities and Practitioner Appeal Rights</b>		
<b>Element A-Actions Against Practitioners</b>		
Factor 1: The range of actions available to the organization	CR 9.0 pg 1 section Policy first paragraph CR 9.0 pg 4-6 section II Implementing Interventions sub-section A & B CR 9.0 pg 6-8 section III Reporting Process CR 9.0 pg 2 section Policy fourth paragraph-Reporting CR 10.0 pg 4 section II Medical Director and CQC Review D CR 10.0 pg 3 section I Actionable Issues B.1	X
Factor 2: Making the appeal process known to practitioners	CR 10.0 pg 4-6 section III Appeal Process A & B	X
<b>CR7: Assessment of Organizational Providers</b>		
<b>Element A Review and Approval of Provider</b>		
Factor 1: Confirms that the provider is in good standing with state and federal regulatory bodies.	CR 11.0 pg 3, section I B.1 CR 11.0 pg 8-12 section IV	X
Factor 2: Confirms that the provider has been reviewed and approved by an accrediting body.	CR 11.0 pg 4-5 section I B.11 CR 11.0 pg 8-12section IV	X
Factor 3: Conducts an onsite quality assessment if the provider is not accredited.	CR 11.0 pg 5-6 section I B.12	X
<b>Element B Medical Providers</b>		
Factor 1 Hospitals	CR 11.0 pg 1, section Appiles to:	X
Factor 2 Home health agencies.	CR 11.0 pg 1, section Appiles to:	X
Factor 3 Skilled nursing facilities.	CR 11.0 pg 1, section Appiles to:	X
Factor 4 Free-standing surgical centers	CR 11.0 pg 1, section Appiles to:	X
<b>Element C Behavioral Healthcare Providers</b>		
Factor 1 Inpatient	CR 11.0 pg 1, section Appiles to:	X
Factor 2 Residential	CR 11.0 pg 1, section Appiles to:	X
Factor 3 Ambulatory	CR 11.0 pg 1, section Appiles to:	X
<b>Element D Assessing Medical Providers</b>		
Assessment of medical providers tracking log	Verification conducted during credentialing file audit	X
<b>Element E Assessing Behavioral Healthcare Providers</b>		
Assessment of behavioral provides tracking log	Verification conducted during credentialing file audit	X
<b>CR8: Delegation of CR</b>		
<b>Element A – Delegation Agreement</b>		
Factor 1: Is mutually agreed upon.	CR 6.0 pg 2 section Policy and pg 4 section II Delegation Agreement B Delegation Agreement pg 1 and pg 12	X
Factor 2: Describes the delegated activities and the responsibilities of the organization and the delegated entity.	CR 6.0 pg 4 section II Delegation Agreement B Delegation Agreement section III and section IV pg 2-11	X
Factor 3: Requires at least semiannual reporting of the delegated entity to the organization.	CR 6.0 pg 4 section II Delegation Agreement B Delegation Agreement pg 8-9 section III.H	X
Factor 4: Describes the process by which the organization evaluates the delegated entity's performance.	CR 6.0 pg 4 section II Delegation Agreement B Delegation Agreement pg 10 section IV. B	X

<b>NCQA Element/Factor</b>	<b>Internal materials</b>	<b>Status</b>
Factor 5: Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making	CR 6.0 pg 4 section II Delegation Agreement B Delegation Agreement pg 2 section II B	X
Factor 6: Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	CR 6.0 pg 4 section II Delegation Agreement B Delegation Agreement pg 11-12 section V Termination Process	X
<b>Element B- Pre-Delegation Evaluation</b>		
For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.	CR 6.0 Pg 2-3 section I Pre-delegation Evaluation CQC oversight/Pre-delegation report	X
<b>Element C-Review of Delegate's Credentialing Activities</b>		
Factor 1: Annually reviews its delegate's credentialing policies and procedures.	CR 6.0 pg 4-5 section III Annual Audit and Oversight of Delegation A & B Evidence of Delegation Agreement/Annual Delegation Report	X
Factor 2: Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.	CR 6.0 pg 5 section III Annual Audit and Oversight of Delegation B Evidence of CQC annual oversight/Annual Delegation Report	X
Factor 3: Annually evaluates delegate performance against NCQA standards for delegated activities.	CR 6.0 pg 4-5 section III Annual Audit and Oversight of Delegation A-C Evidence of CQC oversight review Annual Delegation Report	X
Factor 4: Semiannually evaluates regular reports, as specified in Element A.	CR 6.0 pg 4 section III Annual Audit and Oversight of Delegation A.2 CR 6.0 pg 6-7 section IV Reporting A-B Documented on Delegation Report Review Workbook	X
Factor 5: Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually.	CR 6.0 pg 5 section III Annual Audit and Oversight of Delegation B.4 Evidence of CQC annual oversight/Annual Delegation Report	X
Factor 6: Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvements for one finding over three consecutive quarters.	CR6.0 pg 5 section III Annual Audit and Oversight of Delegation B.4 Evidence of CQC annual oversight/Annual Delegation Report	X
<b>Element D: Opportunities for improvement</b>		
For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.	CR 6.0 pg 5 section III Annual Audit and Oversight of Delegation D Evidence of CQC annual oversight/Annual Delegation Report	X

<b>Policy and Procedure</b>			
SUBJECT: <b>Credentials and Quality Committee</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE:  <b>08/89</b>		DATE(S) REVISED:  <b>08/09; 07/10; 07/11; 7/12; 4/13, 4/14, 6/15, 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 1.0</b>	PAGE: <b>1 of 6</b>

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

- All practitioners
- All organizational providers
- All lines of business

<u>Fully Insured</u>						
<u>Individual</u>	<u>Small Group</u>	<u>Large Group</u>	<u>Self-Insured</u>	<u>Medicare</u>	<u>Medicaid</u>	<u>Delegated Services to Ayin</u>
<input type="checkbox"/> Oregon On Exchange	<input type="checkbox"/> Oregon On Exchange (SHOP)	<input type="checkbox"/> Oregon	<input type="checkbox"/> ASO	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> YCCO
<input type="checkbox"/> Oregon Off Exchange	<input type="checkbox"/> Oregon Off Exchange (SHOP)	<input type="checkbox"/> Washington	<input type="checkbox"/> PBM			<input type="checkbox"/> WHA
<input type="checkbox"/> Washington Off Exchange						
<input checked="" type="checkbox"/> APPLIES TO ALL ABOVE LINES OF BUSINESS						



<b>Policy and Procedure</b>			
SUBJECT: <b>Credentials and Quality Committee</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE:  <b>08/89</b>		DATE(S) REVISED:  <b>08/09; 07/10; 07/11; 7/12; 4/13, 4/14, 6/15, 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 1.0</b>	PAGE: <b>2 of 6</b>

**POLICY:**

As a part of the Quality Improvement Program for the Companies, all practitioners and organizational providers must successfully complete an initial credentialing and periodic recredentialing process. The credentialing and recredentialing process will ensure that all practitioners and organizational providers meet specific criteria and requirements that meet or exceed standards of the National Committee for Quality Assurance (NCQA) and the Center for Medicare and Medicaid Services (CMS). Selection for participation is also impacted by a need for additional practitioners or organizational providers with the specialty qualification, expertise, and geographic location of the applicant. The Credentials and Quality Committee (CQC) that uses a peer-review process is designated to make credentialing decisions.

At any time, the Chief Medical Officer or his/her physician designee determines that an immediate danger to PHP Members/Eligibles is posed by a practitioner warranting summary suspension, the CMO is authorized to issue such a suspension in accord with Credentialing Services policy CR 9.0 Ongoing Monitoring, Corrective Action and Intervention.

In addition, credentialing and recredentialing decisions will not be based on an applicant's race, ethnic/national identity, religion, age, gender, gender identity, sexual orientation, disability, the types of procedures or patient type in which the practitioner specializes, nor will any other such prejudicial policies be made. The Credentialing Department will monitor the provider complaints biannually to ensure that no concerns regarding discrimination exist.

**DEFINITIONS:**

See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

**PROCEDURE:**

- I. Oversight
  - A. A comprehensive review and verification of credentials is conducted for each practitioner or organizational provider prior to initial approval for panel participation and at least every 36 months thereafter.

The CQC is responsible for the oversight of the qualifications of applicants and participating practitioners. The Committee meets monthly, in person or by virtual meeting through video conference or web conference with audio, at a regularly

<b>Policy and Procedure</b>			
SUBJECT: <b>Credentials and Quality Committee</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE:  <b>08/89</b>		DATE(S) REVISED:  <b>08/09; 07/10; 07/11; 7/12; 4/13, 4/14, 6/15, 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 1.0</b>	PAGE: <b>3 of 6</b>

scheduled time. The members provide meaningful advice and expertise while giving thoughtful consideration to the credentialing elements when assessing and reassessing practitioners or organizational providers that have been referred by the Medical Director. All CQC discussions and decisions are documented through meeting minutes.

A quorum is established when four voting members (50%) are present (or participating via phone).

- B. On a quarterly basis, the Credentialing Department submits to Administrative Quality Council (AQC), a CQC report that evaluates the activities and effectiveness of the credentialing program.

II. Committee Members

The CQC utilizes participating practitioners to provide advice and expertise for credentialing decisions. The CQC is comprised of:

- A. The Chief Medical Officer or his/her physician designee – Voting
- B. No less than seven participating physician or nurse practitioner representatives from the range of practitioners in the organizations network who has no other role in the Companies – Voting
- C. Quality Management and Credentialing Services Staff Members – Non-Voting

III. Responsibilities

- A. Review all files that are considered exceptions as outlined in CR 16.
- B. Review and approve, defer, modify or deny panel participation for initial applicants based on specific criteria and standards contained in Credentialing Services policy CR 2.0 Practitioner Credentialing or CR 11.0 Organizational Providers Credentialing.
- C. Review and approve or terminate participating practitioners or organizational providers based on specific criteria and standards contained in Credentialing Services policy CR 2.0 Practitioner Credentialing and CR 11.0 Organizational Providers Credentialing.

<b>Policy and Procedure</b>			
SUBJECT: <b>Credentials and Quality Committee</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE:  <b>08/89</b>		DATE(S) REVISED:  <b>08/09; 07/10; 07/11; 7/12; 4/13, 4/14, 6/15, 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 1.0</b>	PAGE: <b>4 of 6</b>

- D. Evaluate reinstatement of providers whose licenses have been suspended and then reinstated by licensing bodies.
- E. Develop credentialing and recredentialing criteria as needed.
- F. At a minimum the CQC must review the files of practitioners or organizational providers who do not meet PHP criteria or established thresholds.
- G. Credential and/or recredential files that meet all criteria outlined in Credentialing Services policy CR 2.0 Practitioner Credentialing or CR 11.0 Organizational Providers Credentialing are considered to be complete and without exceptions “clean files”, these files may be reviewed and approved by the Chief Medical Officer or his/her physician chair designee. Clean files that meet the Companies criteria may be reviewed and approved by email. This designee may be a Medical Director who is responsible for oversight of the credentialing process. The CQC has final authority regarding panel participation for all practitioners and organizational providers.
- H. CQC members shall not participate in decision making on a particular applicant or participating practitioner if the Committee member or the Committee feels there may be a conflict of interest issue.
- I. The confidentiality of provider information is maintained as per Credentialing Services policy CR 4.0 Practitioners Rights and Confidentiality.
- J. Members of the CQC will sign a confidentiality statement on an annual basis.
- K. Each member agrees to respect and maintain the confidentiality of all discussions that occur during the committee meeting and related to specific committee delegated tasks, deliberations, proceedings, records, complaints, reports and all other information and documents created, collected and/or maintained in connection with these activities. Each member agrees to not disclose such information except to persons authorized to receive it in conducting Company business. All credentialing documentation presented during the CQC meeting should be returned to the Credentialing Department for disposal following the meeting. In the event of a virtual meeting, documentation will be accessed through a secure meeting link. CQC Members who are not in attendance are responsible for destroying credentialing documentation in a manner that maintains confidentiality. CQC members agree to conduct teleconferencing and virtual meetings in a location where their computer screen is not visible to others and where the meeting will not

<b>Policy and Procedure</b>			
SUBJECT: <b>Credentials and Quality Committee</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE:  <b>08/89</b>		DATE(S) REVISED:  <b>08/09; 07/10; 07/11; 7/12; 4/13, 4/14, 6/15, 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 1.0</b>	PAGE: <b>5 of 6</b>

be heard by others. Members also agree to destroy informational materials received via mail or electronically for review purposes in a manner that maintains confidentiality.

- L. Policies and Procedures will be reviewed by the CQC annually. After review, the policies and procedures will be signed off and approved by the Chief Medical Officer or their physician designee.

IV. Non-discrimination

- A. Members of the CQC will not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, religion, age, gender, gender identity, sexual orientation, disability, the types of procedures or patient type in which the practitioner specializes nor any other such prejudicial policy.
- B. Credentialing files will be reviewed by the Credentialing Department at least annually for any indication of discrimination within the decision-making process.

PHP monitors for and prevents discriminatory credentialing by the following, but not limited to:

1. The Companies do not require information on an applicant's race, ethnic/national identity, religion, age, gender, gender identity, sexual orientation, disability, the types of procedures nor patient type in which the practitioner specializes.
2. CQC members are required to attest at the start of each CQC meeting that they have read and understand the Non-discrimination Statement to assure credentialing and recredentialing decisions are not discriminatory or based on an applicant's race, ethnic/national identity, religion, age, gender, gender identity, sexual orientation, disability, the types of procedures nor patient type in which the practitioner specializes.
3. Committee minutes will document reasons, for which providers were accepted, denied or terminated. Based on review of the committee minutes, annual audits will be conducted to ensure providers are not discriminated against.

<b>Policy and Procedure</b>			
SUBJECT: <b>Credentials and Quality Committee</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE:  <b>08/89</b>		DATE(S) REVISED:  <b>08/09; 07/10; 07/11; 7/12; 4/13, 4/14, 6/15, 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 1.0</b>	PAGE: <b>6 of 6</b>

**REFERENCES:**

NCQA Credentialing Standards  
 CMS Credentialing Standards  
 CR 2.0 Practitioner Credentialing  
 CR 4.0 Practitioners Rights and Confidentiality  
 CR 9.0 Ongoing Monitoring, Corrective Action and Intervention  
 CR 11.0 Organizational Providers Credentialing  
 CR 16.0 Exceptions Policy  
 CR 23.0 Credentialing Definitions and Acronyms

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>1 of 36</b>

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

All credentialed practitioners for the following lines of business:

<u>Fully Insured</u>			<u>Self-Insured</u>	<u>Medicare</u>	<u>Medicaid</u>	<u>Delegated Services to Ayin</u>
<u>Individual</u>	<u>Small Group</u>	<u>Large Group</u>				
<input type="checkbox"/> Oregon On Exchange	<input type="checkbox"/> Oregon On Exchange (SHOP)	<input type="checkbox"/> Oregon	<input type="checkbox"/> ASO	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> YCCO
<input type="checkbox"/> Oregon Off Exchange	<input type="checkbox"/> Oregon Off Exchange (SHOP)	<input type="checkbox"/> Washington	<input type="checkbox"/> PBM			<input type="checkbox"/> WHA
<input type="checkbox"/> Washington Off Exchange						
<input checked="" type="checkbox"/> APPLIES TO ALL ABOVE LINES OF BUSINESS						

**POLICY:**

All participating practitioners are required to complete initial credentialing prior to participation and providing care to members. The process includes completion of the application, primary source verification of specific elements, followed by review and decision by the Credentials and Quality Committee (CQC). This process supports The Companies’ commitment that all members will receive quality care from qualified providers.

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>2 of 36</b>

Recredentialing is completed within 3 years to the day of the previous credentialing decision. The recredentialing process establishes regular review of the practitioner’s performance with respect to utilization, quality, access and administrative concerns and includes the following components, as available:

- Profiles on the utilization of resources
- Adverse outcome/sentinel event cases
- Member satisfaction
- Member complaints
- Medical record documentation audit results

Within sixty (60) days after the credentialing decision and recredentialing denials, the Credentialing Department sends practitioners written notification of the decision, either through e-mail or the U.S. Postal Service.

**DEFINITION:** Definitions and Acronyms

Credentialed practitioners: such practitioners include, but are not limited to the following:

- Medical Practitioners:
  - Medical doctors and Osteopath (MD and DO)
  - Oral surgeon (DMD)
  - Chiropractor (DC)
  - Dentist (DDS)
  - Podiatrist (DPM)
  - Certified Nurse Midwife (CNM)
  - Nurse Practitioner (NP)
  
- Other Medical Practitioners:
  - Audiologist (AuD)
  - Certified Registered Nurse Anesthetist (CRNA)
  - Certified Registered Nurse First Assistant (CRNFA)
  - Certified Surgical Assistant (CFA, CST, SA-C)
  - Clinical Nurse Specialist (CNS)
  - Genetic Counselor (GC)
  - Lactation Consultant (LC)
  - Licensed Acupuncturist (LAc)

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>3 of 36</b>

- Licensed Direct Entry Midwife (LDEM)
  - Licensed Massage Therapist (LMT)
  - Naturopathic Doctor (ND)
  - Occupational Therapist (OT)
  - Optometrist (OD)
  - Pharmacist (RPh)
  - Physical Therapist (PT)
  - Physician Assistant (PA)
  - Registered Dietician (RD)
  - Speech Language Pathologist (SLP)
  - Other medical practitioners who may be within the scope of credentialing
- Behavioral Health Practitioners:
    - Addiction medicine specialist (requirements listed below under specific degree type)
    - Board Certified Assistant Behavior Analyst (BCaBA)
    - Board Certified Behavioral Analyst (BCBA-D, BCBA)
    - Licensed Marriage and Family Therapist (LMFT)
    - Licensed Mental Health Counselor (LMHC)
    - Licensed Professional Counselor (LPC)
    - Master’s-level clinical nurse specialist (CNS)
    - Master’s-level clinical social worker (LCSW)
    - Psychiatric Mental Health Nurse Practitioner (PMHNP)
    - Psychiatrists and Other physician (MD and DO)
    - Psychologist (Ph.D, Psy.D)
    - Other behavioral healthcare specialists who may be within the scope of credentialing
  - Non-licensed Professionals for Yamhill Community Care Organization (YCCO) only:
    - Clinical Social Worker (CSW-RA)
    - Marriage and Family Therapist (MFT-RA)
    - Professional Counselor, Registered Associate (PC-RA)
    - Psychology, Resident or Associate Resident (PsyD-R)

**See below for the practitioner-specific credentialing criteria.**

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<b>Policy and Procedure</b>	
SUBJECT: <b>Practitioner Credentialing</b>	DEPARTMENT: <b>CR: Credentialing Services</b>
ORIGINAL EFFECTIVE DATE: <b>09/97</b>	DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>
NUMBER: <b>CR 2.0</b>	PAGE: <b>4 of 36</b>

<b>Types of Practitioner</b>	<b>Current Valid State License</b>	<b>Hospital Privileges</b>	<b>Valid DEA or CDS</b>	<b>Education</b>	<b>Board Cert.</b>	<b>Work History</b>	<b>Current Malprac. Insur.</b>	<b>History of Liability Claims</b>	<b>NPDB Queries</b>	<b>Medicare / Medicaid</b>
Audiologist (AuD)	Oregon Board of Examiners for Speech-Language Pathology and Audiology, Washington State Department of Health	N/A	N/A	Graduate of approved program in Communicative Disorders & Internship	N/A	X	X	X	X	X
Board Certified Assistant Behavior Analyst (BCaBA)	Oregon Behavior Analysis Regulatory Board, Washington State Department of Health	N/A	N/A	Graduate of approved ABA program and documented participating supervising practicing as BCBA or BCBA-D)	X	X	X	X	X	X
Board Certified Behavior Analyst (BCBA-D, BCBA)	Oregon Behavior Analysis Regulatory Board, Washington State Department of Health	N/A	N/A	Graduate of approved ABA program	X	X	X	X	X	X
Certified Registered Nurse Anesthetist (CRNA)	Oregon State Board of Nursing, Washington State Department of Health	As applicable	As applicable	Graduate of approved CRNA program	X	X	X	X	X	X
Certified Registered Nurse First Assist (CRNFA)	Oregon State Board of Nursing, Washington State Department of Health	N/A	N/A	Completion of perioperative nursing practice (CNOR) Graduation from an accredited RNFA nursing program associated with an institute of higher education	N/A	X	X	X	X	X

<b>Policy and Procedure</b>	
SUBJECT: <b>Practitioner Credentialing</b>	DEPARTMENT: <b>CR: Credentialing Services</b>
ORIGINAL EFFECTIVE DATE: <b>09/97</b>	DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>
NUMBER: <b>CR 2.0</b>	PAGE: <b>5 of 36</b>

<b>Types of Practitioner</b>	<b>Current Valid State License</b>	<b>Hospital Privileges</b>	<b>Valid DEA or CDS</b>	<b>Education</b>	<b>Board Cert.</b>	<b>Work History</b>	<b>Current Malprac. Insur.</b>	<b>History of Liability Claims</b>	<b>NPDB Queries</b>	<b>Medicare / Medicaid</b>
Certified Surgical Assistant (CFA, CST, SA-C)	N/A	Affiliation with a participating physician	N/A	Graduate of approved Surgical Assist program	X	X	X	X	X	X
Certified Nurse Midwife (CNM)	Oregon State Board of Nursing, Washington State Department of Health	Admit plan with a participating practitioner with admitting and cesarean section privileges at a participating hospital.	X	Graduation from CNM program	X	X	X	X	X	X
Certified Nurse Specialist (CNS)	Oregon State Board of Nursing, Washington State Department of Health	As Applicable	X	Graduation from CNS program	X	X	X	X	X	X
Chiropractor (DC)	Oregon Board of Chiropractic Examiners, Washington State Department of Health	N/A	N/A	Graduation from Chiropractic College	N/A	X	X	X	X	X
Dentists (DDS)	Oregon Board of Dentistry, Washington State Department of Health	As Applicable	DEA	Grad. from Dental School, Completion of specialty training ADA Master file	N/A	X	X	X	X	N/A
Genetic Counselor	Oregon Health Authority/ Health Licensing Office, Genetic Counseling Program, Washington State Department of Health	N/A	N/A	Documented successful completion of an approved specialty program Or Current certification by the American Board of Genetic Counseling	N/A	X	X	X	X	X

<b>Policy and Procedure</b>	
SUBJECT: <b>Practitioner Credentialing</b>	DEPARTMENT: <b>CR: Credentialing Services</b>
ORIGINAL EFFECTIVE DATE: <b>09/97</b>	DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>
NUMBER: <b>CR 2.0</b>	PAGE: <b>6 of 36</b>

<b>Types of Practitioner</b>	<b>Current Valid State License</b>	<b>Hospital Privileges</b>	<b>Valid DEA or CDS</b>	<b>Education</b>	<b>Board Cert.</b>	<b>Work History</b>	<b>Current Malprac. Insur.</b>	<b>History of Liability Claims</b>	<b>NPDB Queries</b>	<b>Medicare / Medicaid</b>
Lactation Consultant (LC)	Oregon Health Authority/ Health Licensing Office, Lactation Consultant Program	N/A	N/A	Documented successful completion of an approved specialty program Or Current certification as an International Board Certified Lactation Consultant (IBCLC) issued by the International Board of Lactation Consultant Examiners (IBLCE)	X	X	X	X	X	X
Licensed Acupuncturist (LAc)	Oregon Medical Board, Washington State Department of Health	N/A	N/A	Graduate of approved acupuncture program	N/A	X	X	X	X	X
Licensed Direct Entry Midwife	Board of Direct Entry Midwifery, Washington State Department of Health	Admit plan with a participating practitioner with admitting and cesarean section privileges at a participating hospital.	N/A	Graduate of a MEAC approved midwifery program	Certified Professional Midwife (CPM) credential from the North American Registry of Midwives (NARM)	X	X	X	X	X
Licensed Marriage and Family Therapy	Oregon Board of Licensed Professional Counselors and Therapists,	N/A	N/A	Graduate of Master's Program	N/A	X	X	X	X	X

<b>Policy and Procedure</b>	
SUBJECT: <b>Practitioner Credentialing</b>	DEPARTMENT: <b>CR: Credentialing Services</b>
ORIGINAL EFFECTIVE DATE: <b>09/97</b>	DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>
NUMBER: <b>CR 2.0</b>	PAGE: <b>7 of 36</b>

Types of Practitioner	Current Valid State License	Hospital Privileges	Valid DEA or CDS	Education	Board Cert.	Work History	Current Malprac. Insur.	History of Liability Claims	NPDB Queries	Medicare / Medicaid
	Washington State Department of Health									
Licensed Massage Therapist (LMT)	Oregon Board of Massage Therapists, Washington State Department of Health	N/A	N/A	Approved massage education program	N/A	X	X	X	X	X
Licensed Mental Health Counselor (LMHC)	Oregon Board of Licensed Professional Counselors and Therapists, Washington State Department of Health	N/A	X	Graduate of Master's Program	N/A	X	X	X	X	X
Licensed Professional Counselors (LPC)	Oregon Board of Licensed Professional Counselors and Therapists, Washington State Department of Health	N/A	X	Graduate of Master's Program	N/A	X	X	X	X	X
Master's-level Clinical Nurse Specialist	Oregon State Board of Nursing, Washington State Department of Health	As applicable	As applicable	Graduation from CNS program	X	X	X	X	X	X
Master's-level Licensed Clinical Social Workers (LCSW)	Oregon Board of Licensed Social Workers, Washington State Department of Health	N/A	N/A	Graduate of Master's Program	N/A	X	X	X	X	X
Medical Doctors (MD, DO)	Oregon Medical Board, Washington State Department of Health	As Applicable	X	Graduation from Medical School Completion of Residency	X	X	X	X	X	X

<b>Policy and Procedure</b>	
SUBJECT: <b>Practitioner Credentialing</b>	DEPARTMENT: <b>CR: Credentialing Services</b>
ORIGINAL EFFECTIVE DATE: <b>09/97</b>	DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>
APPROVED BY:                      DATE: <b>Medical Director                      04/19/2023</b>	NUMBER:                      PAGE: <b>CR 2.0                      8 of 36</b>

<b>Types of Practitioner</b>	<b>Current Valid State License</b>	<b>Hospital Privileges</b>	<b>Valid DEA or CDS</b>	<b>Education</b>	<b>Board Cert.</b>	<b>Work History</b>	<b>Current Malprac. Insur.</b>	<b>History of Liability Claims</b>	<b>NPDB Queries</b>	<b>Medicare / Medicaid</b>
Naturopath (ND)	Oregon Board of Naturopathic Medicine, Washington State Department of Health	N/A unless Acting as PCP (admit plan)	X	Graduate from accredited Naturopathic residency program	N/A	X	X	X	X	X
Nurse Practitioners (NP)	Oregon State Board of Nursing, Washington State Department of Health	As Applicable	X	Graduation from NP education program Completion of Specialty Focus	X	X	X	X	X	X
Occupational Therapist (OT)	Oregon Occupational Therapy Licensing Board, Washington State Department of Health	N/A	N/A	Graduate of Master's Program	N/A	X	X	X	X	X
Optometrist (OD)	Oregon Board of Optometry, Washington State Department of Health	N/A	N/A	Graduate from accredited School of Optometry	N/A	X	X	X	X	X
Oral Surgeon (DMD)	Oregon Medical Board, Washington State Department of Health	As Applicable	X	Graduation from Medical School Completion of Residency	X	X	X	X	X	X
Pharmacists (RPh)	Oregon Board of Pharmacy, Washington State Department of Health	N/A	N/A	Graduate from a PGY1 residency Or Approved board certification				X	X	X
Physical Therapy (PT)	Oregon Physical Therapy Licensing Board, Washington State Department of Health	N/A	N/A	Graduate from approved physical therapy program	N/A	X	X	X	X	X

<b>Policy and Procedure</b>	
SUBJECT: <b>Practitioner Credentialing</b>	DEPARTMENT: <b>CR: Credentialing Services</b>
ORIGINAL EFFECTIVE DATE: <b>09/97</b>	DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>
NUMBER: <b>CR 2.0</b>	PAGE: <b>9 of 36</b>

<b>Types of Practitioner</b>	<b>Current Valid State License</b>	<b>Hospital Privileges</b>	<b>Valid DEA or CDS</b>	<b>Education</b>	<b>Board Cert.</b>	<b>Work History</b>	<b>Current Malprac. Insur.</b>	<b>History of Liability Claims</b>	<b>NPDB Queries</b>	<b>Medicare / Medicaid</b>
Physician Assistant (PA)	Oregon Medical Board, Washington State Department of Health	As Applicable	X	Graduate from an Accredited Masters Program	N/A	X	X	X	X	X
Podiatrists (DPM)	Oregon Medical Board, Washington State Department of Health	As Applicable	X	Grad. from Podiatry School Completion of a residency program if applicable	X	X	X	X	X	X
Psychiatric Mental Health Nurse Practitioner	Oregon State Board of Nursing, Washington State Department of Health	As Applicable	X	Graduation from NP education program Completion of Specialty Focus	N/A	X	X	X	X	X
Psychologists	Oregon Board of Psychologist Examiners, Washington State Department of Health	As Applicable	N/A	Graduation from a professional school	N/A	X	X	X	X	X
Registered Dietician (RD)	Oregon Board of Licensed Dietitians, Washington State Department of Health	N/A	N/A	Graduate of Master's Program	N/A	X	X	X	X	X
Speech Language Pathology (SP)	Oregon Board of Examiners for Speech-Language Pathology (Conditional license requires credentialed and contracted supervising SLP) and Audiology, Washington State Department of Health	N/A	N/A	Graduate from Master's Program, Internship	N/A	X	X	X	X	X

<b>Policy and Procedure</b>	
SUBJECT: <b>Practitioner Credentialing</b>	DEPARTMENT: <b>CR: Credentialing Services</b>
ORIGINAL EFFECTIVE DATE: <b>09/97</b>	DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>
APPROVED BY:                      DATE: <b>Medical Director                      04/19/2023</b>	NUMBER:                      PAGE: <b>CR 2.0                      10 of 36</b>

<b>Types of Practitioner</b>	<b>Current Valid State License</b>	<b>Hospital Privileges</b>	<b>Valid DEA or CDS</b>	<b>Education</b>	<b>Board Cert.</b>	<b>Work History</b>	<b>Current Malprac. Insur.</b>	<b>History of Liability Claims</b>	<b>NPDB Queries</b>	<b>Medicare / Medicaid</b>
Clinical Social Worker (CSW-A) YCCO Only	Oregon Board of Licensed Social Workers	N/A	N/A	Graduate of Master's Program	N/A	X	X	X	X	X
Marriage and Family Therapist (MFT-A) YCCO Only	Oregon Board of Licensed Professional Counselors and Therapists	N/A	N/A	Graduate of Master's Program	N/A	X	X	X	X	X
Professional Counselor, Registered Associate (PC-A) YCCO Only	Oregon Board of Licensed Professional Counselors and Therapists	N/A	N/A	Graduate of Master's Program	N/A	X	X	X	X	X
Psychology, Resident or Associate Resident (PsyD-A) YCCO Only	Oregon Board of Psychology	N/A	N/A	Graduation from a professional school	N/A	X	X	X	X	X

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>11 of 36</b>

**PROCEDURE:**

I. Credentialing Procedure

The selection for participation is based on a need for additional practitioners with the specialty qualifications, expertise, and geographic location of the applicant to form a balanced, efficient network of practitioners within a service area.

- A. At any point in the credentialing process, credentialing staff will submit applicants who do not meet credentialing criteria to the Provider Relations Department for Network Need assessment prior to taking any action.
- B. Non-response by an applicant within 30 days of any credentialing request will be considered a voluntary withdrawal of the application. Credentialing staff will notify Provider Relations of non-response in order to suspend the request for credentialing.
- C. All practitioners must complete an approved application and attest to the following:
  - 1. Reasons for any inability to perform the essential functions of the position with or without accommodation.
  - 2. Lack of present illegal drug use
  - 3. Any history of loss of license and/or felony convictions
  - 4. Hospital privilege status, history of loss or limitations of privileges, or disciplinary activity
  - 5. Current malpractice insurance
  - 6. Confirming the correctness and completeness of the application. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired, and the disability is documented in the practitioner's file.



<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>12 of 36</b>

D. Credentialing decisions will be based on the verification of a complete application. The Credentialing Department obtains all relevant documentation required in the application or as requested to address concerns identified by the CMO, CMO Physician Designee, or CQC. Primary (issuing) source verification of specific elements is completed by qualified Credentialing staff and may be written, electronic, or verbal. Verification requires documentation in the credentialing file that includes who verified the item, the date it was verified, and how it was verified. Credentialing staff review each required element of the credentialing file to ensure that the element is current at the time of credentialing approval and is void of derogatory information that would be considered an exception as outlined in Credentialing Services policy CR 16.0 Exceptions Policy. Credentialing applications will be processed within an average of 60 days of receipt of a complete application. Information contained in the complete application, including the signed release of information and the attestation shall be current and not be more than 180 days old at the time of the CQC’s decision. Complete application includes, but is not limited to the following (primary source verification requirements are indicated by an asterisk \*):

1. \*Licensure - Any current, active, valid licensure and/or certification to practice within the applicable “Scope of Practice” rules by the appropriate State licensing authority in which the provider treats Members. Sanctions, limitations, and restrictions must cover the most recent five (5) years. The license must be in effect at the time of the CQC decision.

Practitioners with a limited license can be reviewed and approved by CQC. The Credentialing Department will follow-up to verify permanent license.

Any practitioner who has an open “interim stipulated order” with a licensing board is ineligible for application until the interim order is closed.

2. DEA or CDS Certificates - Current, valid Drug Enforcement Agency (DEA) Certificate if applicable to the scope of practice. In the event a practitioner is in the process of applying for a DEA Certificate, they may submit documentation showing an alternative process where a practitioner with a valid DEA certificate has agreed to provide necessary prescriptions for patients until the practitioner’s DEA Certificate has been issued.

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>13 of 36</b>

Practitioners must be registered in each state where Member care is provided. Credentialing Staff will review DEAs to ensure the registration corresponds to where the practitioner is providing care to Members. If an incorrect address is noted the practitioner will be notified. Follow-up documentation will be noted within the file. All updated DEAs will be added to practitioner files as received.

If an eligible provider does not maintain or have a valid DEA or CDS certificate, an alternative process must be arranged for another participating practitioner to fill prescriptions. Specialties in which prescribing drugs is not the usual practice may not require a DEA certificate. For a list of exceptions refer to section VI. Primary Source Verification Procedure.

3. \*Education and Training – During initial credentialing, the highest of the following three levels of education and training obtained by the practitioner must be verified (verification of Fellowship does not meet this intent).
  - a. Graduation from medical school or professional training (If the state licensing agency performs primary-source verification of professional school training, confirmation may be received from the state licensing agency. An annual letter will be kept on file from the state licensing agency noting they perform primary source verification of a provider’s education and training information.)
  - b. Residency
  - c. Board certification
  
4. \*Board Certification - Board certification is required for MDs, DOs, and DPMs. Physicians whose residencies were completed after 1980 must be board certified as recognized by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine (ABPM), American Board of Oral and Maxillofacial Surgery (ABOMS), The College of Family Physicians of Canada, or Royal College of Physicians and Surgeons, Canada. If the practitioner’s specialty board requires periodic recertification or maintenance of certification, the practitioner is required to take all necessary steps to maintain board certification, or meet maintenance of

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>14 of 36</b>

certification, and be in good standing with their specialty board in order to remain a participating practitioner. Exceptions will be considered on a case-by-case basis by the CQC.

- a. Participating status may be granted without exception to a physician who has completed an accredited residency program within the past 5 years and shows intent to become board certified. Status will be reviewed on an ongoing basis.
- b. Failure to pass the board examination after three attempts and/or within 5 years will result in a review by the CQC and may result in a recommendation for denial or termination based on lack of compliance with the credentialing criteria.
- c. If a practitioner is practicing in a specialty they are not board certified in they may be subject to review by the CQC. This will be reviewed on a case-by-case basis and will require documentation of training and experience acquired in the specialty they are practicing. The following will be requested prior to CQC review:
  - i. Thirty (30) hours of Category I CME in the specialty area requested for the prior year or 60 Category I CME for the previous two years.
  - ii. Two peer references who have direct clinical observation of the applicant in the past 12 months and who can validate that the practitioner is adequately trained and demonstrates competency in the requested specialty.
- d. Participating practitioners approved prior to January 1, 1996, who were not board certified are considered to be “grandfathered”. All practitioners who are granted grandfathering status will be required to obtain 90 category 1 CMEs within the past three years or 60 category 1 CMEs in the past two years. If a “grandfathered” practitioner becomes board certified they must maintain their board certification in their practice specialty. Grandfathered practitioners who do not maintain their board certification status will be subject to termination.

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>15 of 36</b>

- e. Physicians who are subject to suspension of board certification due to a pending or open licensing action may be granted exception upon review and approval by the CQC.
  
- f. Board recertification and/or maintenance of certification may be waived for practitioners with a minimum of nine years of credentialing history with The Companies and intending to retire within 36 months of their board expiration. Applicable practitioners must submit notification stating intent to retire and a specific retirement date. Board certification waiver is non-renewable and practitioners utilizing this policy will be terminated no later than the retirement date specified. The following conditions apply:
  - The applicant is in good standing.
  - Practitioner must demonstrate compliance with continuing medical education requirements (90 hours of category 1 CME in the past three years or 60 in the past two years); and maintain compliance by submitting 30 hours of category 1 CME per year until their specified retirement date. CME will be requested annually and must be within the practitioner’s specialty.
  - Practitioners with an inconsistent history of maintaining board certification are not eligible.

Requests to extend panel participation beyond 36 months of the practitioner’s board certification expiration will not be considered under this policy; however, CQC may review if practitioner meets an exception allowed under CR policy 16.0 Exceptions Policy.

- g. Practitioners who have not maintained board certification and who do not meet policies for exception or waiver will be sent notification upon discovery of the expired board certification to request their plan to become board certified within 12 months. The practitioner, with or without a plan to recertify will be presented to CQC for review and decision.
5. Work History – Work history is requested from the end of training to current. A complete application includes a minimum of the most recent five years of

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>16 of 36</b>

work history (three years for recredentialing application) as a health professional and is confirmed by review of the practitioner’s application or CV. The application or CV must include the beginning and ending (if applicable) month and year for each position of employment. If a practitioner has less than five years of work history, the time frame starts at the initial licensure date. An explanation is required for any gap in work history that is greater than two months.

6. \*Malpractice History - History of professional liability claims that resulted in settlements or judgments-must cover most recent five-year period (three years for recredentialing application). Queries are completed via the NPDB.
  
7. Current Professional Liability Insurance – Practitioners must have current professional liability insurance effective at all times during participation subject to limit and career requirements approved by the CQC, currently set at a minimum of \$1 million each occurrence and \$3 million aggregate. Evidence of private malpractice insurance coverage must also include a roster listing the practitioner being credentialed and covered under the policy or attested to in the practitioner’s application. At the approval of the Medical Director and in certain instances of network need non-physician clinicians may be allowed to maintain lesser amounts. Exceptions will be made for providers that work exclusively for the county or state that is self-insured for liability in accordance with the provision of the Tort Actions Against Public Bodies, ORS 30.260 to 30.300. A federal tort letter, face sheet or attestation in the practitioner application is approved documentation and a roster is not required for practitioners covered under federal or state torts. Independent contractors are not covered under the Oregon Tort Claims Act. The face sheet, federal tort letter or employer professional liability policy must include the effective and expiration dates, future effective dates are acceptable.
  
8. \*Medicare or Medicaid Sanction or Exclusion
  - a. OIG - Sanctions are verified through the Cumulative Sanction Report available from the Office of Inspector General (OIG).

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>17 of 36</b>

b. SAM - GSA/ System Award Management parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits.

c. Opt Out - A documented review of the Medicare opt-out list for each state in which the provider is treating Members.

Practitioners who have opted out or have been excluded/ sanctioned from participation with Medicare or Medicaid will not be considered for membership with any Medicare or Medicaid lines of business.

d. Preclusion – The most up-to-date CMS Preclusion List is reviewed and results are documented in the credentialing checklist.

Practitioners who have been precluded from participation with Medicare or Medicaid will not be considered for membership with any Medicare or Medicaid lines of business.

9. \*National Practitioner Data Bank

10. Contact Information – All practitioners are required to provide current contact information including, but not limited to: current office addresses, phone, fax, and e-mail address.

11. \*National Provider Identifier (NPI)

12. Call Coverage - Practitioners (MDs, DOs, DPMs, NPs, NDs as PCPs, and PAs) are expected to have continuous call coverage. The covering providers must be participating providers in the same or similar specialty. If the provider does not have the same specialty coverage, has out of plan coverage, or lacks coverage due to geographic location, they may be subject to review by the CQC.

13. Admitting Privileges or Admit Plan - Providers (including without limitation: MDs, DOs, DPMs, NPs, NDs as PCPs, and PAs) must have active admitting hospital privileges at participating or contracted hospitals. These privileges will be verified at initial credentialing and recredentialing. If a practitioner does not have privileges at a participating or contracted hospital, they must

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>18 of 36</b>

submit a hospital admit plan which documents their process in the event of a Member requiring hospitalization.

- a. The practitioner must have a system in place that allows a patient to be evaluated telephonically by a live person. The evaluator will be able to give the patient clinical advice or to facilitate contact with another individual who has that ability.
  - b. Contracts or agreements with hospitalists are considered to be an acceptable form of coverage. The agreement may include patient flow through the emergency room as established by the facility's Hospitalist program.
  - c. When considering a practitioner with hospital privileges at a contracted hospital only, PR must determine that the practitioner is practicing in a specialty that is of need for the Health Plan.
  - d. Practitioners that perform deliveries outside of a hospital setting must have formal documentation of a working relationship with a practitioner who has full obstetrical hospital privileges at a participating hospital.
- E. Nurse Practitioners who request to be listed in the provider directory with a subspecialty will provide the following information:
1. Documented successful completion of specialty training in the requested specialty or current experience within the past three years
  2. Two peer reference letters from practitioners who have had direct clinical observation of the applicant within the past twelve months, who can verify that the practitioner is currently competent in the requested specialty.
  3. Provide verification of current accredited national board certification from a Nurse Practitioner national certification examination.
  4. 90 hours of continuing medical education (CME) or ongoing education documentation from the past three years or 60 hours of CME in the past two years within the requested specialty.
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<b>Policy and Procedure</b>	
SUBJECT: <b>Practitioner Credentialing</b>	DEPARTMENT: <b>CR: Credentialing Services</b>
ORIGINAL EFFECTIVE DATE: <b>09/97</b>	DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>
APPROVED BY:                      DATE: <b>Medical Director                      04/19/2023</b>	NUMBER:                      PAGE: <b>CR 2.0                      19 of 36</b>

- F. Supervising physician agreements, collaboration agreements, or other practice agreements as required by the applicable state licensing board are required as part of the credentialing process. Physician Assistants must have a practice agreement with a participating practitioner (MD, DO, DPM) or group who is competent to collaborate with the physician assistant on the performance of medical services for which the physician has training and experience.
  
  - G. Applied Behavior Analysts must possess state licensure in states that license behavior analysts, a masters or doctoral degree with active certification from the national Behavior Analyst Certification Board as Board Certified Behavior Analysts (BCBA), and possess a minimum of six (6) months experience or training in applied behavior analysis/intensive behavior therapies under the supervision of a Board Certified Behavior Analyst or a licensed clinician. Board Certified Assistant Behavior Analysts (BCaBA) must have a participating supervising practitioner practicing as a Board Certified Behavior Analyst (BCBA) or Board Certified Behavior Analyst - Doctoral (BCBA-D).
  
  - H. On an individual basis and where professional conduct or competency concerns are identified through the credentialing process, additional information may be requested prior to making a credentialing decision or as a stipulation of credentialing. The need to request additional information may be identified by CMO, CMO physician designee, or CQC. Additional information requested may include the following without restriction:
    - 1. Specific health screening or evaluation (at the expense of the applicant)
    - 2. Peer reference
    - 3. Work history verification
    - 4. Completion of specific CME
  
  - I. Primary Care Practitioner (PCP) shall mean a participating practitioner who meets PCP criteria. Practitioners who typically provide primary care specialize in Internal Medicine, Family Practice, Pediatrics, Geriatrics, Advanced Nurse Practitioner (specializing in Family Practice, Internal Medicine, Pediatrics or Geriatrics), Physician
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<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>20 of 36</b>

Assistants, or Naturopathic Doctors. Obstetrics/Gynecology practitioners may also apply as PCPs if they: (A) are the case manager who acts as a Member's point of entry to the delivery system; and (B) manage/oversee all services for the Member, including office care, routine preventive health maintenance and referral management.

All reviewed practitioners must meet the minimum threshold of the Clinical Review Program (CRP) audit to remain in the network.

1. PCP Scope of Practice

The Companies maintains a panel of qualified practitioners who have agreed to be PCPs. The scope of practice of PCPs is inclusive but not limited to the following:

- a. Preventive services health maintenance and disease screening as defined by the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention (CDC).
- b. Evaluation and care of patients with undifferentiated complaints.
- c. Diagnosis and management of chronic clinical problems, which are common in the population being served

2. As a PCP, the following practice guidelines are required:

- a. Acceptance of members from all lines of business
- b. Practitioners are able to show evidence of coordination and continuity of care including referral management with a system in place in the office to accommodate referral notification to the Companies.
- c. Call Coverage – All PCPs are expected to have continuous call coverage. The covering providers must be participating providers in the same or similar specialty and also be designated as a PCP. If the provider does not have the same specialty coverage, has out of plan coverage, or lacks

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>21 of 36</b>

coverage due to geographic location, they may be subject to review by the CQC.

3. Additional PCP Criteria for NPs, PAs, and NDs:
    - a. NPs are to be certified by one of the following accredited organizations:
      - American Association of Nurse Practitioner Certification Program (AANP)
      - American Nurses Credentialing Center (ANCC)
      - National Certification Corporation (NCC)
      - Pediatric Nursing Certification Board (PNCB)
      - American Midwifery Certification Board
    - b. PAs are to be certified by the National Commission on Certification of Physician Assistants (NCCPA).
    - c. NDs must have completed one of the following accredited naturopathic medicine programs. The following four institutions have been approved by the Council on Naturopathic Medical Education (CNME):
      - Bastyr University;
      - Canadian College of Naturopathic Medicine
      - National University of Natural Medicine; and
      - Southwest College of Naturopathic Medicine & Health Sciences
  4. OB/GYN PCPs, including certified nurse midwives, will have no limitation of female age in the panel.
  5. Prior to the first recredentialing application, medical record and access reviews are performed per Quality Management policy QM 212 Clinical Review Program.
  6. Practitioner specialties that do not typically provide primary care (e.g. gastroenterologists and emergency medicine practitioners) will be presented to the CQC for review and determination. At initial and recredentialing, 30 Category 1 CME for the prior year or 60 Category 1 CME for the previous two
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<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>22 of 36</b>

years in the area of primary care will be collected. Examples of primary care CME includes preventive care and chronic care.

## II. Recredentialing procedure

- A. Credentialing Services staff generates a list of practitioners to be credentialed prior to mail out date. This list is saved in the Provider Profile folder in Excel format. Clinical Analytics pulls this report to compile a practitioner performance profile that includes information, when available, on sentinel events, adverse outcomes, member complaints, utilization (under and over) and medical record documentation audit results. Thresholds for RN Review of these reports are established by the Quality Management staff.
  - B. If the practitioner fails to meet the threshold, Quality Management staff completes a more comprehensive Practitioner Performance Review. This documentation is submitted to the Medical Director for review. The Medical Director will either approve or refer the documentation to the CQC.
  - C. The Practitioner Performance Review will be assessed at the next meeting of the CQC and a recommendation sent back to the referring Credentialing Services staff.
  - D. Requests for further monitoring including updates on corrective action plans and focus studies are implemented and tracked by the Quality Management staff and the CQC.
  - E. Extending the Recredentialing Cycle Length - Providers who are on active military assignment, maternity leave or a sabbatical (will be documented in the credentialing database), and the contract between Companies and the practitioner remains in place, may possibly not be recredentialed within the 3 year time frame. The practitioner will be recredentialed within 60 calendar days of when they resume seeing patients. The practitioner must have a valid state license prior to seeing Members. If the contract is terminated while on active military assignment, maternity leave or sabbatical for more than 30 days the provider must be initially credentialed.
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<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>23 of 36</b>

### III. Nonresponsive to Credentialing Requests

#### A. Nonresponsive to initial application requests

All applicants must meet initial credentialing requirements. Failure to respond within 30 days to any request for information during the initial credentialing process will result in withdrawal of the application.

#### B. Nonresponsive to recredentialing application requests

All practitioners and organizational providers must meet recredentialing requirements. Failure to meet established standards or guidelines may result in termination.

1. The recredentialing process will begin at least four months in advance to ensure that participating practitioners and organizational providers are re-evaluated within 3 years of the previous credentialing decision.
2. The participating practitioner or organizational provider will be sent a recredentialing application and given 30 days to return the completed application.
3. If the practitioner or organizational provider fails to respond within 30 days, a second request for information will be sent, stating the practitioner must return the completed application within 14 days.
4. If the practitioner or organizational provider fails to respond within 14 days from the second request, a final request will be sent stating that a complete application must return within 14 days or be voluntarily resigned for failure to return a recredentialing application.

A list of practitioners and organizational providers who were sent the third request is forwarded to Provider Relations.

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<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>24 of 36</b>

5. If the practitioner or organizational provider fails to respond within 14 days of the final request, they will be presented to the Credentialing Quality Committee (CQC) for termination due to non-responsiveness.
6. Provider Relations will be notified of terminations due to non-responsiveness approved by CQC.

IV. Termination and Reinstatement - If a practitioner is terminated for administrative reasons (e.g. the practitioner failed to provide complete credentialing information) and not for quality reasons, the practitioner may be reinstated with their current recredentialing date within 30 calendar days of termination and will not be required to complete initial credentialing.

If the request to reinstate is more than 30 calendar days from the termination date, initial credentialing will be completed. Static information does not require reverification if confirmed by the Credentialing Coordinator to be previously verified.

<b>Policy and Procedure</b>					
SUBJECT: <b>Practitioner Credentialing</b>			DEPARTMENT: <b>CR: Credentialing Services</b>		
ORIGINAL EFFECTIVE DATE: <b>09/97</b>			DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>		
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>25 of 36</b>		

#### V. Primary Source Verification Procedure

<b>CREDENTIAL</b>	<b>VERIFICATION TIME LIMIT</b>	<b>CREDENTIALING SERVICES VERIFICATION SOURCE(S)</b>	<b>INITIAL</b>	<b>RECREC</b>	<b>Methods of receipt</b>
Current, active, valid license to practice in the states where the provider sees our members, <i>to meet CMS and NCQA requirements</i>	180 days	<ul style="list-style-type: none"> <li>Documented verbal contact with the appropriate state licensing or certification agency.</li> <li>Electronic verification to state boards where active licenses are held.</li> </ul>	X within the last 5 years	X within the last 3 years	Verbal Electronic
Clinical privileges in good standing at primary admitting facility (must be active admitting privileges at a participating hospital or a written admit plan)	180 days	<ul style="list-style-type: none"> <li>Documented verbal contact with the facility,</li> <li>Copy of the practitioner directory/roster including name of the hospital, practitioner name, status of provider at hospital</li> <li>Verification letter from the hospital noting admitting privilege status</li> </ul>	X	X	Verbal Mail Fax Electronic
Current valid DEA or CDS DEA = Drug Enforcement Agency CDS = Controlled Dangerous Substance	180 days Must be in effect at time of decision	<ul style="list-style-type: none"> <li>Copy of DEA certificate showing expiration date</li> <li>U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control</li> <li>National Technical Information Service (NTIS) database</li> <li>American Medical Association (AMA) Physician Masterfile or American Osteopathic Association Official Osteopathic Physician Profile Report (DEA only)</li> <li>Address listed on the DEA is within the same state the practitioner is treating the member.</li> <li>Exceptions for DEA include specialties in which prescribing drugs are not the usual practice (AuD, CRNFA, DC, CNS, LPC, LAc, LMT, OT, OD, RPh, PT, RD, SLP and certified first assists.</li> </ul>	X	X	Mail Fax Electronic

Policy and Procedure					
SUBJECT: <b>Practitioner Credentialing</b>			DEPARTMENT: <b>CR: Credentialing Services</b>		
ORIGINAL EFFECTIVE DATE: <b>09/97</b>			DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>		
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>26 of 36</b>		

CREDENTIAL	VERIFICATION TIME LIMIT	CREDENTIALING SERVICES VERIFICATION SOURCE(S)	INITIAL	RECRED	Methods of receipt
Education & training including graduation from medical school & completion of a residency program	Prior to the credentialing decision	<p>Any one of the following:</p> <ul style="list-style-type: none"> <li>• Board certification – ABMS or its member boards; or</li> <li>• Approved boards in the United States or Canada that are not members of ABMS;</li> <li>• AOA official Osteopathic Physician Profile Report or AOA Physician Master File;</li> <li>• Letter from school or facility;</li> <li>• Telephone verification to school/facility;</li> <li>• American Medical Association (AMA) Physician Master File;</li> <li>• Letter from Medical Board stating all education will be verified prior to licensing and it performs primary source verification;</li> <li>• Nurse Practitioner certifying board</li> <li>• Physician Assistants certifying board</li> <li>• Pharmacists – PGY1 ASHP accredited residency certificate of completion</li> <li>• National Student Clearinghouse (NSC) for educational programs who have an agreement with NSC to provider primary source verification. Verification must include programs proof of participation with NSC.</li> </ul>	X		Verbal Mail Fax Electronic
Board Certification (all approved board certifications must be verified)	180 days	<p>Any one of the following:</p> <ul style="list-style-type: none"> <li>• ABMS or its member boards, or an official ABMS Display Agent, (<i>Certifax</i>) ABMS = American Board of Medical Specialties;</li> <li>• Approved boards in the United States or Canada that are not members of ABMS for all credentialed practitioner types as defined in this policy;</li> <li>• AMA Physician Master File;</li> <li>• AOA Official Osteopathic Physician Profile Report or AOA Physician Master File</li> </ul>	X (highest level of education must be verified when not board certified)	X	Verbal Mail Fax Electronic

<b>Policy and Procedure</b>					
SUBJECT: <b>Practitioner Credentialing</b>			DEPARTMENT: <b>CR: Credentialing Services</b>		
ORIGINAL EFFECTIVE DATE: <b>09/97</b>			DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>		
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>27 of 36</b>		

CREDENTIAL	VERIFICATION TIME LIMIT	CREDENTIALING SERVICES VERIFICATION SOURCE(S)	INITIAL	RECRED	Methods of receipt
		<ul style="list-style-type: none"> <li>• American Academy of Nurse Practitioners</li> <li>• American Nurses Credentialing Center</li> <li>• Pediatric Nursing Certification Board</li> <li>• American Midwifery Certification Board</li> <li>• National Commission on Certification of Physician Assistants</li> </ul>			
Work history within the most recent 5-year period. Gaps not to exceed 2 months.	180 days	Completed practitioner application, Curriculum Vitae showing last five years of work history (includes the beginning and ending month and year for each position of employment experience). If a gap greater than 2 months is discovered, an explanation of the gap will be required.	X within the last 5 years	X Within the last 3 years	Verbal Mail Fax Electronic
Current adequate malpractice insurance within \$1,000,000 for each occurrence and \$3,000,000 aggregate.	180 days	Copy of insurance face sheet with practitioner's name, Attestation, letter of intent from malpractice carrier. Providers with federal tort coverage can include a copy of the federal tort letter or attestation from the practitioner of federal tort coverage.	X	X	Mail Fax Electronic
History of professional liability claims that resulted in settlements or judgments within the most recent 5-year period.	180 days	Query to and report from NPDB NPDB = National Provider Data Bank	X	X	Electronic
NPDB Query	180 days	Query to and report from NPDB	X	X	Electronic
State sanctions, restrictions on licensure and/or limitations on scope of practice. Covers most recent 5-year period in all	180 days	<ul style="list-style-type: none"> <li>• Documentation from appropriate state agencies</li> <li>• NPDB</li> </ul>	X	X	Electronic



<b>Policy and Procedure</b>					
SUBJECT: <b>Practitioner Credentialing</b>			DEPARTMENT: <b>CR: Credentialing Services</b>		
ORIGINAL EFFECTIVE DATE: <b>09/97</b>			DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>		
APPROVED BY: <b>Medical Director</b>		DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>		PAGE: <b>28 of 36</b>

<b>CREDENTIAL</b>	<b>VERIFICATION TIME LIMIT</b>	<b>CREDENTIALING SERVICES VERIFICATION SOURCE(S)</b>	<b>INITIAL</b>	<b>RECRED</b>	<b>Methods of receipt</b>
states where the practitioner has practiced.					
Medicare/Medicaid Sanctions History, OIG	180 days	<ul style="list-style-type: none"> <li>List of Excluded Individuals and Entities (maintained by OIG), available over the Internet</li> <li>State Medicaid agency</li> <li>NPDB</li> <li>Per CMS NPDB is not an acceptable source. CMS requires documentation of providers who have been sanctioned by Federal Medicare/Medicaid programs.</li> <li>Preclusion List</li> </ul>	X	X	Electronic
Opt Out  Note: Opt Out applies to MD, DO, DDS, DMD, DPM, OD, PA, NP, CNS, CRNA, CNM, Psychologist, LCSW, RD, Nutrition professional	180 days	<ul style="list-style-type: none"> <li>CMS website: data.cms.gov</li> </ul>	X	X	Electronic
GSA/System Awards Management	180 days	<ul style="list-style-type: none"> <li>SAM.gov</li> </ul>	X	X	Electronic
Preclusion	180 days	<ul style="list-style-type: none"> <li>CMS website: data.cms.gov</li> </ul>	X	X	Electronic
NPI	180 days	<ul style="list-style-type: none"> <li>NPPES NPI Registry: npiregistry.cms.hhs.gov</li> </ul>	X	X	Electronic
Death Master File	180 days	<ul style="list-style-type: none"> <li>ladmf.ntis.gov</li> </ul>	X	X	Electronic

<b>Policy and Procedure</b>	
SUBJECT: <b>Practitioner Credentialing</b>	DEPARTMENT: <b>CR: Credentialing Services</b>
ORIGINAL EFFECTIVE DATE: <b>09/97</b>	DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>
APPROVED BY:                      DATE: <b>Medical Director                      04/19/2023</b>	NUMBER:                      PAGE: <b>CR 2.0                      29 of 36</b>

<b>CREDENTIAL</b>	<b>VERIFICATION TIME LIMIT</b>	<b>CREDENTIALING SERVICES VERIFICATION SOURCE(S)</b>	<b>INITIAL</b>	<b>RECRED</b>	<b>Methods of receipt</b>
Oregon Provider Enrollment List	180 days	P:\OMAP\Encounter Data\Provider Information\ <i><u>(Year)</u></i> <u>DMAP Provider Spreadsheets</u>  For Physical Therapists with a Medicaid Contract	X		Electronic

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>30 of 36</b>

## VI. Electronic Credentialing Process

The Credentialing Department utilizes electronic processes and makes every effort to be paperless.

### A. Application Process

#### 1. E-Application

Credentialing applications may be received utilizing the credentialing software, Council for Affordable Quality Healthcare (CAQH) or Washington's OneHealthPort/ Provider Source. When e-applications are submitted from the practitioner, the application is automatically dated by the credentialing software and the practitioner's information is accepted or manually entered into the database by the Credentialing Staff. All images are uploaded and stored in the practitioner's electronic file.

#### 2. Scanned Application

Credentialing applications received by mail, fax or e-mail are date stamped or watermarked with the date received, scanned and stored in the practitioner's electronic file.

### B. Primary Source Verification Process

All primary source verification is reviewed by Credentialing Staff to ensure the verification is current and meets credentialing requirements as defined in this policy. All credentialing data is entered and electronically tracked in the credentialing database and may be received as follows:

1. Verbal – When a verbal verification is obtained, the Credentialing Staff will document the verification in the credentialing database. The documentation will include the verification source, contact name from the verifying agency, information verified (i.e. status, date, standing), verification date and verifying credentialing staff initials. Documentation is scanned or imaged and stored in the practitioner's electronic file within the credentialing database.

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>31 of 36</b>

2. Mail- When a verification is received by mail, it is date stamped with the date received, scanned, and stored into the practitioner’s electronic file within the credentialing database.
3. Fax – When a verification is received by fax, it is date stamped with the date received, scanned, and stored into the practitioner’s electronic file within the credentialing database.
4. Online – Online verification includes verifications from a source’s website. The verification is saved as a PDF and stored in the practitioner’s electronic file within the credentialing database. If the online verification is not already date stamped the credentialing coordinator will add a date stamp confirming the date received.
5. Web crawlers - Verifications that are obtained by web crawler technology from approved primary source websites through the credentialing software. An image of the verification is ingested into the practitioner’s electronic file within the credentialing database. A web crawler verification is automatically date stamped with the date received and reviewed by the Credentialing Staff.

#### C. Electronic Verification Workflow

The Credentialing Department utilizes an electronic verification workflow function within the credentialing software. The workflow is developed to function as a checklist for Credentialing Coordinators to document verifications and activities for each practitioner credentialed. The workflow includes all requirements of the initial and recredentialing process to ensure compliance with NCQA, CMS, and internal credentialing policies and procedures. Each workflow includes the following information for each verification or credentialing activity, as applicable:

- Source of the verification
- Verification date
- Verifying staff
- Report date
- Issue and expiration date
- Findings

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>32 of 36</b>

## VII. Storage

All credentialing documentation is imaged and stored in the credentialing database. When hard copy documents are received, they are physically date stamped or watermarked, scanned, and stored in the credentialing database. Once the credentialing information has been saved in the database, all hardcopy documents are shredded for confidentiality.

## VIII. Quality Assurance and Performance Improvement

### A. Clinical Review Program

All practitioners are subject to review of medical records, office sites, and office access through the Clinical Review Program (CRP) as documented in Quality Management policy QM 212 Clinical Review Program.

1. The CQC evaluates the CRP reports, monitors for trends, and recommends actions; Quality Management staff may be involved in any follow-up action.
  2. If an opportunity for improvement is identified for a practitioner, a practice site, or provider group, the involved parties have an opportunity to develop a plan of action (POA).
  3. If a corrective action plan is needed for the clinic site, medical records, or clinic access the following timeframes will be followed:
    - a. The clinic site will be re-reviewed within 6 months following the documentation of the POA.
    - b. Provider medical records and clinic access will be re-reviewed within 12 months following the documentation of the POA.
  4. If a passing score is not achieved on re-review further action is determined by the CQC.
-

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>33 of 36</b>

5. Quality Management staff routinely provides a follow-up progress report back to the CQC at appropriate intervals for all providers on corrective action for follow-up review and revision or resolution of the POA.
6. If at any time a physician is not compliant with a recommended corrective action, Quality Management staff works with the Chief Medical Officer or physician designee to facilitate compliance. Continued non-compliance may result in the initiation of disciplinary action, up to and including termination.

#### B. Complaint Reports

Clinic sites are also monitored for quality through a bi-annual complaint report. Complaint data on physical access, appearance, and waiting/exam room space for all clinics is collected on an ongoing basis. If established thresholds are reached, a site review will be performed. The site review will be completed within 60 days of identification of the threshold being met. See Quality Management policy QM 213 Practitioner and Facility Quality of Care Review, and policy CR 9.0 Ongoing Monitoring, Corrective Action, and Intervention for further details of this process and definition of thresholds.

It is the expectation of the Companies that providers participating with the Oregon Health Plan (OHP) line of business have policies in place which recognize that each patient has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in Federal regulations. Complaints received regarding Restraint and Seclusion will be monitored within Quality Management.

#### IX. Residents

Providence Residents who moonlight during training will be credentialed if the following criteria are met:

- A. Liability insurance that covers their activity in the practice setting.
- B. Letter of permission from their Residency Director.

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>34 of 36</b>

C. Assurance that a participating practitioner on panel will be available to them for consultation during their shifts.

X. Practitioners Who Do Not Need To Be Credentialed

The following practitioners do not need to be credentialed:

- A. Dentists who provide primary dental care only under a dental plan or rider.
- B. Pharmacists who work for a pharmacy benefits management (PBM) organization to which the Companies delegate utilization management (UM) functions.
- C. Locum tenens who do not have an independent relationship with the Companies and who do not practice in a clinical location for greater than sixty (60) consecutive days.
- D. Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants).
- E. Rental network practitioners that are specifically for out-of-area care, and there are no incentives communicated to members; members have no obligation to seek care from rental network practitioners and may see any out-of-area practitioner.
- F. Hospital-based practitioners who practice exclusively within a credentialed facility (Organizational Provider) and provides care for members only as a result of members being directed to the hospital or an inpatient setting, including but not limited to:
  - Pathologists
  - Radiologists
  - Anesthesiologists
  - Neonatologists
  - Emergency room physicians
  - Hospitalists
  - Telemedicine consultants
  - Wound Care providers

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>35 of 36</b>

If the practitioner also has an independent relationship with The Companies (Members will be directed to see the practitioner specifically) and provides care under The Companies' medical benefits, the practitioner needs to be credentialed.

**XI. Auditing Process**

Credentialing Department audits to ensure that practitioner credentialing meets the Companies' policies including compliance with NCQA and CMS standards for initial and recredentialing processes. In addition, the department audits credentialing system integrity.

**A. File Audit for Credentialing and Data Integrity**

Credentialing files are audited monthly and include a minimum of 200 files annually. Utilizing the monthly CQC credentialing report, the Credentialing Delegation Auditor randomly selects and reviews files for each Credentialing Coordinator. Audit results are reported to the Credentialing Manager for oversight. Audit includes without limitation the following:

- Compliance with required credentialing verifications as defined in the credentialing policies
- Review of data integrity, which includes reviewing primary source verifications and dates of the verifications are accurately recorded in the database
- Recredentialing cycle doesn't exceed 36 months or as otherwise approved by CQC
- Indications of discrimination

**XII. Directory Maintenance**

A direct systematic nightly feed from the system of record updates directory information to ensure consistency between the credentialing information and the information made available to Members. Directory and system of record consistency includes practitioner education, training, board certification, hospital affiliation, and designated specialty for all actively licensed practitioners and organizational providers.



<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioner Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/97</b>		DATE(S) REVISED: <b>4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/2023</b>	NUMBER: <b>CR 2.0</b>	PAGE: <b>36 of 36</b>

**REFERENCES:**

NCQA Credentialing Standards  
 CMS Credentialing Standards  
 QM 212 Clinical Review Program  
 QM 213 Practitioner and Facility Quality of Care Review and Ongoing Monitoring Process  
 CR 16.0 Exceptions Policy  
 CR 9.0 Ongoing Monitoring, Corrective Action, and Intervention  
 CR 20.0 Primary Care Practitioner Criteria  
 CR 23.0 Credentialing Definitions and Acronyms  
 The Controlled Substances Act: Drug Enforcement Administration

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<b>Policy and Procedure</b>	
SUBJECT: <b>Chief Medical Officer – Role and Responsibilities</b>	DEPARTMENT: <b>CR: Credentialing Services</b>
ORIGINAL EFFECTIVE DATE: <b>11/90</b>	DATE(S) REVISED: <b>08/09; 07/10; 7/11; 7/12; 4/13, 4/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>
APPROVED BY:                      DATE: <b>Medical Director                      4/19/23</b>	NUMBER:                              PAGE: <b>CR 3.0                                      1 of 2</b>

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

Chief Medical Officer

<u>Fully Insured</u>			<u>Self-Insured</u>	<u>Medicare</u>	<u>Medicaid</u>	<u>Delegated Services to Ayin</u>
<u>Individual</u>	<u>Small Group</u>	<u>Large Group</u>				
<input type="checkbox"/> Oregon On Exchange	<input type="checkbox"/> Oregon On Exchange (SHOP)	<input type="checkbox"/> Oregon	<input type="checkbox"/> ASO	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> YCCO
<input type="checkbox"/> Oregon Off Exchange	<input type="checkbox"/> Oregon Off Exchange (SHOP)	<input type="checkbox"/> Washington	<input type="checkbox"/> PBM			<input type="checkbox"/> WHA
<input type="checkbox"/> Washington Off Exchange						
<input checked="" type="checkbox"/> APPLIES TO ALL ABOVE LINES OF BUSINESS						

<b>Policy and Procedure</b>			
SUBJECT: <b>Chief Medical Officer – Role and Responsibilities</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>11/90</b>		DATE(S) REVISED: <b>08/09; 07/10; 7/11; 7/12; 4/13, 4/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 3.0</b>	PAGE: <b>2 of 2</b>

**POLICY:**

The Chief Medical Officer (CMO) is the principal manager of medical care and is responsible for the following:

- Appropriateness and quality of medical care delivered
- Working in close alliance with senior management staff
- Regular interactions with panel practitioners and facilities
- Provides supervision of Medical Directors
- Utilization/Quality Management and Credentialing programs.

The CMO performs all duties in a manner, which promotes the team concept and reflects the Companies’ mission and core values.

**DEFINITIONS:**

See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

**PROCEDURE:**

- A. The CMO or physician designee actively participates in the credentialing and recredentialing process through membership on the Credentials and Quality Committee (CQC).
- B. The CMO or physician designee is responsible for monitoring practitioner and organizational provider performance and compliance with established standards through an active role in the peer review processes of the enforcement committees.
- C. The CMO or physician designee assists in regular communications with physicians and provides daily support and appropriate direction to staff on issues pertaining to quality and credentialing issues.
- D. In the event the CMO or physician designee determines that a practitioner or organizational provider poses immediate danger to Members/ Eligibles, the CMO is authorized to approve summary suspension or immediate and automatic termination.
- E. The CMO or physician designee has the right to review and approve clean files. A clean file is a file that meets established credentialing criteria, all information is current within the prescribed time limits and does not lack substantiating

<b>Policy and Procedure</b>			
SUBJECT: <b>Chief Medical Officer – Role and Responsibilities</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>11/90</b>		DATE(S) REVISED: <b>08/09; 07/10; 7/11; 7/12; 4/13, 4/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 3.0</b>	PAGE: <b>3 of 2</b>

documentation. One report with all required credentials for all practitioners and organizational providers will be reviewed and approved with electronic signature via e-mail. The credentialing decision date for clean files will be the CMO or physician designee’s approval date. A credentialing report that includes all clean file approvals will be presented to CQC for review at the next scheduled meeting.

**REFERENCES:**

CR 23.0 Credentialing Definitions and Acronyms  
 Job Description - Chief Medical Officer  
 NCQA Standards

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioners Rights and Confidentiality</b>		DEPARTMENT: <b>CR Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/97</b>		DATE(S) REVISED: <b>6/07; 06/08; 08/09; 07/10; 7/11; 7/12; 4/13; 4/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 4.0</b>	PAGE: <b>1 of 6</b>

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

All Practitioners

<u>Fully Insured</u>			<u>Self-Insured</u>	<u>Medicare</u>	<u>Medicaid</u>	<u>Delegated Services to Ayin</u>
<u>Individual</u>	<u>Small Group</u>	<u>Large Group</u>				
<input type="checkbox"/> Oregon On Exchange	<input type="checkbox"/> Oregon On Exchange (SHOP)	<input type="checkbox"/> Oregon	<input type="checkbox"/> ASO	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> YCCO
<input type="checkbox"/> Oregon Off Exchange	<input type="checkbox"/> Oregon Off Exchange (SHOP)	<input type="checkbox"/> Washington	<input type="checkbox"/> PBM			<input type="checkbox"/> WHA
<input type="checkbox"/> Washington Off Exchange						
<input checked="" type="checkbox"/> APPLIES TO ALL ABOVE LINES OF BUSINESS						

**POLICY:**

Participating practitioners, organizational providers, and applicants are afforded certain rights and protections during the credentialing and recredentialing process. These rights include the right to view and clarify discrepancies, have misinformation corrected, and to be informed of the status of their application during the credentialing process. These rights are made available to all applicants, participating practitioners, and participating organization providers at the time of initial and subsequent credentialing.

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioners Rights and Confidentiality</b>		DEPARTMENT: <b>CR Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/97</b>		DATE(S) REVISED: <b>6/07; 06/08; 08/09; 07/10; 7/11; 7/12; 4/13; 4/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 4.0</b>	PAGE: <b>2 of 6</b>

The Companies do not discriminate in the administration of these rights based upon the practitioner’s race, ethnic/national identity, religion, age, gender, gender identity, sexual orientation, disability, the types of procedures, or patient type in which the practitioner specializes. The Companies credentialing policies apply equally and no more stringently to behavioral health practitioners or organizational providers.

The Companies respect and maintain the confidentiality of all practitioner information collected during the credentialing or recredentialing process. Confidential information is only available to authorized staff and cannot be disclosed to the public at any time as required by the laws and regulations governing this information.

All policies including those relating to practitioner rights and the fair hearing process are posted on ProvLink.

**DEFINITION:**

See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

**PROCEDURE:**

I. Right to Review Credentialing Information

The practitioner has the right to review information submitted from outside sources (i.e. malpractice insurance carriers, state licensing boards) in support of his or her credentials application, except for protected information, such as references, recommendations, or peer review protected information. If copies of information are prohibited by the agency providing such information, the practitioner will be given the name and address of the agency to obtain a copy.

A. The Credentialing Department sends the practitioner a cover letter with the credentials packet via U.S. mail or secure e-mail. The letter advises the practitioner of his/her right to review the information submitted in support of the credentials application, except for references, recommendations, or peer review protected information.

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioners Rights and Confidentiality</b>		DEPARTMENT: <b>CR Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/97</b>		DATE(S) REVISED: <b>6/07; 06/08; 08/09; 07/10; 7/11; 7/12; 4/13; 4/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 4.0</b>	PAGE: <b>3 of 6</b>

B. If a practitioner elects to review the information submitted in support of his/her credentials application, the Chief Medical Officer or designee will be in attendance during the time the practitioner reviews his/her credentials file.

1. The Credentialing Department must receive 24-hour advance written notification from a practitioner or applicant to review contents of his/her credentialing file.
2. Subpoenas requesting information contained in the credentials file will be directed to the Assistant Vice President of Quality, Chief Medical Officer, or his/her designee.

## II. Notification of Erroneous or Varying Information

A. Applications determined to contain conflicting information will be addressed with the practitioner. The practitioner will be notified by Credentialing Staff of any information obtained during the credentialing process that varies substantially from the information provided by the practitioner. Acceptable methods for contacting the practitioner may include, but are not limited to, telephone, fax, e-mail, or letter. Conflicting information may result in the practitioner's file being presented to the Credentials and Quality Committee (CQC) as an exception. The practitioner has the right to correct erroneous information or explain any discrepancy or omission that conflicts with information obtained from another party, with the exception of peer references, peer review information, NPDB response, or other information that is peer protected. The practitioner is notified of these rights in the cover letter that is sent to the practitioner with the credentials packet. All correspondence, conversations and/or documentation related to this process will be documented in the practitioner credentialing file.

B. Credentialing Staff will notify the practitioner in writing, via fax, e-mail, or letter of any information received that is possibly erroneous, or that substantially varies from the information provided by the practitioner, such as malpractice claims history, actions on licensure, or board certification decisions. Notification and request for clarification upon discovery of erroneous or varying information will be sent to the practitioner within 14 days of discovery and will include the following:

- Request for response within 14 days

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioners Rights and Confidentiality</b>		DEPARTMENT: <b>CR Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/97</b>		DATE(S) REVISED: <b>6/07; 06/08; 08/09; 07/10; 7/11; 7/12; 4/13; 4/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 4.0</b>	PAGE: <b>4 of 6</b>

- Request for explanation of the conflicting information
  - A copy of the portion of the application or attached documentation from the practitioner that contains the conflicting information
  - Format for submitting corrections and where to submit corrections. Such formats may include, but are not limited to, faxes, e-mails, or mailed copies.
- C. When the practitioner’s correction/explanation is received, this information will be verified in the same manner that the original information was checked. The corrected information becomes part of the practitioner’s credentials file and is maintained in the same manner as the other credentialing material.
- D. The lack of response within the stated time frames may result in a certified letter from the CQC Chair informing the practitioner of the steps taken by the CQC.
- E. All issues will be reviewed by the CQC. Information included will be a summary of the conflicting information and the practitioner’s response.
1. If the practitioner’s response and support proves the information received from another party was erroneous, the information stands corrected in the credentials file.
  2. If the practitioner’s response and support does not prove the information received from another party was erroneous, the information does not stand corrected and CQC will act accordingly.
  3. Based on the information available to the CQC, the committee may decide to request additional information, approve, approve with stipulations, deny, or terminate panel participation.
- G. The practitioner will be notified of the CQC decision regarding the conflicting information within 60 calendar days. Acceptable methods for notifying the practitioner may include, but are not limited to, fax, e-mail or letter.

### III. Right to Know Status of Application

- A. Practitioners and applicants have the right, upon request, to be informed of the status of their application. The cover letter that is sent to the practitioner with the



<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioners Rights and Confidentiality</b>		DEPARTMENT: <b>CR Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/97</b>		DATE(S) REVISED: <b>6/07; 06/08; 08/09; 07/10; 7/11; 7/12; 4/13; 4/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 4.0</b>	PAGE: <b>5 of 6</b>

credentials packet advises the practitioner of his/her right to be informed of the status of their application. The practitioner may contact the Credentialing Department via telephone, email, or in writing. The Credentialing Department will inform the practitioner via telephone, email, or in writing of any information which is affecting the status of their application within 14 days of the inquiry. The response could include any of the following, as applicable:

- Missing information that the practitioner is responsible for supplying that is delaying application processing, e.g., malpractice insurance face sheet, DEA certificate, a complete application.
  - Missing information that must be primary source verified, or obtained from an outside source, that is delaying application processing, e.g., verification of board certification, licensure, hospital privileges.
  - Any other circumstance that is delaying application processing, as long as release of the information is lawful.
- B. Information such as references, recommendations, or peer review protected information will not be shared.
- C. The practitioner’s response for missing information must be received via telephone, email, or in writing within 14 days of the request from the Credentialing Coordinator. Upon receipt of the requested documentation, the Credentialing Coordinator will acknowledge receipt of the information either via e-mail or telephone.

#### IV. Confidentiality

- A. Practitioner files are electronically imaged; per record retention requirements, all documentation will be maintained on a permanent basis. Access to practitioner information is limited by the assignment of different security clearances and confidentiality requirements as defined in Credentialing Services policy CR 17.0 System Controls, Maintenance and Storage of Credentialing Information and Provider Directories.

<b>Policy and Procedure</b>			
SUBJECT: <b>Practitioners Rights and Confidentiality</b>		DEPARTMENT: <b>CR Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/97</b>		DATE(S) REVISED: <b>6/07; 06/08; 08/09; 07/10; 7/11; 7/12; 4/13; 4/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 4.0</b>	PAGE: <b>6 of 6</b>

- B. Authorized staff are required to sign a confidentiality statement prior to accessing the credentialing database and confidential practitioner information.
  
- C. Practitioners and their designated agents as listed below also have access to non-protected information in their individual files upon request and in the presence of qualified Credentialing Services staff or the Chief Medical Officer or his/her physician designee:
  1. Practitioner’s designee with written permission from the practitioner or contractual authorization
  2. Practitioner entity, e.g., IPA, by practitioner permission
  3. Regulatory bodies
  4. Accreditation bodies

**REFERENCES:**

CR 17.0 System Controls, Maintenance and Storage of Credentialing Information  
 CR 23.0 Credentialing Definitions and Acronyms  
 Provider Directories  
 Provider Relations Program  
 NCQA Credentialing Standards

<b>Policy and Procedure</b>			
SUBJECT: <b>Delegated Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/95</b>		DATE(S) REVISED: <b>4/13; 4/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 6.0</b>	PAGE: <b>1 of 8</b>

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

This policy applies to all groups eligible and approved for delegated credentialing in the Companies’ network(s).

<u>Fully Insured</u>			<u>Self-Insured</u>	<u>Medicare</u>	<u>Medicaid</u>	<u>Delegated Services to Ayin</u>
<u>Individual</u>	<u>Small Group</u>	<u>Large Group</u>				
<input type="checkbox"/> Oregon On Exchange	<input type="checkbox"/> Oregon On Exchange (SHOP)	<input type="checkbox"/> Oregon	<input type="checkbox"/> ASO	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> YCCO
<input type="checkbox"/> Oregon Off Exchange	<input type="checkbox"/> Oregon Off Exchange (SHOP)	<input type="checkbox"/> Washington	<input type="checkbox"/> PBM			<input type="checkbox"/> WHA
<input type="checkbox"/> Washington Off Exchange						
<input checked="" type="checkbox"/> APPLIES TO ALL ABOVE LINES OF BUSINESS						

<b>Policy and Procedure</b>			
SUBJECT: <b>Delegated Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/95</b>		DATE(S) REVISED: <b>4/13; 4/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 6.0</b>	PAGE: <b>2 of 8</b>

**POLICY:**

Delegated credentialing may occur when The Companies agree to give another entity the authority to perform credentialing activities that The Companies would otherwise perform. The Credentials and Quality Committee (CQC) approves and maintains oversight of an entity's credentialing program prior to delegation and at least annually thereafter.

Unless otherwise defined in the Credentialing Delegation Agreement, credentialing activities summarized below and agreed upon must all be performed in a manner that meets or exceeds National Committee for Quality Assurance (NCQA) standards and, when applicable, Centers for Medicare and Medicaid Services (CMS) standards, Oregon Division of Medical Assistance (DMAP) standards, and any other applicable state guidelines, in addition to Companies' standards. A mutually agreed upon Credentialing Delegation Agreement describes the assigned responsibilities, reporting requirements, performance monitoring, the right to approve, suspend, terminate, and the consequences for failure to perform. The credentialing process may be delegated to entities who meet the following criteria and as further defined in the Credentialing Delegation Agreement:

- The entity has a defined and documented credentialing process that will comply with Companies' credentialing standards.
- The entity has the ability to report at minimum the following data elements required to populate Companies' systems:
  - Full name
  - Degree
  - Specialty
  - Board certification information, including Board name, specialty, status, initial certification date and expiration date
  - Primary address (billing also if different) primary cannot be a PO box
  - Phone number
  - NPI number
  - Tax ID
- The entity allows audits at least annually, as required by NCQA standards.
- The entity provides reports semi-annually.
- The entity enters into a mutually agreed upon agreement.
- The entity agrees to provide notification of any material changes in their ability to perform delegated functions.

<b>Policy and Procedure</b>			
SUBJECT: <b>Delegated Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/95</b>		DATE(S) REVISED: <b>4/13; 4/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 6.0</b>	PAGE: <b>3 of 8</b>

**DEFINITION:**

See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

**PROCEDURE:**

When an entity requests to be delegated, The Companies will confirm there is a need and mutual benefit. If it is determined there is a need the following activities will occur:

I. Pre-delegation Evaluation

Prior to delegating credentialing and recredentialing activities, a pre-delegation evaluation (either a site visit, or virtual review) will be performed for all delegation candidates to determine whether to delegate or not within the 12 months prior to implementing delegation. If the time between the pre-delegation evaluation and implementation of delegation exceeds 12 months, another pre-delegation evaluation will be conducted.

A. The pre-delegation evaluation will include a review and approval of the following:

1. Entity’s policies and procedures as requested that outline the credentialing program.
  2. Credentialing Committee membership roster and meeting minutes, which must show evidence of peer review and the committee’s decision-making process.
  3. File audit review of practitioners and organizational providers, as applicable.
  4. Ongoing monitoring and interventions pertaining to practitioner sanctions, complaints, and quality issues
  5. If applicable, documentation of delegation agreements and oversight of any sub-delegated entity
-

<b>Policy and Procedure</b>			
SUBJECT: <b>Delegated Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/95</b>		DATE(S) REVISED: <b>4/13; 4/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 6.0</b>	PAGE: <b>4 of 8</b>

**B. Pre-Delegation Audit Results**

The pre-delegation audit results are presented to the CQC for review. The CQC approves the delegation, pends a decision and requests a corrective action plan to address deficiencies, or denies the organization’s request for delegation.

1. If the CQC approves the delegation, the Companies will proceed with a Credentialing Delegation Agreement.
2. If the delegation is denied, a letter is sent to the entity delineating the results of the CQC’s review within seven (7) business days of the decision.

**II. Delegation Agreement**

A. Upon approval for delegated credentialing by the CQC, the Credentialing Delegation Agreement will be sent to the entity for signature.

B. The Credentialing Delegation Agreement states:

1. Effective date of the delegation agreement
  2. Credentialing activities being delegated
  3. Assigned credentialing responsibilities
  4. Reports with required data elements and submission deadlines
  5. Requirement to comply with Companies’ credentialing policies and procedures
  6. Companies retain the right to approve, deny, terminate, suspend, or restrict the participation of any individual practitioner, organizational provider or site even if the Companies delegate decision-making.
  7. Responsibilities for sub-delegation
  8. The process for performance evaluation at least annually
  9. Timely submission for requested documentation needed for regulatory or accrediting audits
  10. Circumstances under which delegation is terminated or modified
-

<b>Policy and Procedure</b>			
SUBJECT: <b>Delegated Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/95</b>		DATE(S) REVISED: <b>4/13; 4/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 6.0</b>	PAGE: <b>5 of 8</b>

III. Annual Audit and Oversight of Delegation

A. The Credentialing Department is responsible for the oversight of the Delegate’s compliance with the delegation agreement and credentialing activities. Oversight responsibilities include without limitation:

1. Conduct audit at least annually
2. Monitor routine reporting, at least semi-annually
3. Review Delegate’s sub-delegation oversight
4. Report to CQC at least annually or as needed
5. Provide the Delegate with opportunities for improvement

B. At least annually, an audit will be performed to assess the Delegate’s credentialing processes. The audit will include the following as defined in the Credentialing Delegation Agreement:

1. Credentialing policies and procedures
2. Credentialing Committee roster and meeting minutes
3. Evidence of ongoing monitoring and interventions
4. Evidence of System Security Control monitoring
5. Evidence of practitioner office site standards, as applicable
6. Sub-delegation oversight
7. File audit of five percent or 50 practitioner files, whichever is less, with a minimum of 10 credential files and 10 recredential files for practitioners, and organizational provider file audit as applicable. If fewer than 10 practitioners were credentialed or recredentialed within the look-back period, the universe of files will be audited rather than a sample. The NCQA 8/30 file review methodology may be used. File audit includes elements as defined in the agreement.

C. The audit findings are compiled and reviewed with the Delegate’s credentialing staff in the exit interview at the time of the audit. During the exit interview the auditor provides the delegated entity with audit findings and any noted deficiencies. The auditor works with the delegate to resolve any disputes during the survey. File review results may not be disputed and may not be appealed once the survey is

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<b>Policy and Procedure</b>			
SUBJECT: <b>Delegated Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/95</b>		DATE(S) REVISED: <b>4/13; 4/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 6.0</b>	PAGE: <b>6 of 8</b>

complete.

- D. Audit results are presented to the CQC for review within 60 calendar days after the audit is performed. The completed audits include the scores, areas for improvement and recommendations.
- E. The CQC reviews the audit outcomes and will decide to approve a score of 90% or above, or request a corrective action plan (CAP), require a re-audit within 3 to 6 months, or a termination of delegation. A delegated relationship will be terminated in the event of non-compliance with the established standards if a corrective action plan is not completed within the agreed time frame or if audit scores indicate excessive non-compliance. Delegates are required to obtain an overall score of 90% or higher and a score of 50% or higher within each element.
- F. If the Delegate is approved with a CAP, the CQC will determine a deadline for the Delegate to submit the CAP. If necessary, a re-audit will be scheduled. Deadlines are established depending on the severity of noncompliance with standards. Subsequent action plans and audit results are reviewed by the CQC to determine if further action is needed for final approval.
- G. In the event of termination, the Companies require an unbroken string of recredentialing at least every 3 years. If files can be obtained from the delegate, the Companies are not required to start over with initial credentialing; credentialing process may be continued by The Companies and recredential practitioners or organizational providers when they are due.

If credentialing files cannot be obtained from the delegate, the Companies must perform initial credentialing within 6 months of the delegate's termination date.

#### IV. Reporting

- A. The Delegate is required to submit the following reports within the timeframes stated:



<b>Policy and Procedure</b>			
SUBJECT: <b>Delegated Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/95</b>		DATE(S) REVISED: <b>4/13; 4/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 6.0</b>	PAGE: <b>7 of 8</b>

1. Practitioner Roster – Delegate submits rosters after credentialing decisions for all new and recredentialed practitioners (monthly or no less than twice annually), at least annually for Delegate’s audit and as requested for audit or survey of Companies’ networks. Delegate provides practitioner data in an excel format for all practitioners to include the minimum data elements of:
    - a. Full name (as it appears in the license board)
    - b. Degree
    - c. Specialty practiced
    - d. Date of birth
    - e. Primary practice address, city, state, zip
    - f. Office phone and fax number
    - g. Initial credential date
    - h. Most current credential date
    - i. State license number
    - j. NPI number
    - k. Primary care provider designation
    - l. Name of medical/graduate school where degree was received
    - m. Graduation date from medical/graduate school
    - n. Board certification information, including Board name, specialty, status, initial certification date and expiration date
  
  2. Evidence of System Security Control monitoring is required at least annually. Companies will review and document any of the delegates non-compliant modifications that do not meet the policies and procedures. Companies will implement a quarterly monitoring process with the delegate until the delegate demonstrates improvement for at least one finding over three consecutive quarters.
  
  - B. The Delegate and Companies report to each other any adverse action affecting a practitioner’s appointment status, practice of clinical privileges, including termination, suspension, limitation, restriction, whether the practitioner is subject of a formal investigation within two business days of the action. The party taking adverse action is responsible for reporting to the National Practitioner Data Bank (NPDB) in the timeframe specified by the NPDB, respectively.
-

<b>Policy and Procedure</b>			
SUBJECT: <b>Delegated Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>9/95</b>		DATE(S) REVISED: <b>4/13; 4/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 6.0</b>	PAGE: <b>8 of 8</b>

Delegate and Companies inform each other of any reports made about the practitioner to any state or federal regulatory agency such as the state licensing board, NPDB and CMS, whichever is applicable to the reporting party, within two business days.

V. Auto-Credit

Auto-credit for elements of the pre-delegation and annual audits may apply to Delegates who are accredited by NCQA as it applies to the Delegates accreditation and as defined by current accreditation standards.

**REFERENCES:**

CR 23.0 Credentialing Definitions and Acronyms  
 NCQA Credentialing Standards  
 CMS Credentialing Standards  
 Credentialing Delegation Agreement

<b>Policy and Procedure</b>			
SUBJECT: <b>Ongoing Monitoring, Corrective Action and Intervention</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>11/02</b>		DATE(S) REVISED: <b>6/07; 6/08; 10/08; 08/09; 07/10; 7/11; 7/12; 4/13; 5/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 9.0</b>	PAGE: <b>1 of 9</b>

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

All practitioners  
All organizational providers

<u>Fully Insured</u>			<u>Self-Insured</u>	<u>Medicare</u>	<u>Medicaid</u>	<u>Delegated Services to Ayin</u>
<u>Individual</u>	<u>Small Group</u>	<u>Large Group</u>				
<input type="checkbox"/> Oregon On Exchange	<input type="checkbox"/> Oregon On Exchange (SHOP)	<input type="checkbox"/> Oregon	<input type="checkbox"/> ASO	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> YCCO
<input type="checkbox"/> Oregon Off Exchange	<input type="checkbox"/> Oregon Off Exchange (SHOP)	<input type="checkbox"/> Washington	<input type="checkbox"/> PBM			<input type="checkbox"/> WHA
<input type="checkbox"/> Washington Off Exchange						
<input checked="" type="checkbox"/> APPLIES TO ALL ABOVE LINES OF BUSINESS						

**POLICY:**

Practitioners and organizational providers will be subject to interim monitoring between credentialing cycles. Monitoring of Medicare /Medicaid Sanctions, practitioners who opt out of Medicare, licensing agency sanctions, or limitations on licensure, Sentinel Events and Adverse Outcomes (SEAO’s), adverse events, complaints and complications will be obtained

<b>Policy and Procedure</b>			
SUBJECT: <b>Ongoing Monitoring, Corrective Action and Intervention</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>11/02</b>		DATE(S) REVISED: <b>6/07; 6/08; 10/08; 08/09; 07/10; 7/11; 7/12; 4/13; 5/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 9.0</b>	PAGE: <b>2 of 9</b>

and reviewed on a regular basis. If a quality of care or other professional misconduct issue is discovered, it will be reviewed by the Medical Director and, if appropriate, referred to the Credentials and Quality Committee (CQC) for final determination.

Upon receipt of adverse information, the CQC may decide to deny, restrict or terminate panel participation, or take other appropriate action for the protection of Members or the Companies. Appropriate action will be taken if there is evidence of serious quality deficiencies related to professional conduct or competence.

The CQC may also decide to place a practitioner or organizational provider in “Ongoing Monitoring” to review periodic progress with concerns identified at the time of credentialing. This allows practitioners and organizational providers who may have had deficiencies the opportunity to rectify their issues while still participating in the panel under certain conditions, terms, or stipulations. Appropriate action will be taken if there is evidence of serious quality deficiencies related to professional conduct or competence. Practitioners or organizational providers who fail to comply with established standards relating to quality of care and service, utilization of resources, compliance with administrative processes, and/or credentialing standards may be subject to disciplinary action or termination as provided in the Companies’ Policies and Procedures.

Participating practitioners have the right to appeal certain adverse actions pursuant to the Companies’ Policies and Procedures. If the adverse action is upheld and is reportable by law to National Practitioner Data Bank and state licensing agencies, the appropriate authorities of the quality deficiency and related actions will be notified as required.

**DEFINITION:**

See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

**PROCEDURE:**

I. Ongoing Monitoring Activities

All practitioners and organizational providers are subject to interim monitoring between credentialing cycles. Ongoing monitoring includes, but is not limited to the following:

A. Medicare and Medicaid sanctions

<b>Policy and Procedure</b>			
SUBJECT: <b>Ongoing Monitoring, Corrective Action and Intervention</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>11/02</b>		DATE(S) REVISED: <b>6/07; 6/08; 10/08; 08/09; 07/10; 7/11; 7/12; 4/13; 5/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 9.0</b>	PAGE: <b>3 of 9</b>

Credentialing staff will review the following information sources on a regular basis, and no later than 30 calendar days after the information becomes available. If a practitioner or organizational provider is found to be on any Medicare or Medicaid sanction report, Provider Relations will be notified, and all Medicare/Medicaid products will be terminated immediately. Credentialing staff will also notify the Special Investigations Unit (SIU) by forwarding names and source documents, if available, for investigation. The following sources are reviewed:

- OIG
- SAM
- Opt Out
- Preclusion
- NPDB Continuous Query

#### B. Sanctions and limitations on licensure

The following licensing action reports are monitored within 30 days of the release by the reporting entity noted below, for any sanctions or limitations on licensing. If the reporting entity does not publish sanction information on a monthly basis, information will be queried at least every six months. Reports are downloaded from the appropriate web site by the Credentialing Staff. If a practitioner or organizational provider is found on a report, the Credentialing Supervisor will be notified immediately for determination of further action.

The following sources are reviewed for sanctions and limitations on licensure:

- NPDB Continuous Query
- OR
- Idaho Board of Medicine
- Idaho Board of Nursing
- Oregon Board of Chiropractic Examiners
- Oregon Board of Dentistry
- Oregon Board of Examiners of Licensed Dietitians
- Oregon Board of Licensed Professional Counselors and Therapists
- Oregon Board of Licensed Social Workers
- Oregon Board of Massage Therapists
- Oregon Board of Naturopathic Examiners
- Oregon Board of Nursing
- Oregon Board of Optometry

<b>Policy and Procedure</b>			
SUBJECT: <b>Ongoing Monitoring, Corrective Action and Intervention</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>11/02</b>		DATE(S) REVISED: <b>6/07; 6/08; 10/08; 08/09; 07/10; 7/11; 7/12; 4/13; 5/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 9.0</b>	PAGE: <b>4 of 9</b>

- Oregon Board of Pharmacy
- Oregon Board of Psychology
- Oregon Board of Speech-Language Pathology & Audiology
- Oregon Department of Human Services
- Oregon Health Authority
- Oregon Medical Board
- Oregon Occupational Therapy Licensing Board
- Oregon Physical Therapist Licensing Board
- Washington State Department of Health

#### C. Complaints and adverse events

Complaints, adverse events, and complications are reviewed as they are received, along with any history of complaints, if applicable. This process is documented in Quality Management policy QM 213 Practitioner and Facility Quality of Care Review and Ongoing Monitoring Process, which includes escalation to CQC, if necessary. The aggregate information is reviewed on a biannual basis and documented on the Ongoing Monitoring Log.

## II. Implementing Interventions

When there is evidence of quality of care concerns or professional misconduct that could potentially affect the health and safety of Members, findings will be reported to the Chief Medical Officer or designee to review the case with the Corporate Counsel and potentially escalate the case for CQC review.

### A. CQC Review and Determination

When issues related to quality of care or professional misconduct are identified and referred to CQC for review and determination, a complete credentialing and quality summary will be presented. The summary will include the current situation, current and historical background, assessment, and proposed recommendation.

The CQC may take without limitations the following actions:

1. Determine that no quality or safety issue exists
2. Request further investigation

<b>Policy and Procedure</b>			
SUBJECT: <b>Ongoing Monitoring, Corrective Action and Intervention</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>11/02</b>		DATE(S) REVISED: <b>6/07; 6/08; 10/08; 08/09; 07/10; 7/11; 7/12; 4/13; 5/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 9.0</b>	PAGE: <b>5 of 9</b>

3. Issue a letter of reprimand or censure
4. Place the practitioner in ongoing monitoring for cause
5. Require a corrective action plan from the provider
6. Recommend that patient access be limited
7. Impose a financial sanction
8. Require medical or professional consultation
9. Restrict or terminate the provider from panel participation

All discussion and action by the CQC will be documented in meeting minutes. For additional information on the processes used to review and track information from identified adverse events, complications, and complaints see Quality Management policies QM 211 Patient Safety, QM 212 Clinical Review Program, and QM 213 Practitioner and Facility Quality of Care Review and Ongoing Monitoring Process.

#### B. Ongoing Monitoring For Cause

The CQC may place a practitioner or organizational provider in ongoing monitor for cause due to not meeting credentialing criteria or not improving performance as required by the corrective action plan.

All available data and reports of performance are reviewed to determine whether performance falls within acceptable quality standards. A practitioner or organizational provider may be placed in ongoing monitoring for cause due to, but not limited to the following:

1. Acts, demeanor, or conduct below applicable professional community or quality standards
2. Conduct which is reasonably likely to be disruptive to the care of the patient
3. Violation of the Companies' contracts, agreements or rules and regulations
4. Personal use of drugs and/or alcohol which affects professional performance
5. Revocation, suspension, or restriction of hospital privileges
6. Probation or restriction of license
7. Actively pursuing, but not having received, board certification as required by the Companies' policy
8. Criminal conviction or violation

<b>Policy and Procedure</b>			
SUBJECT: <b>Ongoing Monitoring, Corrective Action and Intervention</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>11/02</b>		DATE(S) REVISED: <b>6/07; 6/08; 10/08; 08/09; 07/10; 7/11; 7/12; 4/13; 5/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 9.0</b>	PAGE: <b>6 of 9</b>

Upon the CQC's determination to place a practitioner or organizational provider in ongoing monitoring for cause, the practitioner or organizational provider will be sent a letter outlining the review, determination, and any requirements, which may result in termination if requirements are not met.

### III. Reporting Process

#### A. Grounds for reportable adverse actions based on professional competence or conduct may include, but are not limited to:

1. Acts, demeanor, or conduct below applicable professional community standards
2. Conduct detrimental to patient safety or the delivery of substandard quality patient care
3. Unethical practice
4. Conduct which is reasonably likely to be unduly disruptive to the care of the patient
5. The cause of a conviction of a felony or misdemeanor related to the practitioner's practice
6. Violation of contracts or rules and regulations
7. Personal use of drugs and/or alcohol which affects professional performance as identified by a facility, sentinel events/adverse outcomes or by patient complaints
8. Revocation, suspension, or restriction of hospital privileges or health plan participation
9. Probation or restriction of license
10. Loss of professional liability coverage in required amounts
11. The provision of false or misleading information to patients or in the medical record concerning the Companies' requirements or actions
12. A refusal or failure to cooperate in credentialing, investigative or hearing procedure
13. Practitioner admits to, or is found to have engaged in, sexual misconduct
14. Practices considered to include fraud, waste, or abuse
15. The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession



<b>Policy and Procedure</b>			
SUBJECT: <b>Ongoing Monitoring, Corrective Action and Intervention</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>11/02</b>		DATE(S) REVISED: <b>6/07; 6/08; 10/08; 08/09; 07/10; 7/11; 7/12; 4/13; 5/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 9.0</b>	PAGE: <b>7 of 9</b>

16. Incompetence, negligence, or malpractice which creates unreasonable risk that a patient may be harmed
  17. Aiding or abetting an unlicensed person to practice when a license is required
  18. Practicing beyond the scope of practice as defined by law or rule.
- B. Practitioners or organizational providers subject to reportable adverse actions will be reported to the National Practitioner Data Bank (NPDB), and the appropriate state licensing board as required by law.
- C. An Adverse Action Report (AAR) will be completed within 30 days of the date of the adverse action and submitted electronically to the NPDB.
- D. The Report Verification Document (RVD) provided by the NPDB will be submitted to the appropriate state licensing board.
- E. A copy of the report will be maintained in the practitioner’s credentials file.
- F. Changes in previously reported adverse actions must be submitted directly to the NPDB as soon as possible after the discovery of an error or omission in a report, with a copy of the modified RVD mailed to the appropriate state licensing board. Changes can include:
1. Correction or modification (supersedes the contents of the original report)
  2. Void previous report (retraction of report)
  3. Revision to action (considered a new action which is related to and which modifies a previously submitted adverse action)

**REFERENCES:**

NCQA Credentialing Standards  
 CMS Credentialing Standards  
 QM 211 Patient Safety  
 QM 212 Clinical Review Program  
 QM 213 Practitioner and Facility Quality of Care Review and Ongoing Monitoring Process  
 CR 10.0 Actions and Appeals Process  
 CR 23.0 Credentialing Definitions and Acronyms

<b>Policy and Procedure</b>	
SUBJECT: <b>Actions and Appeals Process</b>	DEPARTMENT: <b>CR: Credentialing Services</b>
ORIGINAL EFFECTIVE DATE: <b>09/95</b>	DATE(S) REVISED: <b>6/07; 6/08; 09/08; 08/09; 07/10; 9/10; 7/11, 7/12, 2/13; 4/13; 5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22</b>
APPROVED BY:                      DATE: <b>Medical Director                      5/25/22</b>	NUMBER:                      PAGE: <b>CR 10.0                      1 of 10</b>

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

All Practitioners  
All Organizational Providers

<u>Fully Insured</u>			<u>Self-Insured</u>	<u>Medicare</u>	<u>Medicaid</u>	<u>Delegated Services to Ayin</u>
<u>Individual</u>	<u>Small Group</u>	<u>Large Group</u>				
<input type="checkbox"/> Oregon On Exchange	<input type="checkbox"/> Oregon On Exchange (SHOP)	<input type="checkbox"/> Oregon	<input type="checkbox"/> ASO	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> YCCO
<input type="checkbox"/> Oregon Off Exchange	<input type="checkbox"/> Oregon Off Exchange (SHOP)	<input type="checkbox"/> Washington	<input type="checkbox"/> PBM			<input type="checkbox"/> WHA
<input type="checkbox"/> Washington Off Exchange						
<input checked="" type="checkbox"/> APPLIES TO ALL ABOVE LINES OF BUSINESS						

**POLICY:**

Practitioners or organizational providers who fail to comply with established standards relating to quality of patient care, utilization of resources, compliance with administrative processes, and/or credentialing standards may be subject to termination or other corrective action. The purpose of this policy is to protect Members from inappropriate care and from

<b>Policy and Procedure</b>			
SUBJECT: <b>Actions and Appeals Process</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/95</b>		DATE(S) REVISED: <b>6/07; 6/08; 09/08; 08/09; 07/10; 9/10; 7/11, 7/12, 2/13; 4/13; 5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>5/25/22</b>	NUMBER: <b>CR 10.0</b>	PAGE: <b>2 of 10</b>

medical malpractice, and otherwise to enforce credentialing and contract requirements. This policy defines:

- The process when a need to take action with regard to limiting or terminating credentialing occurs.
- Appeal rights to notice and opportunity to be heard when there is an action to remove or to limit participation.

**DEFINITION:**

See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

**PROCEDURE:**

I. Actionable Issues

A. Credentialing or Contract Issues

1. All participating practitioners and organizational providers are required to meet and maintain compliance with credentialing criteria as defined in Credentialing Services Policy CR 2.0 Practitioner Credentialing and CR 11.0 Organizational Providers Credentialing.

Credentialing or contract issues include without limitation, the following:

- a. Failing to maintain required professional liability insurance coverage
- b. Leaving active practice in contracted service area
- c. Failing otherwise to comply with the contract or with the Companies' rules and regulations
- d. Failing to meet credentialing criteria
- e. Failing to comply with billing or coding standards generally accepted by the profession
- f. Submitting inaccurate or false information, which is identified during or after a credentialing cycle

<b>Policy and Procedure</b>			
SUBJECT: <b>Actions and Appeals Process</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/95</b>		DATE(S) REVISED: <b>6/07; 6/08; 09/08; 08/09; 07/10; 9/10; 7/11, 7/12, 2/13; 4/13; 5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>5/25/22</b>	NUMBER: <b>CR 10.0</b>	PAGE: <b>3 of 10</b>

2. A participating practitioner or organizational provider has no right to appeal the Companies' decision to terminate credentialing based on failure to comply with the following credentialing or contracting requirements:
  - a. Failure to maintain active professional licensure without limitations
  - b. Failure to obtain or maintain board certification
  - c. Failure to maintain professional liability insurance coverage
  - d. Change in practice location when credentialing approval is based on network need
  - e. Failure to respond to a request for credentialing information within 30 calendar days of the request
  - f. Failure to comply with conditional credentialing requirements, including without limitation obtaining and maintaining any required board certification
3. Upon discovery of noncompliance with credentialing or contracting requirements, the Credentialing Department will notify the Chief Medical Officer (CMO) or physician designee of the non-compliance and Provider Relations to initiate appropriate action.
4. When a credentialing action is taken based on credentialing or contracting requirements, a report may be required to the National Practitioners Data Bank (NPDB) as required by law.

#### B. Quality of Patient Care Issues

1. "Quality of patient care" refers to standards of practice that, in the Companies' judgment, are related to ensuring an appropriate medical outcome of treatment, including without limitation, practitioner competency, rather than to patient convenience or to other concerns. In general, whenever a credentialing action is taken based on quality of patient care, a report will be required to the National Practitioners Data Bank (NPDB) as prescribed by law.

<b>Policy and Procedure</b>			
SUBJECT: <b>Actions and Appeals Process</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/95</b>		DATE(S) REVISED: <b>6/07; 6/08; 09/08; 08/09; 07/10; 9/10; 7/11, 7/12, 2/13; 4/13; 5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>5/25/22</b>	NUMBER: <b>CR 10.0</b>	PAGE: <b>4 of 10</b>

2. Quality of Patient Care Issues include, without limitation the following:
  - a. Incompetence
  - b. Unethical practice
  - c. Felony Conviction
  - d. Abuse of drugs and/or alcohol
  - e. Loss or reduction of hospital privileges
  - f. Licensing board actions related to patient care
  - g. Misrepresentations to Members regarding the provision of medical services or payment
  - h. Other conduct reasonably deemed to be detrimental to quality of patient care or a failure to observe quality assurance and utilization protocols

## II. Medical Director and CQC Review

- A. Any information that may result in a credentialing action will be immediately referred to the CMO or physician designee for review.
- B. The CMO or designee shall conduct a preliminary investigation and review the case with the Providence Corporate Counsel, as appropriate.
- C. Unless the CMO or designee exonerates the practitioner, the CMO or designee shall refer the matter with recommendation to the Credentials and Quality Committee (CQC) for decision.
- D. Credentialing actions by the CQC are listed in Credentialing Services Policy CR 9.0 Ongoing Monitoring, Corrective Action and Intervention.
- E. If the CQC recommends exoneration, the CQC's decision to exonerate will stand. In the event the CQC determines that any action other than exoneration is appropriate,

<b>Policy and Procedure</b>			
SUBJECT: <b>Actions and Appeals Process</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/95</b>		DATE(S) REVISED: <b>6/07; 6/08; 09/08; 08/09; 07/10; 9/10; 7/11, 7/12, 2/13; 4/13; 5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>5/25/22</b>	NUMBER: <b>CR 10.0</b>	PAGE: <b>5 of 10</b>

the participating practitioner or organizational provider will be given written notice of the decision and the opportunity to request a hearing, if applicable.

### III. Appeal Process

- A. A participating practitioner or organizational provider subject to an adverse decision of the CQC on a credentialing or contracting matter may request a hearing as provided in this Section III. No appeal is available to initial credentialing applicants or when credentialing or contract is terminated for one of the reasons set out in Section I.A.2 of this policy.
- B. Written notice of opportunity to request a hearing shall include:
  1. That a credentialing action is proposed;
  2. The reasons for the proposed action;
  3. The appeal rights to request a hearing on the proposed action;
  4. That practitioner or organizational provider has thirty (30) calendar days after the notification was sent to request a hearing. The request must be in writing.
  5. A summary of hearing rights, including the rights to:
    - a. Representation by an attorney or other person of the practitioner or organizational provider's choice;
    - b. Select one of the three Hearing Panel members if the termination is related to quality of patient care or otherwise "with cause," provided that the nominee must be qualified by training to evaluate the issues involved, not have previously participated in the matter and not be in direct economic competition with the practitioner or organizational provider.
    - c. Have a record made of the proceeding, copies of which may be obtained by the practitioner or organizational provider upon payment of a reasonable charge;

<b>Policy and Procedure</b>			
SUBJECT: <b>Actions and Appeals Process</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/95</b>		DATE(S) REVISED: <b>6/07; 6/08; 09/08; 08/09; 07/10; 9/10; 7/11, 7/12, 2/13; 4/13; 5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>5/25/22</b>	NUMBER: <b>CR 10.0</b>	PAGE: <b>6 of 10</b>

- d. Call, examine, and cross-examine witnesses;
  - e. Present evidence determined to be relevant by the Hearing Panel regardless of its admissibility in any court of law; and
  - f. Submit a written statement at the hearing.
6. A statement of the practitioner or organizational provider’s status pending the hearing, particularly including whether Members may or may not be served without limitation or restriction pending the hearing. The standards for summary suspension are detailed in Section IV.
- C. Within fifteen (15) days of a request for hearing, or such longer time as may be required based on delay in appointment of a panel member by the practitioner or organizational provider, a Hearing Panel will be appointed. The Panel is composed of three persons professionally qualified to evaluate the standards applicable to the practitioner or organizational provider, none of whom is in direct economic competition with the practitioner or organizational provider. Whenever reasonably possible, the majority of the hearing panel members will be clinical peers. A clinical peer is defined as a medical practitioner with the same professional degree or higher.
- D. In the event the termination was based on quality of patient care or otherwise “with cause,” two of the three Hearing Panel members will be appointed by the Companies and the third may be appointed by the practitioner or organizational provider. If the practitioner or organizational provider fails to appoint a panel member within ten (10) days of notice, or such longer time as may be granted, the failure will constitute authorization to the Companies to appoint the third member. The Chief Medical Officer or a designee shall appoint Hearing Panel members and determine which of the Hearing Panel members shall serve as chairperson. Continued participation on the hearing panel is at the discretion of the Companies, which may remove a hearing panel member for lack of timeliness in responding to the necessary steps needed to move the process forward.
- E. In the event the termination was based on credentialing or contract issues other than quality of patient care, the Companies will appoint the three members of the panel.

<b>Policy and Procedure</b>			
SUBJECT: <b>Actions and Appeals Process</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/95</b>		DATE(S) REVISED: <b>6/07; 6/08; 09/08; 08/09; 07/10; 9/10; 7/11, 7/12, 2/13; 4/13; 5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>5/25/22</b>	NUMBER: <b>CR 10.0</b>	PAGE: <b>7 of 10</b>

- F. The Companies will not be held responsible for any expenses incurred by the practitioner or organizational provider, including, but not limited to, panel representation, expert witnesses, preparatory work, work-day interruption, and/or case reviewers. In particular, panel members chosen by the practitioner or organizational provider to participate on the panel are not compensated by the Companies for service on the panel.
- G. Within ten (10) business days after panel members have been appointed, the hearing will be scheduled, and notification will be sent to the Hearing Panel members and the practitioner or organizational provider. Notification will include date, time, and place of the hearing (hereafter "Fair Hearing"). The Fair Hearing date should not be less than thirty (30) days after the notice without consent of the practitioner and should be scheduled in any event within sixty (60) days of the notice. The Companies will make all reasonable efforts to meet these timelines but will coordinate hearing dates with the practitioner or organizational provider.
- H. The Fair Hearing will be scheduled and completed within 180 days from the date of the request for hearing. Absent waiver of this requirement by the Companies, failure of the practitioner requesting a hearing to accept a hearing date within 180 days constitutes a waiver of rights to a Fair Hearing and a voluntary acceptance of the final proposed or adverse action, which will become effective on the date specified in the notice informing the practitioner that the right to a Fair Hearing has been waived.
- I. Failure to appear at a scheduled Fair Hearing, without good cause, constitutes a waiver of the right to a Fair Hearing.
- J. The process for Fair Hearings will be as follows:
1. A record of the hearing will be made by electronic recording if all participants agree and/or by staff minutes;
  2. The Companies will be represented by staff or by counsel, and will begin with an opening statement, followed by such testimony or other evidence as it wishes to present;



<b>Policy and Procedure</b>			
SUBJECT: <b>Actions and Appeals Process</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/95</b>		DATE(S) REVISED: <b>6/07; 6/08; 09/08; 08/09; 07/10; 9/10; 7/11, 7/12, 2/13; 4/13; 5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>5/25/22</b>	NUMBER: <b>CR 10.0</b>	PAGE: <b>8 of 10</b>

3. At the discretion of the Hearing Panel, the practitioner or organizational provider may offer an opening statement either after the Companies' opening statement or after completion of the Companies' evidence;
  4. After completion of the Companies' evidence, the practitioner or organizational provider shall offer such testimony or other evidence as they wish to present;
  5. The Hearing Panel in its discretion may ask any questions it wishes to ask, may permit such rebuttal as it deems useful, and may invite verbal or written closing arguments from the parties;
  6. The practitioner or organizational provider will be excused so the Hearing Panel may deliberate, with or without participation by the Companies at the Panel's discretion.
- K. The record will be considered closed at the end of the Fair Hearing unless the practitioner or organizational provider requests and the Hearing Panel grants additional time to submit supplementary materials or briefing, in which case the record will be considered closed upon receipt of those materials by the Hearing Panel. The Hearing Panel shall issue a written notice of the appeal decision to the Companies, copy to the practitioner or organizational provider, within ten (10) days after the record is closed. The decision shall be in writing, including a statement of the specific reason(s) for the decision.
- L. In the event the Hearing Panel upholds a practitioner's appeal requesting continuation of full credentialing, the practitioner will be recredentialed without further action. In the event the Hearing Panel determines to impose conditions under which the credentialing will be upheld or denied, those conditions will be given effect without any additional hearing. In the event the Hearing Panel denies the practitioner's appeal, no further administrative appeal is provided and any required report regarding credentialing, participation, or quality of patient care will be made to the NPDB as prescribed by law.
- M. Reporting to Authorities - The decision of the Hearing Panel is final unless overturned by an order of a court of competent jurisdiction. If the final determination is a reportable event, the reporting process is followed as defined in

<b>Policy and Procedure</b>			
SUBJECT: <b>Actions and Appeals Process</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/95</b>		DATE(S) REVISED: <b>6/07; 6/08; 09/08; 08/09; 07/10; 9/10; 7/11, 7/12, 2/13; 4/13; 5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>5/25/22</b>	NUMBER: <b>CR 10.0</b>	PAGE: <b>9 of 10</b>

Credentialing Services policy CR 9.0 Ongoing Monitoring, Corrective Action and Intervention.

- N. Reporting to Providence St. Joseph Health Entities – If the Companies determine that a practitioner is subject to an adverse credentialing decision based on quality of care concerns and the practitioner maintains privileges at any entity of Providence St. Joseph Health, the Companies retain the right to report adverse credentialing decisions to Providence St. Joseph Health. If such action is determined to be appropriate after legal review, the Providence Regional Quality Director and/or the affected Providence entities will be notified of the credentialing decision and of any other relevant information.

#### IV. Summary Suspension

The Chief Medical Officer or designee, the Chief Executive Officer, the Chair of CQC and the Chair of the Administrative Quality Committee each have authority to summarily suspend a participating practitioner or organizational provider’s credentialing status whenever any of them determines that failure to do so may result in an imminent danger to the health and/or safety of any individual or to the reputation of the Companies.

Any such action will be reported to each of the individuals listed above and referred to the CQC at its next regularly scheduled meeting for a determination on whether the practitioner or organizational provider’s credentialing will be terminated or otherwise subjected to further action. The CQC may in its discretion defer a determination until its next regularly scheduled meeting but must make a determination at or before its second regularly scheduled meeting following the imposition of a summary suspension. Any decision of the CQC will be subject to appeal as provided in this policy. The CQC may decide to continue a summary suspension during the appeal process.

A summary suspension is effective immediately upon notification. The notice of suspension shall include the following:

1. An explanation of the cause of the suspension to the affected practitioner or organizational provider; and

<b>Policy and Procedure</b>			
SUBJECT: <b>Actions and Appeals Process</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/95</b>		DATE(S) REVISED: <b>6/07; 6/08; 09/08; 08/09; 07/10; 9/10; 7/11, 7/12, 2/13; 4/13; 5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>5/25/22</b>	NUMBER: <b>CR 10.0</b>	PAGE: <b>10 of 10</b>

2. Notice that the matter will be referred to the CQC at its next regularly scheduled meeting for final determination

V. Member Notification

In the event of termination, Provider Relations will be notified in order to assist Members in the transition care.

**REFERENCES:**

NCQA Credentialing Standards  
 CMS Credentialing Standards  
 QM 212 Clinical Review Program  
 CR 2.0 Practitioner Credentialing  
 CR 9.0 Ongoing Monitoring, Corrective Action and Intervention  
 CR 11.0 Organizational Provider Credentialing  
 CR 23.0 Credentialing Definitions and Acronyms

<b>Policy and Procedure</b>			
SUBJECT: <b>Organizational Providers Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/98</b>		DATE(S) REVISED: <b>7/11; 12/11, 7/12, 8/12; 4/13; 5/14, 10/14; 6/15; 6/16, 6/17; 6/18; 6/19; 5/20; 5/21; 10/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 11.0</b>	PAGE: <b>1 of 11</b>

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayn Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

Behavioral Health Facilities including mental health and substance abuse services: Inpatient, Residential, Ambulatory  
 Birthing Centers  
 Clinical Laboratories  
 Comprehensive Outpatient Rehabilitation Facility (CORF)  
 Durable Medical Equipment (DME) Prosthetic, Orthotics and Supplies (POS)  
 End-Stage Renal Disease Services  
 Free-standing Ambulatory Surgical Centers  
 Genetic Counseling Centers  
 Home Health Agencies  
 Hospice  
 Hospitals  
 Outpatient Diabetes Self-Management Training  
 Outpatient Physical Therapy and Speech Pathology Providers  
 Pharmacies  
 Portable X-Ray Suppliers  
 Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)  
 Skilled Nursing Facilities (short-term and long-term)  
 Telemedicine Organizational Providers  
 Urgent Care Centers  
 All organizational providers with which the company contracts that provide services to members and where members are directed for services rather than being directed to a specific practitioner

<b>Policy and Procedure</b>			
SUBJECT: <b>Organizational Providers Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/98</b>		DATE(S) REVISED: <b>7/11; 12/11, 7/12, 8/12; 4/13; 5/14, 10/14; 6/15; 6/16, 6/17; 6/18; 6/19; 5/20; 5/21; 10/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 11.0</b>	PAGE: <b>2 of 11</b>

<u>Fully Insured</u>						
<u>Individual</u>	<u>Small Group</u>	<u>Large Group</u>	<u>Self-Insured</u>	<u>Medicare</u>	<u>Medicaid</u>	<u>Delegated Services to Ayin</u>
<input type="checkbox"/> Oregon On Exchange	<input type="checkbox"/> Oregon On Exchange (SHOP)	<input type="checkbox"/> Oregon	<input type="checkbox"/> ASO	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> YCCO
<input type="checkbox"/> Oregon Off Exchange	<input type="checkbox"/> Oregon Off Exchange (SHOP)	<input type="checkbox"/> Washington	<input type="checkbox"/> PBM			<input type="checkbox"/> WHA
<input type="checkbox"/> Washington Off Exchange						
<input checked="" type="checkbox"/> APPLIES TO ALL ABOVE LINES OF BUSINESS						

**POLICY:**

All organizational providers are required to complete initial credentialing prior to contracting. The credentialing process includes completion of an organizational provider credentialing application, verification of specific criteria with review and decision by the Credentials and Quality Committee (CQC). This assessment process is repeated at least every 3 years to the day.

**DEFINITION:**

See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

**PROCEDURE:**

- I. Credentialing Procedure
    - A. Credentialing receives a request from Contracting, Provider Relations, or the Pharmacy Department to contract with a new organizational provider.
    - B. Prior to contracting with a new organizational provider and at recredentialing, Credentialing Staff will review to ensure criteria are met. The Credentialing Department obtains all relevant documentation required in the application. The
-

<b>Policy and Procedure</b>			
SUBJECT: <b>Organizational Providers Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/98</b>		DATE(S) REVISED: <b>7/11; 12/11, 7/12, 8/12; 4/13; 5/14, 10/14; 6/15; 6/16, 6/17; 6/18; 6/19; 5/20; 5/21; 10/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 11.0</b>	PAGE: <b>3 of 11</b>

signed application and primary source verification contained in the complete application shall not be more than 180 days old at the time of the CQC's decision. Credentialing decisions will be based on the verification of a complete Organizational Provider Application. Complete application includes, but is not limited to the following (primary source verification requirements are indicated by an asterisk \*):

1. Licensure - Copy of current valid state or equivalent (business license, certificate, etc), as applicable. The Companies relies on active status enrollment of 'moderate' or 'high' risk providers in Medicare; therefore, will verify OHA licensure for 'moderate' or 'high' risk provider types.
2. Current liability insurance - The organizational provider is required to provide evidence of current malpractice liability coverage with liability limits at a minimum or \$1,000,000 per claim and \$3,000,000 aggregate.

Organizational providers are also required to maintain insurance applicable to the organization type and in accordance with applicable state laws, including coverage for workers' compensation.

3. \*Medicare or Medicaid Sanction and Exclusion – must cover most recent three-year period and includes the following:
  - a. OIG - Sanctions are verified through the Cumulative Sanction Report available from the Office of Inspector General (OIG).
  - b. SAM - GSA/ System Award Management parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits.
  - c. Opt Out - A documented review of the Medicare opt-out list by querying the name of the organization's administrator
  - d. Preclusion – A documented review of the monthly CMS Preclusion list.
4. CMS Report - Copy of last CMS inspection report, findings, and documentation submitted to explain any corrective actions necessary
5. Seclusion and Restraint Policy

<b>Policy and Procedure</b>			
SUBJECT: <b>Organizational Providers Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/98</b>		DATE(S) REVISED: <b>7/11; 12/11, 7/12, 8/12; 4/13; 5/14, 10/14; 6/15; 6/16, 6/17; 6/18; 6/19; 5/20; 5/21; 10/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 11.0</b>	PAGE: <b>4 of 11</b>

6. Patient Visitation Policy (hospitals only).
7. Quality Assurance and Performance Improvement (QAPI) Policy (ASC only)
8. Surgical Site Verification Policy (ASC only)
9. Credentialing Policy - Description of credentialing, recredentialing, and clinical staff privileging program to ensure that all providers credential their practitioners

Practitioners who provide care at the facility (such as a hospital) and only interact with members as a result of their role at the facility are credentialed by the facility (i.e. Anesthesiologists, Emergency Room providers, Hospitalists, Neonatologists, Pathologists, Radiologists and Telemedicine consultants).

10. Patient / Hospital Transfer Agreement (ASC only) - ASC must provide a copy of at least one transfer agreement with a participating hospital.
  11. Accreditation – Copy of current accreditation. Recognized accrediting bodies include:
    - National Committee for Quality Assurance (NCQA)
    - The Joint Commission (TJC)
    - Det Norske Veritas Germanischer Lloyd (DNV GL)
    - Accreditation Association for Ambulatory Health Care (AAAHC)
    - Clinical Laboratory Improvement Amendments (CLIA)
    - Utilization Review Accreditation Commission (URAC)
    - American Association of Ambulatory Surgery Centers (AAASC)
    - American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
    - Commission on Accreditation of Rehabilitation Facilities (CARF)
    - Council on Accreditation (COA)
    - American Board for Certification in Orthotics, Prosthetics, and Pedorthics (ABC)
    - Commission for the Accreditation of Birth Centers (CABC)
    - American College of Radiology (ACR)
    - Intersocietal Accreditation Commission (IAC)
    - Community Health Accreditation Program (CHAP)
    - Healthcare Facilities Accreditation Program (HFAP)
-

<b>Policy and Procedure</b>			
SUBJECT: <b>Organizational Providers Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/98</b>		DATE(S) REVISED: <b>7/11; 12/11, 7/12, 8/12; 4/13; 5/14, 10/14; 6/15; 6/16, 6/17; 6/18; 6/19; 5/20; 5/21; 10/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 11.0</b>	PAGE: <b>5 of 11</b>

- Institute for Medical Quality (IMQ)
  - Accreditation Commissions for Healthcare (ACHC)
  - American Osteopathic Association (AOA)
  - Oregon Health Authority (OHA)
- a. Findings by an accrediting body will be collected as well as evidence of corrective actions taken to resolve any cited deficiencies.
12. All Organizational Providers not accredited by a recognized accrediting body must have a process ensuring that they credential their practitioners and must meet one of the following:
- a. CMS or state survey no more than three years old may be collected from the organization or the agency stating that the organization was reviewed and passed inspection
  - b. An on-site quality assessment or equivalent. The following steps will be included in the on-site review process:
    - i. A date for the site visit will be scheduled with the organizational provider. If the organizational provider has satellite facilities that follow the same policies and procedures as the provider, Companies may limit the site visit to the main facility.
    - ii. The organizational provider will be sent a packet, which includes the survey tool and the requirements for the on-site visit, which may include, but not limited to facility tour, staff interview, medical record review and policy review.
    - iii. Following the visit, the reviewer will complete the report and submit it to the CQC for approval. If there are quality issues or other concerns identified, these issues will be discussed with a Medical Director for a recommendation. The determination made by the Medical Director may include the following:
      - no further action,
      - review of medical records,
      - notification/query letter to the organizational provider regarding the issues,
      - third party review of stipulated cases,
-



<b>Policy and Procedure</b>			
SUBJECT: <b>Organizational Providers Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/98</b>		DATE(S) REVISED: <b>7/11; 12/11, 7/12, 8/12; 4/13; 5/14, 10/14; 6/15; 6/16, 6/17; 6/18; 6/19; 5/20; 5/21; 10/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 11.0</b>	PAGE: <b>6 of 11</b>

- referral to the CQC
- any other appropriate action deemed necessary to determine if care is less than satisfactory.

c. If the organizational provider is in a rural area, as defined by the U.S. Census Bureau (<https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html>) and is not accredited, nor has a CMS site survey been conducted within the three year cycle, the on-site survey requirement will be waived.

13. \*National Provider Identifier (NPI)

14. Contact Information – All organizations are required to provide current contact information including, but not limited to: current addresses, phone, fax, and e-mail address.

## II. Recredentialing Process

Organizational providers are recredentialed by Credentialing Staff at least every 3 years to the day. The recredentialing process includes verification as defined in this policy and a current quality profile.

## III. CQC Oversight

- A. If quality issues are identified, the organizational provider will be referred to CQC for review and determination as defined in Credentialing Services policy CR 9.0 Ongoing Monitoring, Corrective Action and Intervention.
  - B. Failure of an organizational provider to comply with the corrective action plan may result in CQC recommending termination from panel participation. The organizational provider has the right to appeal in accordance with Credentialing Services policy CR 10.0 Actions and Appeals Process.
  - C. Within sixty (60) days after the credentialing decision and recredentialing denials, the Credentialing Department sends written notification of the CQC's decision.
-

<b>Policy and Procedure</b>			
SUBJECT: <b>Organizational Providers Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/98</b>		DATE(S) REVISED: <b>7/11; 12/11, 7/12, 8/12; 4/13; 5/14, 10/14; 6/15; 6/16, 6/17; 6/18; 6/19; 5/20; 5/21; 10/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 11.0</b>	PAGE: <b>7 of 11</b>

#### IV. Organizational Providers Primary Source Verification Procedure

Facility Type	Credentialing Elements	Explanation / Verifying Source*	Accrediting Body
<b>All Organizational Provider Credentialing Criteria</b>	State License or equivalent license or certificate	Copy of document. Source may be further defined in specific organizational provider sections within this document.	NCQA / CMS
	Accreditation / State Survey	Accreditation or State Survey must be completed every 3 years unless in a rural area (total population of 2,500 persons). If neither have been completed in the last 3 years, PHP is required to perform site survey or equivalent	NCQA / CMS
<b>Not limited to specific organization providers further defined in this document</b>	OIG	Office of Inspector General (OIG)*  Two OIG verifications must be queried: 1. Administrator first and last name (Search for an Individual) 2. Facility name – separate report queried for both multiple names (Legal, DBA) (Search for a Single Entity or Search for Multiple Entities)	CMS / MAP / PHP
	SAM	System for Award Management (SAM)*  Two SAM verifications must be queried: 1. Administrator first and last name. 2. Facility name – separate report queried for both multiple names (Legal, DBA)	CMS / MAP / PHP
	Preclusion	Updated Preclusion List is downloaded monthly. Document findings at the time of credentialing.	CMS / MAP / PHP
	W-9 or IRS Letter	Copy of document	PHP
	NPI – Type 2 Organizational	Verified online (can be searched either by facility name or NPI number listed on page 4 of OPCA): National Plan & Provider Enumeration System (NPPES)*	CMS / MAP / PHP
	Malpractice Insurance	Current malpractice insurance, PHP Health requires limits of liability \$1,000,000 per claim and \$3,000,000 aggregate amount (minimum).  Two ways to verify: 1. Attested to on page 4 of OPCA by facility administrator. 2. Verified through copy of malpractice insurance certificate, provided by facility administrator.	NCQA / CMS
	Credentialing Program or Hiring Policy	Copy of document to ensure that organizational providers credential their practitioners.	CMS / MAP / PHP
	Seclusion & Restraint Policy (CFR 438.100)	Copy of document	CMS / MAP
	Medicare Certification	Copy of document required only for organizational providers certified through Medicare. Medicare does not certify Behavioral Health or Genetic Counseling facilities in Oregon or Washington.	CMS
	NPDB	Required for all organizational providers*	PHP

<b>Policy and Procedure</b>			
SUBJECT: <b>Organizational Providers Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/98</b>		DATE(S) REVISED: <b>7/11; 12/11, 7/12, 8/12; 4/13; 5/14, 10/14; 6/15; 6/16, 6/17; 6/18; 6/19; 5/20; 5/21; 10/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 11.0</b>	PAGE: <b>8 of 11</b>

<b>Provider Type</b>	<b>Credentialing Elements</b>	<b>Explanation / Verifying Source*</b>	<b>Accrediting Body</b>
<b>Ambulatory Surgery Center (ASC)</b>	State License	Active/Current license in good standing: <ul style="list-style-type: none"> <li>- Copy</li> <li>- OR: Oregon Health Authority (OHA)</li> <li>- WA: Washington State Department of Health</li> </ul>	NCQA / CMS
	Roster	List of all providers performing procedures, including Anesthesia	PHP
	Privileges	Copy of privileges granted at ASC	PHP
	QAPI Policy	ASC must provide a copy of their current Quality Improvement policy along with the current projects	PHP
	Transfer Agreement	ASC must provide a copy of at least one transfer agreement with a participating hospital	PHP
<b>Behavioral Health Facilities including mental health and substance abuse services: Inpatient, Residential, Ambulatory</b>	State License / Certificate of Approval (COA)	<p>Oregon Outpatient/ambulatory Mental Health and Chemical Dependency Organizational Providers (excluding privately owned) are issued a Certificate of Approval (COA).</p> <ul style="list-style-type: none"> <li>- Copy</li> <li>- OR: Oregon Health Authority (OHA)</li> </ul> <p>Oregon Residential Treatment and Inpatient Organizational Providers are issued a state license</p> <ul style="list-style-type: none"> <li>- Copy</li> <li>- OR: Oregon Health Authority (OHA)</li> </ul> <p>Washington Behavioral Health Organizational Providers</p> <ul style="list-style-type: none"> <li>- Copy</li> <li>- WA: Washington State Department of Health</li> </ul> <p>COA: Provided by facility Administrator, must have COA for each provider type (Mental Health and/or Chemical Dependency) unless both types are listed on one COA. Institution for Oregon COA's is Oregon Health Authority Addictions and Mental Health Division (<a href="#">OHA MH/CD</a>).</p> <p>Residential Treatment and Inpatient Organizational Providers License: Provided by facility Administrator, cannot be verified online.</p>	NCQA / CMS
	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ <b>(Year)</b> DMAP Provider Spreadsheets	OHA
<b>Birthing Center (BC)</b>	State License	Active/Current license in good standing:	NCQA / CMS

<b>Policy and Procedure</b>			
SUBJECT: <b>Organizational Providers Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/98</b>		DATE(S) REVISED: <b>7/11; 12/11, 7/12, 8/12; 4/13; 5/14, 10/14; 6/15; 6/16, 6/17; 6/18; 6/19; 5/20; 5/21; 10/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 11.0</b>	PAGE: <b>9 of 11</b>

<b>Provider Type</b>	<b>Credentialing Elements</b>	<b>Explanation / Verifying Source*</b>	<b>Accrediting Body</b>
<b>Clinical Laboratory</b>	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ <i>(Year)</i> DMAP Provider Spreadsheets	OHA
<b>Comprehensive Outpatient Rehabilitation Facility (CORF)</b>	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ <i>(Year)</i> DMAP Provider Spreadsheets	OHA
<b>Durable Medical Equipment (DME) Prosthetic, Orthotics and Supplies (POS)</b>	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ <i>(Year)</i> DMAP Provider Spreadsheets	OHA
<b>Genetic Counseling</b>	State License	Copy of business certificate	NCQA / CMS
<b>Home Health Agency (HHA)</b>	State License	Active/Current license in good standing: - Copy - OR: Oregon Health Authority (OHA) - WA: Washington State Department of Health	NCQA / CMS
	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ <i>(Year)</i> DMAP Provider Spreadsheets	OHA

<b>Policy and Procedure</b>			
SUBJECT: <b>Organizational Providers Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/98</b>		DATE(S) REVISED: <b>7/11; 12/11, 7/12, 8/12; 4/13; 5/14, 10/14; 6/15; 6/16, 6/17; 6/18; 6/19; 5/20; 5/21; 10/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 11.0</b>	PAGE: <b>10 of 11</b>

Provider Type	Credentialing Elements	Explanation / Verifying Source*	Accrediting Body
<b>Hospital</b>	State License	Active/Current license in good standing: - Copy - OR: Oregon Health Authority (OHA) - WA: Washington State Department of Health	NCQA / CMS
	CLIA Certificate	CLIA certificate: - Copy - Clinical Laboratory Improvement Amendments (CLIA)	CMS / PHP
	DEA Certificate	DEA certificate: - Copy - Drug Enforcement Administration National Technical Information Service (DEA NTIS)	NCQA / CMS / MAP
	Patient Visitation Policy (CFR 482.013)	Copy of document	CMS
<b>Hospice</b>	State License	Active/Current license in good standing: - Copy - OR: Oregon Health Authority (OHA) WA: Washington State Department of Health	NCQA / CMS
	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ <b>(Year)</b> DMAP Provider Spreadsheets	OHA

<b>Policy and Procedure</b>			
SUBJECT: <b>Organizational Providers Credentialing</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>09/98</b>		DATE(S) REVISED: <b>7/11; 12/11, 7/12, 8/12; 4/13; 5/14, 10/14; 6/15; 6/16, 6/17; 6/18; 6/19; 5/20; 5/21; 10/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 11.0</b>	PAGE: <b>11 of 11</b>

Facility Type	Credentialing Elements	Explanation / Verifying Source*	Accrediting Body
<b>Outpatient Physical Therapy and Speech Pathology Provider</b>	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ ( <b>Year</b> ) DMAP Provider Spreadsheets	OHA
<b>Pharmacy</b>	State License (for each Pharmacy)	Active/Current license in good standing: - Copy - OR: Oregon Board of Pharmacy WA: Washington State Department of Health	NCQA / CMS
	DEA Certificate (for each Pharmacy)	DEA certificate: - Copy - Drug Enforcement Administration National Technical Information Service (DEA NTIS)	NCQA /CMS/ MAP/ PHP
	Inspection Reports	State Board of Pharmacy Inspection Reports- most recent results	PHP
	Policies and Procedures	For the provision of birth control assessment and prescribing. Must have copy in file at each recredential	PHP
<b>Portable X-Ray Supplier</b>	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ ( <b>Year</b> ) DMAP Provider Spreadsheets	OHA
<b>Skilled Nursing Facility (SNF)</b>	State License	Active/Current license in good standing: - Copy - OR: Oregon Department of Human Resources - WA: Washington State Department of Health	NCQA / CMS
	Medicare Nursing Home Compare	Required only for Skilled Nursing Facilities* Medicare.gov/nursinghomecompare	PHP

**REFERENCES:**

- NCQA Credentialing Standards
- CMS Credentialing Standards
- CR 9.0 Ongoing Monitoring, Corrective Action and Intervention
- CR 10.0 Actions and Appeals Process
- CR 23.0 Credentialing Definitions and Acronyms

<b>Policy and Procedure</b>			
SUBJECT: <b>Exceptions Policy (Includes Temporary Policy Emergency Provisions)</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>07/10</b>		DATE(S) REVISED: <b>02/11; 7/11;7/12; 4/13; 5/14, 11/14; 6/15; 4/16; 6/16; 1/18; 6/18; 6/19; 5/20; 5/21; 8/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 16.0</b>	PAGE: <b>1 of 7</b>

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

All practitioners  
All organizational providers

<u>Fully Insured</u>						
<u>Individual</u>	<u>Small Group</u>	<u>Large Group</u>	<u>Self-Insured</u>	<u>Medicare</u>	<u>Medicaid</u>	<u>Delegated Services to Ayin</u>
<input type="checkbox"/> Oregon On Exchange	<input type="checkbox"/> Oregon On Exchange (SHOP)	<input type="checkbox"/> Oregon	<input type="checkbox"/> ASO	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> YCCO
<input type="checkbox"/> Oregon Off Exchange	<input type="checkbox"/> Oregon Off Exchange (SHOP)	<input type="checkbox"/> Washington	<input type="checkbox"/> PBM			<input type="checkbox"/> WHA
<input type="checkbox"/> Washington Off Exchange						
<input checked="" type="checkbox"/> APPLIES TO ALL ABOVE LINES OF BUSINESS						

**POLICY:**

<b>Policy and Procedure</b>			
SUBJECT: <b>Exceptions Policy (Includes Temporary Policy Emergency Provisions)</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>07/10</b>		DATE(S) REVISED: <b>02/11; 7/11;7/12; 4/13; 5/14, 11/14; 6/15; 4/16; 6/16; 1/18; 6/18; 6/19; 5/20; 5/21; 8/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 16.0</b>	PAGE: <b>2 of 7</b>

The Chair of the Credentialing and Quality Committee (CQC) has the right to approve any credentialing files that are determined to be complete and without exceptions (clean files).

The CQC will review all files that are considered exceptions.

In the event that an applicant is needed to fulfill a network need, Provider Relations will submit information detailing the need and request to the CQC.

**DEFINITION:**

See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

**PROCEDURE:**

I. Types of Credentialing Exceptions

Credentialing Exceptions include, but not limited to the following:

- A. Non-Board Certified practitioners who do not meet grandfathering criteria
- B. Current or previous malpractice claims, lawsuits, judgments, settlements, or other incidents that might indicate a quality of care or competency issue, including the following:
  - 1. Malpractice claims with settlements of \$100,000 or greater
  - 2. Two or more malpractice claims with settlements
  - 3. Malpractice claims pending disposition
  - 4. Malpractice claims that are dismissed or result in a judgment of no fault and/or no payment on the practitioner’s behalf may be reviewed by the Credentialing Supervisor to determine if the file requires review by the CQC
  - 5. Practitioners with malpractice claims during residency or professional training will not be considered an exception



<b>Policy and Procedure</b>			
SUBJECT: <b>Exceptions Policy (Includes Temporary Policy Emergency Provisions)</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>07/10</b>		DATE(S) REVISED: <b>02/11; 7/11;7/12; 4/13; 5/14, 11/14; 6/15; 4/16; 6/16; 1/18; 6/18; 6/19; 5/20; 5/21; 8/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 16.0</b>	PAGE: <b>3 of 7</b>

- C. Current or previous disciplinary actions by licensing boards, DEA or CDS agencies, hospitals, managed care plans, health delivery systems, facilities, medical review boards, or other administrative bodies or government agencies including Medicare and Medicaid, etc. The CQC has the sole discretion to consider any licensing board activity as a reason for suspension or termination from the Companies network.
- D. Previous misdemeanor (except non-work related, or prior to medical school/education), all felony convictions, and DUI's less than 10 years old or more than 1 DUI
- E. Any other sanction or disciplinary action indicated in the Attestation section of the clinician's application
- F. Any violations of state or federal law or standards of ethical conduct governing the applicant's profession
- G. Practitioners who did not complete a portion of their training or transferred to another training institution for completion (i.e. medical school, internship, residency, fellowship). If the practitioners left a training program for good cause and completed their training at another facility, this will not be considered an exception. These situations may be reviewed by the Credentialing Supervisor to determine if the file requires review by the CQC.
- H. Indication of need for accommodations in order to perform essential functions of the position
- I. Insufficient call coverage
- J. Insufficient admit plan and/or lack of hospital privileges
- K. Professional liability insurance (malpractice) minimum limits that do not meet credentialing criteria with the following exclusions:
  - 1. Clinicians with Federal Tort Coverage do not require review as an exception as long as they provide a copy of the Federal Tort letter or a signed attestation that they have federal tort coverage for professional liability

<b>Policy and Procedure</b>			
SUBJECT: <b>Exceptions Policy (Includes Temporary Policy Emergency Provisions)</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>07/10</b>		DATE(S) REVISED: <b>02/11; 7/11;7/12; 4/13; 5/14, 11/14; 6/15; 4/16; 6/16; 1/18; 6/18; 6/19; 5/20; 5/21; 8/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 16.0</b>	PAGE: <b>4 of 7</b>

2. Clinicians with coverage through a state agency that is self-insured do not require review as an exception as long as they provide a copy of the letter from the state agency

L. Quality/patterns of care concerns

II. Network Need Exceptions:

Practitioners or Organizational Providers who do not meet credentialing criteria will be presented to CQC for determination when “network need” has been established and a request has been submitted by the Provider Relations Department for CQC consideration.

A. Geo-access Exceptions

Geo-access exceptions are to address a lack of specific specialty, unique subspecialty or qualifications within a defined geographic area.

B. Business Need Exceptions

Business need exceptions include practitioners practicing in a clinical setting where members do not have a choice of practitioner selection or circumstances in which the Provider Relations Manager determines that Members would be significantly impacted. Network need for business-related circumstances may include the following:

1. Practitioner relationship with a practice group that provides care in a clinical setting where the member has no choice of practitioner selection (i.e., anesthesiology, ER physician, pathology, radiology, urgent care, emergency care, immediate care).
2. Practitioner meets a business need within a group that would be unable to maintain practice (and therefore, Member access) without the practitioner.
3. Practitioner is critical to on-call schedule with other network practitioners within a given medical group.

<b>Policy and Procedure</b>			
SUBJECT: <b>Exceptions Policy (Includes Temporary Policy Emergency Provisions)</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>07/10</b>		DATE(S) REVISED: <b>02/11; 7/11;7/12; 4/13; 5/14, 11/14; 6/15; 4/16; 6/16; 1/18; 6/18; 6/19; 5/20; 5/21; 8/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 16.0</b>	PAGE: <b>5 of 7</b>

4. Other compelling reasons proposed by Provider Relations or other Officer(s).

#### C. Network Need Exception Requirements

1. Practice location – Network need exceptions are specific to the location requested by Provider Relations Department. The CQC approval letter will indicate approval for network need location(s) only. Practitioners must notify the Credentialing Department of any change in practice location. If a practitioner with a network need approval changes practice locations, this information will be forwarded to Provider Relations for a new network need request that will be reviewed by CQC for determination. Termination of panel membership may occur if the practitioner no longer fulfills a network need.
2. Board Certification – The following will be obtained for non-board certified practitioners requesting exception:
  - a. Primary source verification of successful completion of a board-approved residency or fellowship program in the area of specialty
  - b. Receive two (2) current peer reference letters from practitioners who have had direct clinical observation of the applicant within the past twelve (12) months, validating that practitioner is adequately trained in the practice specialty and has demonstrated competency in the practice specialty.
  - c. For initial application, applicants will be required to submit 30 hours of Category 1 CMEs from the prior year or 60 Category 1 CMEs from the previous 2 years. At recredentialing, practitioners will be required to submit 90 Category 1 CMEs within the three-year credentialing cycle or 60 Category 1 CMEs within the past 2 years.

### III. Exception Review

<b>Policy and Procedure</b>			
SUBJECT: <b>Exceptions Policy (Includes Temporary Policy Emergency Provisions)</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>07/10</b>		DATE(S) REVISED: <b>02/11; 7/11;7/12; 4/13; 5/14, 11/14; 6/15; 4/16; 6/16; 1/18; 6/18; 6/19; 5/20; 5/21; 8/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 16.0</b>	PAGE: <b>6 of 7</b>

Exceptions that have been previously approved by the CQC will not be reviewed in subsequent recredentialing cycles, unless changes or concerns are reported or discovered.

#### IV. Quality Improvement Waivers

- A. Practitioners that qualify for board certification waivers adopted by CQC to meet quality improvement goals for access and availability are not considered exceptions and therefore are not subject to CQC case-by-case review. Such applicants may be processed as “clean” files.
- B. Participating practitioners initially approved with a board certification waiver will be grandfathered to board certification requirements at the time of recredentialing regardless of the waiver’s status.
- C. The following will be obtained for non-board certified practitioners credentialed with board certification waiver:
  1. Primary source verification of successful completion of an approved residency or fellowship program in the area of specialty.
  2. Two (2) current peer reference letters from practitioners who have had direct clinical observation of the applicant within the past twelve (12) months and who can verify that the practitioner is currently competent in the requested specialty.
  3. Thirty (30) hours of Category 1 CMEs from the prior year or 60 Category 1 CMEs from the previous 2 years. At recredentialing, practitioners will be required to submit 90 Category 1 CMEs within the three-year credentialing cycle or 60 Category 1 CMEs within the past 2 years.

#### V. Temporary Emergency Provisions to Exceptions Policy

<b>Policy and Procedure</b>			
SUBJECT: <b>Exceptions Policy (Includes Temporary Policy Emergency Provisions)</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>07/10</b>		DATE(S) REVISED: <b>02/11; 7/11;7/12; 4/13; 5/14, 11/14; 6/15; 4/16; 6/16; 1/18; 6/18; 6/19; 5/20; 5/21; 8/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 16.0</b>	PAGE: <b>7 of 7</b>

Establishes exceptions for discretionary Company policy that goes beyond minimum criteria required by state and federal guidelines. The intent of the emergency provisions is to provide needed flexibility and align with state and federal policy waivers announced based on extraordinary circumstances. Temporary exceptions include:

- Exception of expired board certification
- Exception of CME requirements
- Exception of an organizational provider application without a site review
- Exception of in-state licensure when professional licensing agencies are reciprocating licensure between states allowing licensed providers to render services outside of their state of enrollment.
- Any other exceptions or accommodations published by state, federal or accrediting organizations.

The CQC may approve recredentialing applications that contain temporary emergency exceptions for one year. In subsequent re-credentialing applications, the applicant must meet all standard Company requirements and the temporary exception will not be grandfathered.

**REFERENCES:**

- CR 23.0 Credentialing Definitions and Acronyms and Definitions
- NCQA Credentialing Standards

<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing System Controls</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>06/13</b>		DATE(S) REVISED: <b>5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 17.0</b>	PAGE: <b>1 of 7</b>

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

All Practitioners  
Practitioner applicants

<u>Fully Insured</u>			<u>Self-Insured</u>	<u>Medicare</u>	<u>Medicaid</u>	<u>Delegated Services to Ayin</u>
<u>Individual</u>	<u>Small Group</u>	<u>Large Group</u>				
<input type="checkbox"/> Oregon On Exchange	<input type="checkbox"/> Oregon On Exchange (SHOP)	<input type="checkbox"/> Oregon	<input type="checkbox"/> ASO	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> YCCO
<input type="checkbox"/> Oregon Off Exchange	<input type="checkbox"/> Oregon Off Exchange (SHOP)	<input type="checkbox"/> Washington	<input type="checkbox"/> PBM			<input type="checkbox"/> WHA
<input type="checkbox"/> Washington Off Exchange						
<input checked="" type="checkbox"/> APPLIES TO ALL ABOVE LINES OF BUSINESS						

**POLICY:**

The Companies have processes in place to protect the integrity and accuracy of the practitioner data collected during the credentialing process by limiting access, maintaining security groups authorized to make modifications, securing access to data, auditing credentialing processes, monitoring and oversight of all modifications made to practitioner data.

<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing System Controls</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>06/13</b>		DATE(S) REVISED: <b>5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 17.0</b>	PAGE: <b>2 of 7</b>

**DEFINITION:**

See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

**PROCEDURE:**

I. Securing Information

A. Limiting Physical Access

The electronic and physical access to the Companies' systems is granted at the time of hire. The credentialing database is a cloud-based application that requires a single sign-on through the Companies' system access. The vendor is responsible for ensuring that there is not unauthorized access to servers' physical location and appropriate protections for security of data.

B. Preventing Unauthorized Access

Hiring managers request or update access as applicable to a staff member's job responsibilities or disable access at the time of separation. When access is requested to the credentialing database, the Credentialing Manager must authorize the level of access. Levels of permissions within the credentialing database dictate the ability to access, modify and release credentialing information. In addition to permissions being granted by the Credentialing Manger all authorized staff are required to utilize a password to access the credentialing database. The Company's password protected electronic system in conjunction with Credentialing Manager's authorization of all staff member's level of access prevents unauthorized access, changes to, and release of credentialing information.

C. Password Protecting Electronic Systems

Password management for the credentialing database includes the following:

1. Use of strong passwords
2. Avoid writing down passwords
3. User IDs and passwords unique to individual staff
4. Change passwords when requested by staff or if passwords are compromised
5. Disabling or removing passwords of staff who leave the Companies and alert appropriate staff who oversee computer security

<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing System Controls</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>06/13</b>		DATE(S) REVISED: <b>5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 17.0</b>	PAGE: <b>3 of 7</b>

## II. Authorization to Modify Information

A. Levels of authorization to access credentialing data are set by user groups in the credentialing database. User groups are established with specific security setting to allow a staff member with access to read, modify, add, or delete information.

1. Read-only access is authorized for the following staff members:

- a. Quality Management
- b. EHealth
- c. Provider Contracting
- d. Chief Medical Officer and Associate Medical Directors
- e. Legal counsel
- f. Credentials and Quality Committee (CQC)
- g. Providence St Joseph Health Internal Auditors
- h. Regulatory External Auditors

2. Read-modify-add access to credentialing information is authorized for the following staff members:

- a. Credentialing Manager
- b. Credentialing Coordinators
- c. Credentialing Analyst
- d. Credentialing Technicians
- e. Credentialing Delegation Auditor

3. Upon identification of a duplicate record or inaccurate information in a practitioner record, only the following staff members have authorization to delete this information:

- a. Credentialing Manager
  - b. Credentialing Analyst
-



<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing System Controls</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>06/13</b>		DATE(S) REVISED: <b>5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 17.0</b>	PAGE: <b>4 of 7</b>

### III. Tracking Modifications

#### A. Types of Modifications

1. The Companies define a modification as any change made to credentialing information after it is initially recorded in the electronic credentialing system. Allowable modifications include:
  - a. Correction of data entry errors – both changes and deletions, including typographic errors
  - b. Updates to verifications of expired credentials
  - c. Auto-update of licensure and board certification expiration dates by web-crawl
  - d. Deletion of information recorded in the incorrect practitioner’s file
  - e. Deletion of a duplicate practitioner’s record
  
2. The following activities are not considered modifications:
  - a. Initial credentialing of a practitioner
  - b. Entry of new cycle of recredentialing primary source verification and decision
  - c. Initial documentation of a credentialing or recredentialing date in the system
  - d. Modifications to practitioner demographic information
  
3. The following modifications do not meet the Companies’ policy:
  - a. Any modification without documentation of who, what, how and why a modification was made
  - b. Modifications made by unauthorized staff
  - c. Any modifications that are not specified as allowable per the terms of this policy

#### B. Documenting Modifications

The credentialing database automatically tracks who, what and when data was modified. Staff members are required to document modifications in the “Notes” section within the practitioner’s electronic file. Through database reporting the

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<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing System Controls</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>06/13</b>		DATE(S) REVISED: <b>5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 17.0</b>	PAGE: <b>5 of 7</b>

following data is reviewed to track and ensure compliant practices for modifying data:

- When the information was modified to ensure that modifications are not made inappropriately after credentialing approval
- How the information was modified, specifically if data was added, edited or deleted
- Staff who made the modification
- Why the information was modified with documentation in the “Notes” section
- Old data value and new data value

#### IV. System Controls Monitoring and Oversight Process

- A. Annually, a sampling of modifications is reviewed and analyzed to identify modifications made that do not meet the Companies policy as defined in Section II of this policy. The Companies will follow the NCQA definition of sampling that includes review of 5% or 50 files, whichever is less (at least 10 initial credentialing and 10 recredentialing files).
  - B. System controls monitoring is completed by the Credentialing Analyst and the results are documented in the ongoing monitoring log that is reviewed by the Credentialing Manager for a qualitative and quantitative analysis and oversight of all modifications that do not meet policy. The Credentialing Manager is ultimately responsible for the monitoring process.
  - C. Annually the Credentialing Analyst will complete the following process to identify modifications that do not meet the Companies’ policy:
    1. Generate a report from the credentialing database that identifies all modifications made.
    2. Review to determine whether modifications were made by unauthorized staff members. If any cases are found they will be pulled for audit.
    3. Randomly select 50 files (at least 10 initial credentialing and 10 recredentialing files) to review and analyze for modifications or deletions that do not meet policy.
-

<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing System Controls</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>06/13</b>		DATE(S) REVISED: <b>5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 17.0</b>	PAGE: <b>6 of 7</b>

4. Documentation of the annual monitoring in the ongoing monitoring log includes:
    - a. Report date
    - b. Review date
    - c. Reviewed by
    - d. Total modifications reviewed
    - e. Number of non-compliant modifications reported to the Credentialing Manager
    - f. Actions identified and taken for all findings that do not meet the Companies' policies
    - g. Quarterly quantitative assessment analyzing number of non-compliant modifications made to identify potential outliers, barriers, or deficiencies
    - h. Quarterly qualitative assessment identifying deficiencies or processes that create barriers to improvement or may contribute to additional deficiencies
  
  - D. All non-compliant modifications identified are reviewed by the Credentialing Manger for corrective action. When non-compliance is confirmed, the Credentialing Manager will take appropriate action including without limitation:
    1. Review the reason for corrective action with the involved staff member and provide necessary actions, remediation or education needed for correction.
    2. Quarterly monitoring will be implemented to assess effectiveness and review for improvement of each specific finding for at least three consecutive quarters.
    3. Quarterly monitoring will be documented in the ongoing monitoring log to include the number of corrective actions monitored, the actions identified and taken, the date of the monitoring review, and monitoring results. Specific staff member information will be kept confidential in the staff member's personnel file.
    4. Depending on the nature of the deficiencies identified, non-compliance with this policy may lead to corrective action and/or termination.
  
  - E. Credentialing database access and level of authorization is reviewed and approved on an annual basis. The Credentialing Analyst will request a review and continued authorization of staff member access from the appropriate managers. Accounts that are no longer needed or have inappropriate access will be disabled or updated as identified.
-

<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing System Controls</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>06/13</b>		DATE(S) REVISED: <b>5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/2023</b>	NUMBER: <b>CR 17.0</b>	PAGE: <b>7 of 7</b>

**REFERENCES:**

CR 23.0 Credentialing Definitions and Acronyms

NCQA Credentialing Standards

<b>Policy and Procedure</b>			
SUBJECT: <b>Annual Review &amp; Development of Policies &amp; Procedures</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>10/15</b>		DATE(S) REVISED: <b>6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 21.0</b>	PAGE: <b>1 of 2</b>

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

All practitioners  
All organizational providers

<u>Fully Insured</u>			<u>Self-Insured</u>	<u>Medicare</u>	<u>Medicaid</u>	<u>Delegated Services to Ayin</u>
<u>Individual</u>	<u>Small Group</u>	<u>Large Group</u>				
<input type="checkbox"/> Oregon On Exchange	<input type="checkbox"/> Oregon On Exchange (SHOP)	<input type="checkbox"/> Oregon	<input type="checkbox"/> ASO	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> YCCO
<input type="checkbox"/> Oregon Off Exchange	<input type="checkbox"/> Oregon Off Exchange (SHOP)	<input type="checkbox"/> Washington	<input type="checkbox"/> PBM			<input type="checkbox"/> WHA
<input type="checkbox"/> Washington Off Exchange						
<input checked="" type="checkbox"/> APPLIES TO ALL ABOVE LINES OF BUSINESS						

**POLICY:**

Credentialing policies and procedures are maintained by the Credentialing Manager to meet or exceed the standards established by the National Committee for Quality Assurance (NCQA), the Center for Medicare and Medicaid Services (CMS), and other standards within the Companies. These policies are reviewed at least annually and revised as needed by the Credentials and Quality Committee (CQC) and subject to approval by the Clinical Network Committee (CNC).

<b>Policy and Procedure</b>			
SUBJECT: <b>Annual Review &amp; Development of Policies &amp; Procedures</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>10/15</b>		DATE(S) REVISED: <b>6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>4/19/23</b>	NUMBER: <b>CR 21.0</b>	PAGE: <b>2 of 2</b>

**DEFINITION:**

See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

**PROCEDURE:**

1. The Chief Medical Officer (CMO) or physician designee, and/or CQC members in conjunction with the Credentialing Manager recommend revisions to credentialing policies and procedures.
2. The Credentialing Manager performs an annual review of the credentialing policies and procedures for compliance with business practices, NCQA and CMS standards, and other applicable state and federal laws.
3. The CQC holds responsibility for reviewing and approving all credentialing policies and procedures annually.

**REFERENCES:**

CR 23.0 Credentialing Definitions and Acronyms  
 NCQA Credentialing Standards  
 CMS Credentialing Standards

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<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing Definitions and Acronyms</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>6/16</b>		DATE(S) REVISED: <b>6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/23</b>	NUMBER: <b>CR 23.0</b>	PAGE: <b>1 of 10</b>

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

All practitioners  
All organizational providers

<u>Fully Insured</u>			<u>Self-Insured</u>	<u>Medicare</u>	<u>Medicaid</u>	<u>Delegated Services to Ayin</u>
<u>Individual</u>	<u>Small Group</u>	<u>Large Group</u>				
<input type="checkbox"/> Oregon On Exchange	<input type="checkbox"/> Oregon On Exchange (SHOP)	<input type="checkbox"/> Oregon	<input type="checkbox"/> ASO	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> YCCO
<input type="checkbox"/> Oregon Off Exchange	<input type="checkbox"/> Oregon Off Exchange (SHOP)	<input type="checkbox"/> Washington	<input type="checkbox"/> PBM			<input type="checkbox"/> WHA
<input type="checkbox"/> Washington Off Exchange						
<input checked="" type="checkbox"/> APPLIES TO ALL ABOVE LINES OF BUSINESS						

**POLICY:**

Identification of definitions and acronyms pertaining to credentialing.

<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing Definitions and Acronyms</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>6/16</b>		DATE(S) REVISED: <b>6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/23</b>	NUMBER: <b>CR 23.0</b>	PAGE: <b>2 of 10</b>

**PROCEDURE:**

1. Action – approval, modify, deny, termination, suspension, or reduction
  2. Acupuncturist – person licensed to practice acupuncture by the relevant state licensing board. Acupuncture is legally defined in Oregon as “an Oriental health care practice used to promote health and to treat neurological, organic, or functional disorders by the stimulation of specific points on the surface of the body by the insertion of needles. Acupuncture includes the treatment method of moxibustion, as well as the use of electrical, thermal, mechanical or magnetic devices, with or without needles, to stimulate acupuncture points and acupuncture meridians and to induce acupuncture anesthesia or analgesia.” (ORS 677.757)
  3. Acute – a condition, diagnosis, or illness with a sudden onset and that is of short duration.
  4. Adequate record keeping – documentation that supports the level of service billed.
  5. Adverse event – an undesirable and unintentional, though not unnecessarily unexpected result of medical treatment.
  6. Ambulatory Surgical Center (ASC) – a facility licensed as an ASC
  7. Appeal – a request for a review of an action.
  8. Applicant – a practitioner that has submitted an Oregon Practitioner Credentialing or Recredentialing Application for initial or continued participation in the Companies’ network.
  9. Audiologist (AuD)– a person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.
  10. Behavioral Health – mental health, mental illness, addiction disorders and substance abuse disorders
  11. Board Certification – designation conferred by one of the affiliated specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine (ABPM), the American Board of Oral and Maxillofacial Surgery, or The College
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<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing Definitions and Acronyms</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>6/16</b>		DATE(S) REVISED: <b>6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/23</b>	NUMBER: <b>CR 23.0</b>	PAGE: <b>3 of 10</b>

of Family Physicians of Canada, or Royal College of Physicians and Surgeons, Canada as applicable, upon a physician or dentist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

12. Board Certified Behavioral Analyst (BCBA) – a practitioner licensed to provide behavior-analytic services.
  13. Burden on the Participating Provider – healthcare professionals who apply for or maintain participation have the burden of providing evidence that demonstrates, at the sole discretion of the Companies, that they meet the established criteria for participation.
  14. Chiropractor – a person licensed to practice chiropractic by the relevant state licensing board.
  15. Clinical Nurse Specialist – a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.
  16. Clinical privileges or privileges – the permission granted to a physician or practitioner by a facility governing board to render specific professional, diagnostic, therapeutic, medical, surgical, or dental services in the hospital or in connection with its programs based on the following: license, education, training, experience, current competence, health status or judgment.
  17. Clinical Social Worker – a person licensed to practice clinical social work pursuant to state law
  18. CMS – Centers for Medicare and Medicaid Services
  19. Collaboration – Consultation between the physician assistant and a physician or podiatric physician or referral by the physician assistant to a physician or podiatric physician
  20. Collaboration Agreement - A written agreement that describes the manner in which the physician assistant collaborates with physicians or podiatric physicians that does not assign supervisory responsibility to or represent acceptance of legal responsibility by a physician or podiatric physician for the care provided by the physician assistant and that is signed by the physician assistant and the physician, podiatric physician or physician assistant's employer.
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<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing Definitions and Acronyms</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>6/16</b>		DATE(S) REVISED: <b>6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/23</b>	NUMBER: <b>CR 23.0</b>	PAGE: <b>4 of 10</b>

21. Collaborating physician – A participating physician approved by the licensing board and holds a written agreement that describes the manner in which a physician assistant collaborates as indicated by the patient’s condition, community standards of care, and the physician assistant’s education, training and experience.
  22. Contracted Hospital – an Organizational Provider credentialed as a hospital and is contracted for specific services (e.g. transplant services).
  23. Credentialing – the process of obtaining, verifying, and assessing the qualifications of a healthcare practitioner to provide patient care services in or for a healthcare organization.
  24. Credentials – documented evidence of licensure, education, training, experience, other qualifications
  25. Delegated Credentialing – a formal written agreement between The Companies’ and an entity for delegation of the entire practitioner credentialing process, which can include primary source verification and decision making.
  26. Dentist – Doctor of Dental Surgery (DDS), or Doctor of Dental Medicine (DMD). A person licensed to practice dentistry pursuant to state law of the state in which he or she practices dentistry
  27. Emergency Department – the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.
  28. Fraud – an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.
  29. Grandfathered exceptions – exceptions to credentialing criteria approved by prior CQC committees do not need to be reconsidered or re-opened in subsequent recredentialing cycles.
  30. Health Care Professionals – individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.
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<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing Definitions and Acronyms</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>6/16</b>		DATE(S) REVISED: <b>6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/23</b>	NUMBER: <b>CR 23.0</b>	PAGE: <b>5 of 10</b>

31. Home Health Agency – a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that is licensed by the Authority as a home health agency.
  
  32. Home Health Services – part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy) and home health aide services
  
  33. Hospice – a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation.
  
  34. Hospital – a facility licensed as a general hospital that meets requirements for participation under Title XVIII of the Social Security Act.
  
  35. License – a method of regulation by which the state grants permission to persons who meet predetermined qualifications to engage in a health profession. The qualifications are set by law and without a license the practice of the specific health professional would be unlawful.
  
  36. Licensed Direct Entry Midwife – a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery pursuant to state law.
  
  37. Licensed Marriage and Family Therapists (LMFT) – a practitioner trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems pursuant to state law.
  
  38. Licensed Massage Therapist (LMT) – a practitioner licensed to practice the manual, or hands-on, movement of soft body tissues to enhance a person’s well-being pursuant to state law.
  
  39. Licensed Professional Counselor (LPC) – a licensed practitioner trained to work with individuals, families, and groups in treating mental, behavioral, and emotional problems and disorders pursuant to state law.
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<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing Definitions and Acronyms</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>6/16</b>		DATE(S) REVISED: <b>6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/23</b>	NUMBER: <b>CR 23.0</b>	PAGE: <b>6 of 10</b>

40. Liability Insurance – insurance that provides payment based on legal liabilities for injuries or illness.
  41. Locum Tenens – a covering practitioner who does not have an independent relationship with the Companies and is not contracted.
  42. Managed Care Organization (MCO) – a contracted health delivery system providing capitated or prepaid health services. An MCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a chemical dependency organization, fully capitated health plan, dental care organization, mental health organization or physician care organization.
  43. Medicaid – a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act.
  44. Medical Faculty – this license allows a physician to practice medicine only to the extent that such practice is incident to and a necessary part of the applicant’s duties as approved by the OMB in connection with the faculty position. This type of license is valid for one year after issuance and may be renewed as frequently as needed for a total period not to exceed four years. The four years must be consecutive.
  45. Medical Services – care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating or correcting a medical problem.
  46. Medicare – a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons.
  47. Military Status License – in the State of Washington. There are no restrictions on this license. The State of Washington has labeled the license as military so they can waive their fees. The only difference between “active” and “military” status is Military licenses need to be renewed annually and not bi-annually like an “active” license. The provider can practice in a civilian facility without issues.
  48. Modification - Any change to a practitioner's credentialing information, within the scope of the CR system controls requirements, after it has been recorded in the system. The organization determines what is an allowable modification based on the organization’s Policies and Procedures.
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<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing Definitions and Acronyms</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>6/16</b>		DATE(S) REVISED: <b>6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/23</b>	NUMBER: <b>CR 23.0</b>	PAGE: <b>7 of 10</b>

49. National Provider Identification (NPI) – federally directed provider number mandated for use on HIPAA covered transactions, individuals, and provider organizations.
  50. Naturopathic doctor (ND)– a person licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine
  51. NCQA – National Committee for Quality Assurance
  52. Nurse Anesthetist (CRNA) – a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.
  53. Nurse Practitioner (not limited to ARNP, NP, FNP, ANP, PNP, PACNP, PPCNP, NNP, GNP, AGNP, AGACNP, AGPCNP, PMHNP, WHNP, CNM) – a licensed independent advanced practice registered nurse who is trained to assume responsibility and accountability for the care of patients pursuant to state law.
  54. Occupational Therapist (OT) – a person licensed by the State Board of Examiners for Occupational Therapy. Provides the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, the aging process, or psychological disability. The treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.
  55. Oregon Health Plan (OHP) – the Medicaid and Children’s Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations and Medicaid and CHIP services under the State Plan.
  56. Organizational provider – a facility, institution or organization where members are directed for services, healthcare or items rather than being directed to a specific practitioner.
  57. Optometrist (OD) – a person licensed to practice optometry pursuant to state law.
  58. Participating – Practitioner or provider who is external to the Companies and are part of the Companies’ networks.
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<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing Definitions and Acronyms</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>6/16</b>		DATE(S) REVISED: <b>6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/23</b>	NUMBER: <b>CR 23.0</b>	PAGE: <b>8 of 10</b>

59. Participating Hospital – an Organizational Provider credentialed as a hospital and is contracted for all services.
60. Pharmacist (RPh or PharmD) – a person licensed to practice pharmacy pursuant to state law. Degrees conferred for a pharmacist are either a Bachelor’s of Science (BS or BS Pharm) or a Doctor Pharmacy (PharmD). The PharmD is now the only degree you can get in pharmacy. Pharmacists who graduated prior to the early 2000’s have a BS Pharm. RPh is used to note a licensed pharmacist. All BS Pharms and PharmDs, if licensed are RPh.
61. Physical Therapist (PT) – a practitioner licensed by the relevant state licensing authority to practice physical therapy. Treatment comprising exercise, massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis, or treatment of human being. Physical therapy may not include radiology or electrosurgery.
62. Physician (MD/DO)– a practitioner licensed to practice medicine pursuant to state law.
63. Physician Assistant (PA or PA-C) – provides medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Oregon Medical Board (OMB).
64. Podiatrist (DPM) – a person licensed to practice podiatric medicine pursuant to state law. A doctor of podiatric medicine.
65. Practitioner – a health care professional licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner’s license or certification.
66. Primary Care Provider (PCP) – practitioner who has responsibility for supervising, coordinating and providing initial and primary care within their scope of practice.
67. Primary Source Verification (PSV) – The affirmation (verification) of a healthcare professional’s reported qualifications, license, experience and competence by direct contact with the sources of the qualifying entity or an approved agent of that source, including but not limited to residency programs, licensing agencies, specialty boards, and professional and practice-related references.
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<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing Definitions and Acronyms</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>6/16</b>		DATE(S) REVISED: <b>6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/23</b>	NUMBER: <b>CR 23.0</b>	PAGE: <b>9 of 10</b>

68. Professional Reference (Peer Reference) – peer of equal or higher licensure or certification that has clinical knowledge and can attest to the practitioner’s professional, clinical abilities
69. Psychiatrist (MD/DO) – a practitioner licensed to provide services related to the diagnosis and treatment of mental health pursuant to state law.
70. Psychologist (PsyD) – a practitioner licensed to provide services related to the science of mind and behavior or the treatment of mental, emotional and behavioral disorders pursuant to state law.
71. Quality Improvement – the efforts to improve the level of performance of a key process or processes in health services or health care.
72. Recredential – process by which a practitioner renews current hospital privileges, membership or health plan participation. Occurs at least every 36 months depending on the entities policy or applicable standards.
73. Request for hearing – a clear expression in writing by an individual or representative that the person wishes to appeal a decision or action and wishes to have the decision considered by a higher authority.
74. Rural – a geographic area that is 10 or more map miles from a population center of 30,000 people or less.
75. Sanction – an action against providers taken in cases of fraud, misuse, or abuse.
76. Social Worker (LCSW or CSW) – a person licensed by the Board of Clinical Social Workers to practice clinical social work.
77. Speech-Language Pathologist (SLP) – a person licensed by the Oregon Board of Examiners for Speech Pathology. The application of principles, methods and procedure for measuring, evaluating, predicting, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.
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<b>Policy and Procedure</b>			
SUBJECT: <b>Credentialing Definitions and Acronyms</b>		DEPARTMENT: <b>CR: Credentialing Services</b>	
ORIGINAL EFFECTIVE DATE: <b>6/16</b>		DATE(S) REVISED: <b>6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23</b>	
APPROVED BY: <b>Medical Director</b>	DATE: <b>04/19/23</b>	NUMBER: <b>CR 23.0</b>	PAGE: <b>10 of 10</b>

78. Supervising Practitioner – a practitioner who is participating and approved by the relevant licensing board to act as the supervising practitioner.
79. Surgical Assistant – a person performing required assistance in surgery as permitted by rules of the Oregon Medical Board (OMB).
80. Telemedicine – the provision of health services to patients by physicians and health care practitioners from a distant site using electronic communications through a telemedicine link formal consultation, diagnosis, or treatment in which the practitioner has either total or shared responsibility for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment and services) or provides official readings of images, tracings, or specimens.
81. Termination – a sanction prohibiting a provider’s participation by canceling the provider’s agreement.
82. Urban – a geographic area that is less than 10 map miles from a population center of 30,000 people or more.
83. Urgent Care – health services that are medically appropriate and immediately required to prevent serious deterioration of a client’s health that are a result of an unforeseen illness or injury.
84. Web crawler - A “web crawler” is software that retrieves information directly from a primary or approved source website (e.g., the state licensing or certification agency)

**REFERENCES:**

NCQA Credentialing Standards  
 CMS Credentialing Standards

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## Providence Health Plan Credentials and Quality Committee Charter



### Committee Scope and Purpose

**Scope:** Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**Purpose:** The Credentials and Quality Committee provides clinical oversight to the quality program. Its main purpose is to perform peer review and make decisions regarding initial credentialing and recredentialing applications based on peer review and quality of care information. The Committee may give input regarding utilization as it affects the member experience. The Committee may make decisions regarding approvals, reinstatement and terminations.

### Attendees and Roles

Members	Functional Area	Subcommittee Role
Ruben Halperin, MD	Medical Director	Chair, Voting Member
Shama Hughes, CPMSM, Manager	Credentialing	Advisor, Nonvoting Member
Janelle Nitzke, CPMSM	Credentialing	Organizer, Nonvoting Member
Brett Francesconi, Sr Director	Quality Management	Nonvoting Member
Nandish Dayal, FNP	Family Nurse Practitioner	Voting Member
Ryan Dix, PsyD	Psychology	Voting Member
Deani Iversen, MD	OB/GYN	Voting Member
Olivia Kamayangi, MD	Family Medicine	Voting Member
Brian Kearns, MD	Hospitalist	Voting Member
David Solondz, MD	Family Medicine	Voting Member
Catherine Wagoner, MD	Pediatrics	Voting Member
Scott Soot, MD	General Surgery	Voting Member

PPP’s Chief Medical Officer (CMO) or designee has responsibility for the credentialing/quality program and the implementation of and compliance with PPP policies and procedures. The Chairman of the Credentials and Quality Committee is a PPP Medical Director. The chairman has the right to approve any credential and/or recredential files that are determined to be complete and without exceptions.

A quorum of at least 50% of the voting members of the committee is necessary to perform committee business (in person, or via telephone). With respect to any voting member of the committee who considers themselves to be in direct economic competition with the practitioner being reviewed on a credentialing or peer review matter, such member should recuse themselves from voting on that matter.

#### Voting Members:

- Medical Director or his/her physician designee
- No less than (7) participating practitioners representing a variety of disciplines and when possible varying service areas.

#### Non-Voting Members:

- Credentialing and Quality Management Staff

Providence Health Plan  
Credentials and Quality Committee Charter



Committee Responsibilities and Decision Authority

The Credentials and Quality Committee has the authority and responsibility for the following functions:

- Review of practitioner and organizational provider qualifications against established criteria and approving, deferring, modifying, or denying participation
- Making decisions regarding terminations related to issues of quality of patient care and safety
- Making decisions for exceptions to credentialing criteria
- Performing peer review which may result in corrective or disciplinary action against practitioners/providers and monitoring of all ongoing corrective action plans
- Evaluation of the reinstatement of practitioners/providers whose licenses have been suspended and then reinstated by licensing bodies
- Review and approval of relevant Credentialing and Quality Management Policies and Procedures
- Making decisions on credentialing and recredentialing criteria, as necessary
- Review of aggregate reports and make recommendations for improvement

Success Metrics and Outcomes:

Metrics and outcomes will be measured in the Committee's effectiveness to accomplish defined responsibilities. Quarterly reports are submitted to the Clinical Network Committee to report the following:

- Total number of practitioners and organizational providers initially credentialed
- Total number of practitioners and organizational providers recredentialed
- Initial application turnaround times within an average of 60 days from the receipt of a complete application
- Recredentialing applications that do not exceed the 3 years to the day

Reporting Relationship(s)

The Credentials and Quality Committee reports to the Clinical Network Committee.

Meeting Structure, Document Management & Communications

CQC meets monthly. Pre-read materials are posted to the Teams site.

Escalation Process:

Escalation will be referred to Clinical Network Committee.

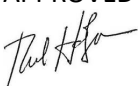
**Approval:**

A handwritten signature in black ink, appearing to read "Ruben Halperin".

4/19/2023

**Ruben Halperin**  
**Medical Director**  
**Providence Plan Partners**

**Date**

<b>Policy and Procedure</b>	
SUBJECT: Practitioner and Facility Quality of Care Review and Ongoing Monitoring Process	DEPARTMENT: <b>Quality Management</b>
ORIGINAL EFFECTIVE DATE: <b>09/95</b>	DATE(S) REVIEWED/REVISED: 09/95; 05/97; 07/97; 10/98; 03/99; 09/99; 11/01; 02/02; 05/03; 07/04; 01/05; 07/05; 07/06; 07/07; 07/08; 07/09; 07/10; 07/11; 07/12; 07/13; 12/13; 07/14; 03/15; 07/15; 7/16; 7/17; 8/18; 10/19; 12/19; 11/20; 11/21; 11/22; 03/23
APPROVED BY:  Quality Medical Director, 03/23	NUMBER: <b>QM 213</b> PAGE: <b>1 of 8</b>

**SCOPE:**


Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

<u>Fully Insured</u>			<u>Self-Insured</u>	<u>Medicare</u>	<u>Medicaid</u>	<u>Delegated Services to Ayin</u>
<u>Individual</u>	<u>Small Group</u>	<u>Large Group</u>				
<input checked="" type="checkbox"/> Oregon On Exchange	<input checked="" type="checkbox"/> Oregon On Exchange (SHOP)	<input checked="" type="checkbox"/> Oregon	<input checked="" type="checkbox"/> ASO	<input checked="" type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Medicaid	<input type="checkbox"/> YCCO
<input checked="" type="checkbox"/> Oregon Off Exchange	<input checked="" type="checkbox"/> Oregon Off Exchange (SHOP)	<input checked="" type="checkbox"/> Washington	<input type="checkbox"/> PBM			<input type="checkbox"/> WHA
<input checked="" type="checkbox"/> Washington Off Exchange						
<input type="checkbox"/> APPLIES TO ALL ABOVE LINES OF BUSINESS						

**POLICY:**

Companies have established the Practitioner and facility Quality of Care (QOC) review process as a systematic approach to evaluate quality of care concerns such as member complaints, adverse outcomes and sentinel events. This process enables the companies to monitor the care and services provided by practitioners and facilities in order to identify potential trends that may require corrective action and find opportunities to improve the quality and safety of care provided to our members. Charges for certain adverse outcomes and sentinel events may have payment withheld and reimbursement to facilities for hospital acquired conditions may be reduced as noted in the payment policies.

<b>Policy and Procedure</b>	
SUBJECT: Practitioner and Facility Quality of Care Review and Ongoing Monitoring Process	DEPARTMENT: <b>Quality Management</b>
ORIGINAL EFFECTIVE DATE: <b>09/95</b>	DATE(S) REVIEWED/REVISED: 09/95; 05/97; 07/97; 10/98; 03/99; 09/99; 11/01; 02/02; 05/03; 07/04; 01/05; 07/05; 07/06; 07/07; 07/08; 07/09; 07/10; 07/11; 07/12; 07/13; 12/13; 07/14; 03/15; 07/15; 7/16; 7/17; 8/18; 10/19; 12/19; 11/20; 11/21; 11/22; 03/23
APPROVED BY:  Quality Medical Director, 03/23	NUMBER: <b>QM 213</b> PAGE: <b>2 of 8</b>

### Quality of Care (QOC) Reviews


Company conducts individual case reviews throughout the year as concerns are identified. The Quality Management (QM) Team initially reviews cases with potential quality of care concerns. Included in the initial review is the evaluation of the practitioner’s history of complaints. After initial review, cases may be escalated to the Medical Director (MD) for further review and determination. If concerns are identified through the MD review, the QM team may send a letter of inquiry to the rendering provider. Concerns identified through the QM review process or MD review process may result in a case referral to the Credentialing and Quality Committee (CQC) for ongoing monitoring, corrective action, and potentially termination from the network. In the case of delegated providers, Companies may coordinate corrective action with the delegate. Charges for adverse outcomes and sentinel events may have payment withheld and reimbursement to facilities for hospital-acquired conditions may be reduced as noted in the Companies’ payment policies.

### Practitioner & Organizational Provider Notification

The Companies will notify the provider and/or the facility of the review outcome and/or the decision of CQC for instances in which a case review requires an inquiry letter be sent to a provider and/or facility. The letter may be sent by postal service or email, if available. Case reviews assigned a severity level of 2-4 may also be communicated to provider or facility medical director/administrator. In addition, the Companies will notify all providers and/or facilities of complaints regardless of severity level if requested.

### Ongoing Monitoring

To ensure the quality and safety of care provided to our members the Companies monitors and tracks complaints, adverse events, and quality issues against practitioners as documented in policy CR2.0 Practitioner Credentialing. Evaluation of aggregate program data occurs bi-annually to for early identification and intervention on emerging trends, identifying barriers and opportunities to improve the quality and safety of care provided to our members. When possible, analysis includes segmentation by member race/ethnicity and language to assess health equity opportunities.

<b>Policy and Procedure</b>	
SUBJECT: Practitioner and Facility Quality of Care Review and Ongoing Monitoring Process	DEPARTMENT: <b>Quality Management</b>
ORIGINAL EFFECTIVE DATE: <b>09/95</b>	DATE(S) REVIEWED/REVISED: 09/95; 05/97; 07/97; 10/98; 03/99; 09/99; 11/01; 02/02; 05/03; 07/04; 01/05; 07/05; 07/06; 07/07; 07/08; 07/09; 07/10; 07/11; 07/12; 07/13; 12/13; 07/14; 03/15; 07/15; 7/16; 7/17; 8/18; 10/19; 12/19; 11/20; 11/21; 11/22; 03/23
APPROVED BY:  Quality Medical Director, 03/23	NUMBER: <b>QM 213</b> PAGE: <b>3 of 8</b>

**DEFINITIONS:**

**Adverse Event:** a patient safety event that results in harm to a patient.

**Credentials and Quality Committee (CQC):** a Company governance committee responsible for the oversight of the qualifications of practitioner applicants and participating practitioners that makes credentialing decisions.

**BH External Caregiver Referral:** a concern generated from a network practitioner, including Providence St. Joseph Health caregivers, about the behavioral healthcare delivered by a provider and /or an episode of care.

**BH Internal Caregiver Referral:** a concern generated from a company caregiver about the behavioral healthcare delivered by a provider and /or an episode of care.

**BH Member Complaint:** a member or member caregiver generated complaint-reporting dissatisfaction with an aspect of the behavioral health organization's operations or activities, including actions of network providers and practitioners.


**Delegation:** when the organization gives an entity the authority to perform certain functions on its behalf.

**Escalated Case:** quality of care case that a medical director determines undergo review by the CQC.

**External Caregiver Referral:** a concern generated from a network practitioner, including those within the Company delivery system, about the care delivered by a provider and /or an episode of care.

**Internal Caregiver Referral:** a concern generated from a company caregiver about the care delivered by a provider and /or an episode of care.

**Member Complaint:** a member or member caregiver generated complaint-reporting dissatisfaction with an aspect of the organization's operations or activities, including actions of network providers and practitioners.

<b>Policy and Procedure</b>	
SUBJECT: Practitioner and Facility Quality of Care Review and Ongoing Monitoring Process	DEPARTMENT: <b>Quality Management</b>
ORIGINAL EFFECTIVE DATE: <b>09/95</b>	DATE(S) REVIEWED/REVISED: 09/95; 05/97; 07/97; 10/98; 03/99; 09/99; 11/01; 02/02; 05/03; 07/04; 01/05; 07/05; 07/06; 07/07; 07/08; 07/09; 07/10; 07/11; 07/12; 07/13; 12/13; 07/14; 03/15; 07/15; 7/16; 7/17; 8/18; 10/19; 12/19; 11/20; 11/21; 11/22; 03/23
APPROVED BY:  Quality Medical Director, 03/23	NUMBER: <b>QM 213</b> PAGE: <b>4 of 8</b>

**Quality of Care Concern (QOC):** a complaint reported by a member or member authorized representative in which it is stated or inferred that they believe they were misdiagnosed, treatment was not appropriate, and/or they received or did not receive care that adversely impacted or had the potential to adversely impact their health.

**QI Case Review Team:** Behavioral Health Medical Director (BH MD) , Medical Director (MD) and Quality Improvement RN (QI RN).


**Quality Management Team:** Quality Improvement Coordinator (QI Coordinator), QI RN, Quality Improvement Technician (QI Tech).

**Sentinel Event:** a patient safety event that reaches the patient and results in death, severe temporary harm or permanent harm to the member.

**Third Party Review:** a practitioner not employed by the Companies that work in the same or similar specialty as the practitioner under review who provides expertise regarding the care received by the member.


**PROCEDURE:**

- I. Quality of Care Review
  - A. Data Collection: Member Quality of Care Concerns, Adverse Events, and Sentinel Events are collected through but not limited to:
    1. Claims (medical, pharmacy, labs)
    2. Plan Data (complaints, appeals, customer service)
    3. Internal caregiver referral
    4. External caregiver referral
  - B. Intake: QI Tech
    1. Initiates QI Case review by logging the complaint in the Provider Monitoring database.
    2. Follow up actions as determined by QI RN. To include:
      - a) Requesting, processing and tracking medical records requests.
      - b) Sending and tracking letter correspondence
      - c) Case closure

<b>Policy and Procedure</b>	
SUBJECT: Practitioner and Facility Quality of Care Review and Ongoing Monitoring Process	DEPARTMENT: <b>Quality Management</b>
ORIGINAL EFFECTIVE DATE: <b>09/95</b>	DATE(S) REVIEWED/REVISED: 09/95; 05/97; 07/97; 10/98; 03/99; 09/99; 11/01; 02/02; 05/03; 07/04; 01/05; 07/05; 07/06; 07/07; 07/08; 07/09; 07/10; 07/11; 07/12; 07/13; 12/13; 07/14; 03/15; 07/15; 7/16; 7/17; 8/18; 10/19; 12/19; 11/20; 11/21; 11/22; 03/23
APPROVED BY:  Quality Medical Director, 03/23	NUMBER: <b>QM 213</b> PAGE: <b>5 of 8</b>

C. Review: QI RN

1. Completes initial QI Case Review by investigating practitioner-specific and/or facility complaints upon their receipt.
2. Sends notification of receipt of BH complaint to Carelon Behavioral Health or Optum within 2 business days.
3. Coordinate review of Carelon Behavioral Health or Optum review outcomes with BH Medical Director.
4. Coordinates expedited QI case reviews where member is identified as being in eminent danger.
5. Researches specific standard of care criteria from national organizations, governmental agencies, and accrediting bodies that may apply to the specific case.
6. Compiles any health care quality measures on the practitioner/facility that provides context to the specific complaint (e.g. may indicate if the specific complaint represents a larger trend in practice patterns).
7. Escalates to the Medical Director all concerns indicating harm to a member or significant variation from standards of care (severity level 1-4) for further review and/or recommendations for action.
8. Evaluates the practitioner and/or facility's history of complaints and adverse events for the past three years. Practitioners found to have two or more member driven complaints and/or adverse outcomes on 8% or more of billed procedures within the review period will be reviewed by the Medical Director for a decision regarding appropriate follow-up actions.
9. Completes follow-up actions as determined by the Medical Director, including preparation of the case file for escalation to CQC. Escalated cases will be summarized for CQC in a standardized SBAR memo (Situation, Background,

<b>Policy and Procedure</b>	
SUBJECT: Practitioner and Facility Quality of Care Review and Ongoing Monitoring Process	DEPARTMENT: <b>Quality Management</b>
ORIGINAL EFFECTIVE DATE: <b>09/95</b>	DATE(S) REVIEWED/REVISED: 09/95; 05/97; 07/97; 10/98; 03/99; 09/99; 11/01; 02/02; 05/03; 07/04; 01/05; 07/05; 07/06; 07/07; 07/08; 07/09; 07/10; 07/11; 07/12; 07/13; 12/13; 07/14; 03/15; 07/15; 7/16; 7/17; 8/18; 10/19; 12/19; 11/20; 11/21; 11/22; 03/23
APPROVED BY:  Quality Medical Director, 03/23	NUMBER: <b>QM 213</b> PAGE: <b>6 of 8</b>


Assessment, and Recommendation) and be reviewed by stakeholders from Quality Management, Credentialing, SIU, and Provider Relations prior to being presented at CQC. The memo will include historical data for a decision regarding appropriate follow-up actions as documented in policy CR 1.0.

10. Sends notification of review outcome and/or CQC decision to provider and/or facility.
11. Initiates case closure upon determination of outcome by sending notification to QI tech in Provider Monitoring database.

D. Medical Director of Quality:

1. Assesses escalated QI RN case reviews and all supplemental, contextual material. May refer case to Medical Director of Behavioral Health or for specialty-specific external review.
2. The Medical Director recommendations for action may include (not limited to): case closure, additional review of medical records, practitioner and/or facility letter of inquiry, Third Party Review and/or referral to CQC for non Carelon Behavioral Health/Optum complaints.
3. A Letter of Inquiry will be sent to a practitioner/facility for all complaints submitted by a member, and for non-member complaints for which additional information is needed to make an outcome determination. Practitioners/facilities have 20 business days (30 days) to respond to the letter of inquiry. If a practitioner/facility does not respond to the initial request, a second and final letter of inquiry will be forwarded to the practitioner/facility. The practitioner/facility will be given 10 business days (14 days) to respond. A nonresponse after the second attempt will be coded with the severity level corresponding under the unresponsive provider U codes or DR Code Declined to respond code. A failure to respond to letters of inquiry could result in be referred to CQC for corrective action.



<b>Policy and Procedure</b>	
SUBJECT: Practitioner and Facility Quality of Care Review and Ongoing Monitoring Process	DEPARTMENT: <b>Quality Management</b>
ORIGINAL EFFECTIVE DATE: <b>09/95</b>	DATE(S) REVIEWED/REVISED: 09/95; 05/97; 07/97; 10/98; 03/99; 09/99; 11/01; 02/02; 05/03; 07/04; 01/05; 07/05; 07/06; 07/07; 07/08; 07/09; 07/10; 07/11; 07/12; 07/13; 12/13; 07/14; 03/15; 07/15; 7/16; 7/17; 8/18; 10/19; 12/19; 11/20; 11/21; 11/22; 03/23
APPROVED BY:  Quality Medical Director, 03/23	NUMBER: <b>QM 213</b> PAGE: <b>7 of 8</b>


4. Cases referred to the QI RN from the Medical Director assigned to the Special Investigations Unit (SIU) will be reviewed by the CQC once the provider has been given a chance to respond to questions regarding quality of care. A second PA review is not needed.
5. Assigns severity level (0-U4 or DR) for review outcome or refers to CQC for a panel review to determine severity level.

II. Ongoing Monitoring

- A. Complaints and adverse event cases are reviewed in aggregate by the Quality Management Staff.
- B. Reviews occur on a monthly basis for practitioners going through the recredentialing process with a three-year lookback period.
- C. Reviews are conducted on a bi-annual basis for all practitioners.
- D. Adverse outcomes are identified using claims data. An adverse outcome rate is calculated for each provider based on the number of claims billed as complications compared to the total number of procedures billed for the timeframe.
- E. Thresholds are established by the Quality Management Team and are reviewed annually.
- F. A practitioner who is identified by the analytics team as having two or more member driven quality of care complaints and/or having adverse outcomes on 8% or more of billed procedures within the review period will be referred to a QI RN for further review.
- G. Practitioners meeting or exceeding on-going monitoring thresholds may be referred to CQC or the Delegate by the Medical Director.

III. Credentialing and Quality Committee (CQC)

- A. Reviews the following:

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APPROVED BY:  Quality Medical Director, 03/23	NUMBER: <b>QM 213</b> PAGE: <b>8 of 8</b>

1. Practitioners and/or facilities cases in which the medical director requires a panel review to determine a severity level.
  2. Practitioners and/or facilities with a QOC Level; such cases are considered “escalated cases” and will be added to monthly agenda.
  3. Practitioners and/or facilities with three or more severity level 2-4 cases; such trends will be reviewed as part of the quality of care annual report.
- B. Determines follow up actions, including additional monitoring and reporting for remediation of quality of care concern, suspension, and termination.
- IV. Case review is protected by the Oregon Revised Statutes 41.675 Peer Review of Healthcare Providers and the Revised Code of Washington State, 4.24.250 Information Sharing.

**REFERENCES:**

Records Retention & Disposal Policy, PROV-ICP-715  
Oregon Revised Statutes 41.675 Peer Review of Healthcare Providers  
Revised Code of Washington State, 4.24.250 Information Sharing  
Revised Code of Washington State, 7.71 Health Care Peer Review  
The Joint Commission Sentinel Event Policy and Procedures, 2019 (online)  
Payment Policy, 73.0 Never Events for Facilities  
Payment Policy, 76 Diagnoses Present on Admission  
Payment Policy, 77.0 Never Events/Practitioners  
Payment Policy, 79 Hospital Acquired Conditions  
CR 1.0 Credentials and Quality Committee  
CR 2.0 Practitioner Credentialing  
CR 9.0 Ongoing Monitoring  
CR 11.0 Organizational Providers Credentialing  
QM210 Standards of Quality Care and Patient Safety