

SANFORD HEALTH PLAN OPERATIONAL	Practitioner Credentialing/Recredentialing Policy NUMBER: PR-06
ISSUED: 01/01/98	DEPARTMENT: PROVIDER RELATIONS
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WRITTEN BY:	APPROVED BY:

POLICY:

DEFINITIONS:

TO PROMULGATE A POLICY THAT RELATES TO PRACTITIONER CREDENTIALING/RECREREDENTIALING

PROCEDURE:

Section 1. Definitions

The following terms shall have the following meanings when used in this Policy:

- (a) “Applicant” means a practitioner who has submitted an initial application to participate as a Participating Practitioner with the Plan or a Recredentialing Application with the Plan.
- (b) “Application” means an initial or recredentialing application.
- (c) “Medical Director” means the physician directly responsible for facilitating the credentialing process during the committee meetings. The Medical Director is responsible for contacting the applicant if the recommendation of the committee is delayed longer than 180 days. The Medical Director also reviews all pertinent information available in recredentialing and makes a verbal recommendation to the Committee. The Medical Director has the authority to sign off on “clean” files. The Medical Director submits a report and verbal recommendation to the Board in circumstances of non-renewals.
- (d) “Covered Services” means those medically necessary health services to which Covered persons are entitled under a health agreement when provided or authorized in accordance with Plan Policy.
- (e) “Member” means any individual who is covered by the Plan.
- (f) “Health Care Services” mean any procedures, diagnoses, facilities or supplies furnished to a human being for the treatment of illness or injury.
- (g) “Health Contract” means a contract whereby the Plan agrees to provide comprehensive health services to Covered persons.
- (h) “Participating.” All Practitioners are either “Participating” or “Non-Participating.”
 - (i) “Participating” means that the Practitioner or someone on the Practitioner’s

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behalf has signed a contract with the Plan to provide services to Covered persons and has been approved by the Credentialing Committee.

- (ii) “Non-Participating” means that the Practitioner has not signed such a contract with the Plan.
- (i) “Physician” means an individual licensed to practice medicine or osteopathy in any state where the Plan is legally authorized to operate.
- (j) “Practitioner” means any individual or group of individuals licensed to practice the healing arts in any state where the Plan is legally authorized to operate. This includes physicians, podiatrists, psychologists, chiropractors, optometrists, speech pathologists, audiologists, physical therapists. MSWs, Ed.Ds, physician assistants, nurse practitioners, nurse midwives, nurse anesthetists.
- (k) “Practitioner Group” shall mean a partnership, professional corporation, nonprofit corporation or other entity that employs or contracts with Practitioners and in turn enters into a contract with the Plan to provide Covered Services to Covered persons.
- (l) “Primary Care Physician” means a family practice physician, internist, pediatrician, or obstetrician/gynecologist who is a Participating Practitioner and has chosen to be designated as a Primary Care Physician as indicated in the Provider Directory and who may be responsible for providing, prescribing, directing and/or authorizing all care and treatment required by Covered persons.
- (m) “Provider” hospital or any other institution that furnishes health care services and is licensed or otherwise authorized to render such services in any state where the Plan is legally authorized to operate.
- (n) “The Plan” shall mean Sanford Health Plan.

Section 2. General

- (a) Nondiscrimination Policy

No Practitioner shall be denied Participating Practitioner status on the basis of sex, race, creed, color, national origin, age, disability, sexual orientation or the types of procedures or patients in which the practitioner specializes. Sanford Health Plan monitors and prevents discrimination on an ongoing basis. Monitoring and preventing is done by completing audits of denied files by the Chief Operations Officer and approved files are audited on an annual basis by the Provider Relations Department. Patient complaints are audited periodically to determine if any complaints are alleging discrimination. Also, all Credentialing Committee members will sign an affirmative statement to make decisions in a nondiscriminatory manner.
- (b) Rights and Duties of Participating Practitioner

The Practitioner shall only have such rights and duties as are set forth in the Practitioner’s contract with the Plan and in other Plan policies and documents which are applicable to the Practitioner pursuant to said contract.
- (c) Right to Inquire About Credentialing Status

Each contracted practitioner with the Sanford Health Plan retains the right to at anytime inquire about their credentialing status. The practitioner at any time may contact any representative of the Sanford Health Plan Provider Relations department, and the Provider Relations department will contact the Sanford Central Verification Office to obtain the exact status. The Provider Relations representative will then respond to the practitioner in a timely fashion with the information requested through

the inquiry with regards to the status of their credentialing.

(d) Right to Review

Practitioners will have the right to review the information submitted in support of their credentialing applications. However, Sanford Health Plan respects the right of the Peer Review aspects that are integral in the credentialing process.

Therefore, practitioners will not be allowed to review references or recommendations or any other information that is peer review protected. All other information obtained from an outside source is open for review. In the event that through the review process, a practitioner discovers an error in the credentialing file, the practitioner does have the right to request a correction of the information in question.

(e) Right to Notification

Practitioners will be notified of any information obtained during the credentialing process that varies substantially from the information provided by the practitioner. The Sanford Central Verification Office will notify the Sanford Health Plan Provider Relations department of the variance within five (5) working days. A designated staff member of Provider Relations will send written communication to the practitioner requesting clarification of the information within another five (5) working days of receiving notification from the CVO.

(f) Right to Correct Erroneous Information

Practitioners will have the right to correct erroneous information. The practitioner will be afforded thirty (30) days to provide corrected information in a written format. Sanford Health Plan will not accept corrected information over the phone, in person, or via voice mail. Corrected information must be submitted to the Director of Provider Relations within that allowed timeframe. The Director of Provider Relations will work with the Sanford CVO to enter the corrected information into the credentialing process. The CVO will document the receipt of corrected information in the practitioner's credentialing file. Upon receipt of the corrected information from the practitioner, the new information will be incorporated into the credentialing process, and the new information will be verified through the appropriate Primary Source. The practitioner will again be informed if the information provided cannot be verified through a Primary Source. Until the discrepancy can be clarified and is verifiable through a Primary Source, the Primary Source Verification will be used for the purpose of credentialing.

(g) Notification of Practitioner Rights

The practitioner is aware of these rights through the Practitioner Credentialing/Recredentialing Policy which is included in all Sanford Health Plan Provider Manuals and is available on the Plan's website. Therefore, practitioners are made aware of their right to review through the delivery of the provider manuals or they can find it on the website.

(h) Confidentiality

All information obtained in the credentialing process will remain confidential, except as otherwise provided by law. All staff that enters confidential information into Sanford Health Plan's information system is assigned passwords to prevent unauthorized staff from accessing screens containing confidential

information. The department manager determines the level of authorized user access to data across the delivery system. The office is locked outside of business hours. Business hours are 8:00am to 5:00pm Monday – Friday. All credentialing files are in file cabinets which are also locked outside of business hours. (Refer to OP 01 Information Systems Access Policy REV 3)

Practitioner Credentialing Information – means that all information that is gathered either in the practitioner’s credentialing application or through primary source verifications will be kept among only those people on the credentialing staff and shared only with the Credentialing Committee, except where required by State and/or Federal laws. As a delegated service to Sanford Central Verification Office (CVO), Sanford Health Plan collaborates with the CVO for exchange of data to ensure the protection of privacy and confidentiality.

Section 3. Criteria

In order to be eligible to be considered as a Participating Practitioner, a Practitioner must meet the applicable criteria set forth in the Plan’s Criteria for Participating Practitioners (Policy PR-10 Criteria for (Selecting) Participating Practitioners). The Plan Board may, in its discretion, waive any of the criteria if it determines that to do so would be in the best interests of the Plan or its Covered persons.

Section 4. Initial Application to Become a Participating Practitioner

(a) Information

Applications to become a Participating Practitioner shall be submitted on forms prescribed by the Plan.

(b) Obtaining Information from Hospital

When the Applicant is applying for or exercises clinical privileges at a Participating Hospital, the Plan shall request the hospital to provide copies of documents in the hospital’s credentialing files that verify compliance by the applicant with the criteria set forth above. When this information is forwarded to the Plan with a certification by the hospital that the information has been verified from the primary source of the information, the Applicant will not have to furnish the document in question. Any other information requested by the Application that is not so provided and verified by the hospital must be provided by the Applicant and verified from its primary source by the Plan.

(c) Burden of Providing Information

The Applicant shall always have the ultimate burden of producing adequate information for a proper evaluation of his or her competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications. The Applicant shall also have the burden of providing evidence that all the statements made and information given on the application are factual and true. Until the Plan has received and verified all information requested by the Application, the Application will be deemed incomplete and will not be processed.

Section 5. Scope of Clinical Practice

Each Participating Practitioner shall receive payment only for such clinical procedures specifically approved pursuant to this Credentialing Policy unless a special exception is

made by the Medical Director. The approved scope of practice shall be based upon the applicant's relevant, recent education, training, experience, demonstrated competence and judgment, references and other relevant information, and conformance with Plan criteria regarding qualifications for performance of such procedures. The Practitioner shall have the burden of establishing his or her qualifications for and competences to exercise the scope of practice him or her requests.

Section 6. Procedure for Initial Application

(a) Submission of Application

The Application shall be submitted by the Applicant to the Plan's Credentialing department. After collecting current certificate of insurance and other information or materials deemed pertinent, the Plan shall determine the Application to be complete.

The application includes:

- (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) History of loss of license and felony convictions;
- (4) History of loss or limitation of privileges or disciplinary activity;
- (5) Current malpractice insurance coverage and
- (6) The correctness and completeness of the application.

The attestation must be signed and dated within 180 days from the Credentialing Committee decision date. Signature stamps are not accepted.

(b) Evaluation Procedure

- (1) Verification process: all verifications must be completed within 180 days of the Credentialing Committee decision date.

The information supplied by the applicant shall be verified as follows and placed in the applicant's file:

- State licensure verified directly with the state licensure board by letter, phone, fax or via state web site for the states the practitioner provides care for SHP members.
- Federal DEA or CDS copy of certificate supplied by applicant (if applicable) and verified through the NTIS table (National Technical Information Service) and/or by current copy.
- Medical school education, residency training or board certification verified depending on the highest level achieved. Sanford Health Plan verified the highest level achieved. Medical school and residencies verified by letter, phone or fax directly with the institution and/or by the AOA (American Board of Osteopathic Association) or the AMA (American Medical Association). Board certification is verified through ABMS, AMA or AOA.
- ECFMG (if applicable) verified directly with the Educational Commission for Foreign Medical Graduates by letter, fax or website electronic verification.
- Hospital affiliations and the primary admitting facility will be gathered from the credentialing application provided by the practitioner.

- Board certification status verified by American Board of Medical Specialties by letter or fax (if not certified), or directory reference, telephone or ABMS CertiFACTS web site (if certified). Board certification can also be verified by the AMA, AOA or confirmation from the appropriate specialty board by letter or fax. Expiration date must be present with the verification.
- A minimum of five year relevant work history must be provided on the application to verify any gaps exceeding six months. Explanation must be verified through letter, phone or fax. Any gaps over a year must be explained by the practitioner in writing. All work history must have a month and year beginning date and month and year end date. If the practitioner has practiced fewer than five years the relevant work history begins at the time of initial licensure.
- Malpractice History verified in writing for the past five years from either the NPDB or the malpractice carrier. If during the five years the practitioner was covered by a hospital insurance policy during a residency or fellowship, confirmation will not be obtained.
- Present professional liability coverage is supplied in the form of a photocopy of the Certificate of Insurance requested from the applicant.
- Medicare/Medicaid sanctions checked through report from National Practitioners Data Bank and the Medicare/Medicaid OIG sanctions list. (Refer to Policy PR-24 Monitoring Policy)
- Sanctions, limitations, restrictions on licensure verified with state medical board or other licensing agency, as appropriate or the NPDB or HIPDB. (Refer to Policy PR-24 Monitoring Policy)

In addition, the following databases shall be queried as appropriate:

- National Practitioner Data Bank.
 - Department of Professional Regulations (if available).
 - State Board of Chiropractic Examiners or the Federation of Chiropractic Licensing Boards.
 - State Board of Dental Examiners.
 - State Board of Podiatric Examiners.
- (2) The Plan’s Credentialing Committee shall examine the evidence of the character, professional competence, qualifications, prior behavior and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from any other sources available, whether the applicant meets all of the necessary qualifications for a Plan contract to perform the clinical procedures requested.
- (3) The Committee receives a report of all “clean” and “unclean” files. Each “unclean” file is reviewed by the Committee to determine that the practitioner meets the above qualifications. The Committee will decide whether to approve or disapprove the practitioner by majority vote. A

“clean” file is determined as there was no information found throughout the verification process in which the Committee would need to review. As for an “unclean” file, information was obtained that the Committee would need to review. Examples include but not limited to: malpractice claims, peer reference unsatisfactory, OIG or NPDB with information on the report or health status that may limit or enable a practitioner to perform his/her specific duties. The Medical Director does have the authority to determine that a file is “clean” and may sign off on it as complete, clean and approved which is considered the committee review date. The Medical Director may use a handwritten signature or handwritten initials as documentation of sign-off; an electronic signature will not be accepted.

(c) Report

- (1) Not later than 180 days from its receipt of the completed Application, the Credentialing Committee shall approve or disapprove the Application and shall make a written report with respect to the applicant to the Plan’s Board, through the Medical Director. The decisions on appointment made by the Plan’s Credentialing Committee are approved by the Sanford Health Plan Board of Director’s.
- (2) The Credentialing Committee is facilitated by the Medical Director. The committee is made up of eight physicians of different specialties. (refer to Policy PR-18 Credentialing Committee Policy) During the meetings, only the physicians discuss and vote on the participation status of each practitioner. Their decisions are based on their own knowledge of the practitioner, the information revealed on the application and through verifications, as well as the results of the site visits and medical record review for a Primary Care Physician and High Volume Behavioral Health Specialists. (Refer to Policy PR-09 Site Visits/Medical Record Review). The Committee may decide to alter a decision. For example, the Committee may decide on a one year recredentialing cycle, may require the practitioner to take continuing education, require supervision for a recommended period of time, etc.
- (3) If the recommendation of the Credentialing Committee is delayed longer than 180 days, the Provider Relations Director shall send a letter to the Applicant, with a copy to the Board through the Medical Director, explaining the reasons for delay. If for any reason a primary source verification becomes older than 180 days, reverification will be completed.
- (4) If the Credentialing Committee recommends that an Application be denied for stated reasons based on the clinical competence or professional conduct of the Applicant, the Applicant may request a hearing pursuant to the Plan’s Hearing Procedures, and all subsequent actions shall be governed by those procedures. Said procedures shall comply with the minimum due process requirements set forth in the federal Health Care Quality Improvement Act of 1986. (Refer to Policy PR-15 Provider Appeal Rights)
- (5) The Credentialing Committee may decide to pend an Application to ask the practitioner for additional information. In this case the Provider Relations Director will send a letter to the Applicant requesting the additional

information. The Applicant will be given 30 days to supply additional information. The new information will be included in the original file which is brought back to the next Credentialing Committee meeting.

- (6) The Sanford Health Plan does not conduct Provisional Credentialing.
- (7) The Sanford Health Plan Provider Relations Department will send out a letter notifying the provider of his/her credentialing decision within sixty (60) days of the Committee's decision.

Section 7. Procedure for Recredentialing

(a) Application

Each Participating Practitioner shall be responsible for providing the Plan with updated information at least every three years pertaining to his or her credentials. Practitioners must be recredentialed within 36 months from previous credentialing date.

(b) Verification Process

The following information will be verified from primary sources and placed in the practitioners file:

- (1) Valid current state license to practice. State licensure verified directly with the state licensure board for each state the practitioner provides care for Sanford Health Plan members by letter, phone, fax or state web site.
- (2) The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility is accepted through the application.
- (3) Valid DEA or CDS certificate (where applicable). DEA or CDS will be verified through the National Technical Information Service (NTIS) and/or by current copy.
- (4) Board certification (where applicable). Board certification status verified by American Board of Medical Specialties by letter or fax (if not certified), or directory reference, telephone or ABMS CertiFACTS web site (if certified). Board certification can also be verified by the AMA, AOA or confirmation from the appropriate specialty board by letter or fax. The expiration date will be noted. Lifetime certification will be verified at recredentialing.
- (5) Professional liability insurance is supplied in the form of a photocopy of the Certificate of Insurance requested from the applicant.
- (6) History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner will be verified through the National Practitioner Data Bank and/or directly from insurance carrier.
- (7) Work History (minimum of 2 years history) to verify any gaps in history exceeding six months will be verified through letter, phone or fax. Any gaps exceeding one year will need to be verified in writing by the practitioner.
- (8) Malpractice History verified in writing for the past five years from either the NPDB or the malpractice carrier. If during the five years the practitioner was covered by a hospital insurance policy during a residency or fellowship, confirmation will not be obtained. (Refer to Policy PR-24 Monitoring Policy)

- (9) State sanctions, restrictions on licensure and /or limitations on scope of practice, as applicable. The NPDB and state sanctions will be queried. (Refer to Policy PR-24 Monitoring Policy)
- (10) Medicare and Medicaid sanction will be queried from the OIG or NPDB. (Refer to Policy PR 24 Monitoring Policy)
- (11) A current, signed attestation statement by the applicant regarding:
 - Reasons for any inability to perform the essential functions of the position, with or without accommodations;
 - Lack of present of illegal drug use;
 - History of loss or limitation of privileges or disciplinary activity;
 - History of loss of license and felony convictions;
 - Current malpractice insurance coverage and,
 - The correctness and completeness of the application.

The following organizations will be queried:

- National Practitioner Data Bank.
- Medicare/Medicaid Sanction List (Refer to PR-24 Monitoring Policy)
- Department of Professional regulations (if available).
- State Board of Chiropractic Examiners or the Federation of Chiropractic Licensing Boards.
- State Board of Podiatric Examiners.

The attestation and all verifications must be signed, dated and completed within 180 days from the Credentialing Committee decision date. A signature stamp is not accepted.

All efforts will be made to maintain the credentialing and recredentialing schedules of the Practitioner's primary admitting facility. This way the Practitioner only needs to complete one application every two years for all facilities of Sanford Health that they participate with.

(c) Factors to be Considered

In determining to continue a Practitioner's participating status, the Plan shall consider the Practitioner's:

- (1) Ethical behavior, clinical competence and clinical judgment in the treatment of patients as determined by the Plan's Quality Improvement Program or otherwise.
- (2) Compliance with Plan policies including, but not limited to, it's Quality Improvement Program.
- (3) Cooperation with Plan personnel.
- (4) Relationships with Plan Covered persons.
- (5) Capacity to satisfactorily treat patients.
- (6) With respect to clinical services not included in the previous contract, relevant documented recent training, observed performance and medical records relevant to the clinical service request.
- (7) Performance and resource allocation evaluation.
- (8) Covered person complaints specific to Primary Care Physicians and high

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- volume Behavioral Health Specialists.
- (9) Results of quality reviews.
 - (10) Utilization management.
 - (11) Covered person satisfaction surveys.
 - (12) The review process shall include consideration of the results of an on-site visit to the practitioner's office for all Primary Care Physicians and all High Volume Behavioral Health Specialists. A structured review form will be used to evaluate the site and the medical record keeping practices to ensure conformity with the National Committee for Quality Assurance (NCQA) standards.
- (d) Procedure
- (1) The Medical Director will review all pertinent information available including data from the Quality Improvement program relative to the Participating Practitioner and will make a recommendation regarding approval to the Credentialing Committee.
 - (2) The Committee will review the Medical Director's recommendation and vote on a decision. The Committee will decide whether to approve or disapprove the practitioner by majority vote. A "clean" file is determined as there was no information found throughout the verification process in which the Committee would need to review. As for an "unclean" file, information was obtained that the Committee would need to review. Examples include but not limited to: malpractice claims, peer reference unsatisfactory, OIG or NPDB with information on the report or health status that may limit or enable a practitioner to perform his/her specific duties. The Medical Director does have the authority to determine that a file is "clean" and may sign off on it as complete, clean and approved which is considered the committee review date. The Medical Director may use a handwritten signature or handwritten initials as documentation of sign-off; an electronic signature will not be accepted. The Committee may decide to alter a decision. For example, the Committee may decide on a one year recredentialing cycle, may require the practitioner to take continuing education, require supervision for a recommended period of time, etc.
 - (3) The Credentialing Committee may decide to pend an Application to ask the practitioner for additional information. In this case the Provider Relations Director will send a letter to the Applicant requesting the additional information. The Applicant will be given 30 days to supply additional information. The new information will be included in the original file which is brought back to the next Credentialing Committee meeting.
 - (4) If the Medical Director's recommendation is for non-renewal, the Medical Director's report and verbal recommendation shall be transmitted to the Board prior to the date on which notice of non-renewal must be given. Where non-renewal is recommended, the reason for such recommendation shall be stated and documented.
 - (5) The decision's of the Sanford Health Plan Credentialing Committee will be reviewed and approved by the Sanford Health Plan Board of Directors.
 - (6) The Sanford Health Plan Provider Relations Department will send out a letter

notifying the practitioner of his/her credentialing decision within sixty (60) days of the Committee's decision.

Section 8. Procedure for Clean File Review

- (a) The Sanford Central Verification Office will run a report every Friday of clean files that are at Committee status. A designated person will print off each practitioner's profile on the clean list. The designated person will review all profiles to confirm each file is complete and ready for the Medical Director to review. The Medical Director will review each practitioner's profile and if approves will sign off on the full clean list.

Section 9. Discontinuation of Participating Practitioner Status for Reasons Related to Clinical Competence or Professional Conduct

- (a) If the Plan has determined to discontinue a Practitioner's participating status after recredentialing for stated reasons based on the clinical competence, professional conduct, and/or quality deficiencies of the Practitioner, the Practitioner shall be notified in writing of the decision and the reasons for it. The Practitioner may request a hearing pursuant to the Plan's Hearing Procedures, and all subsequent actions pertaining to the contract termination or non-renewal shall be governed by those procedures. Said procedures shall comply with the minimum due process requirements set forth in the Health Care Quality Improvement Act of 1986. (Refer to PR-15 Provider Appeal Rights Policy).
- (b) Whenever termination or non-renewal is based on the clinical competence or professional conduct of the practitioner, reports of the action will be made to appropriate federal or state authorities as required by law.
- (c) Applicants are notified of their appeal rights through the Provider Manual which is distributed with the contracts. The Provider Appeal Rights Policy would be sent along with the termination letter to the practitioner.

Section 10. Procedure Relating to Practitioner Dispute Resolution

- (a) If a Participating Practitioner has a grievance, complaint or other problem regarding any aspect of the Plan's operations (other than one relating to Participating Practitioner status or preadmission, admission and continued stay denials) while under contract with the Plan, the Practitioner may contact the Plan's Provider Relations Director to discuss the matter.
- (b) If the matter cannot be resolved informally within a reasonable time to the Practitioner's satisfaction, the Practitioner may submit a written grievance to an ad hoc Dispute Resolution Committee, which shall be appointed by the Provider Relations Director of the Plan. The Committee shall be composed of three individuals, including at least two other Participating Practitioners who are not associated in practice or in economic competition with the practitioner bringing the grievance. The Committee shall consider the matter as soon as practicable after its receipt of the grievance, conduct such investigation of the grievance as may be necessary, and recommend such corrective action (if any) as it deems appropriate to the Board.
- (c) The Board shall take such action, as it deems appropriate upon receipt of the

recommendation of the Committee. The Practitioner shall be notified of the disposition of the grievance and any corrective action taken with respect to the grievance. The decision of the Board shall be final and binding on both the Plan and the Practitioner.

Section 11: Delegated Credentialing

- (a) Sanford Health Plan will in certain circumstances enter into the process of delegating the credentialing responsibilities to large practitioner groups. In such cases, Sanford Health Plan follows the NCQA guidelines with regards to delegation. However, Sanford Health Plan retains the responsibility for ensuring that all credentialing functions are being performed according to Sanford Health Plan expectations and NCQA standards. For further explanation on Delegated Credentialing refer to Policy PR-25 Delegated Credentialing Process.