Sanford Policy Health Plan	PR-006 Practitioner Credentialing
	APPROVED BY: VICE PRESIDENT, MEDICAL OFFICER, HEALTH PLAN
DATE REVIEWED/REVISED: 10/11/2022	**WRITTEN BY:** VICE PRESIDENT, MEDICAL OFFICER, HEALTH PLAN

SCOPE: All

AFFECTED DEPARTMENT(s): Provider Relations, Provider Contracting, Credentialing Services, Credentials Committee, Medical Management

NCQA REVIEW: Yes- direct

Provider Manual Publication: Yes

VENDORS: Central Verification Services (CVS) and Credentialing & Verification Office (CVO) = Sanford Health Credentialing Department

RELATED POLICY (IES) –

Sanford Health Plan

- MM-GEN - 028
- MM-GEN - 030
- MM-GEN – 056
- MM-GEN – 049
- PR – 015
- PR - 023
- PR – 024
- PR - 025

APPENDICES AND ATTACHMENTS –

Appendix A – Sanford Health Plan Scope of Credentialing
Appendix B – Threshold Eligibility Criteria
Appendix C – Verifications
Appendix D – Clean File Criteria

PURPOSE:

To define a systematic approach to obtain Primary Source Verification of credentials and qualification information for all Applicants to Sanford Health Plan and define the process to determine whether or not each individual Practitioner meets the credentialing standards of Sanford Health Plan.

POLICY:

Credentialing Program Oversight

The Vice President Medical Officer (VPM0) is directly responsible for the Plan's Credentialing Program. Responsibilities include: facilitates the SHP Credentials Committee; approves (or designates approval authority) of Applications meeting Clean File criteria on a weekly and as needed basis;

provides guidance to Credentialing Services on the overall direction and goals of the Credentialing Program; reviews all credentialing policies and procedures on an annual basis; oversees quality monitoring indicators of the credentialing process and policy compliance; provides oversight of activities evaluating delegated activities; reports SHP Credentials Committee activity to the Board of Directors; and is available in the event a credentialing issue arises that requires physician involvement. The VPMO may delegate any functions or responsibilities to a Senior Director of Medical Services and may refer to the SHP Credentials Committee as needed.

Scope of Credentialing:

Practitioners will be credentialed if they fall within the Scope of Credentialing for Sanford Health Plan. The Scope of Credentialing is defined in Appendix A of this policy which includes criteria for inclusion and exclusion, as well as eligible and ineligible professional disciplines. Practitioners who do not meet the criteria for Scope of Credentialing are ineligible to apply for Sanford Health Plan participation.

Eligibility Criteria:

In order to be eligible to be considered as a Participating Practitioner, a Practitioner must meet the applicable qualifications set for the in the Plan's Threshold Eligibility Criteria for Participating Practitioners. Refer to Appendix B for a listing of Threshold Eligibility Criteria. Practitioners who do not meet Threshold Eligibility Criteria are ineligible to apply.

The CVO Manager will notify Practitioners in writing if they do not meet Threshold Eligibility Criteria and apprise them that their application will be considered automatically withdrawn. The Practitioner may request consideration for extenuating circumstances and provide rationale and supporting documentation to support their request within 30 days of the notification. The Credentials Committee may, in its discretion, waive criteria if it determines that there is sound rationale and documentation to support the Practitioner's qualifications, and the exception is needed to fulfill an important Member need.

Nondiscrimination Policy:

No Practitioner shall be denied Participating Practitioner status on the basis of gender, race, creed, color, ethnic/national origin, age, disability, sexual orientation, or the types of procedures or patients in which the Practitioner specializes. The Plan does not discriminate against particular Practitioners that serve high-risk populations or specialize in conditions that require costly treatment. The Credentials Committee is given only the Practitioner's name and specialty when reviewing the file. Age, race, ethnic/national origin and other protected status information is not given to the Credentials Committee at the time of file review. On an annual basis, all Credentials Committee members will sign an affirmative statement to make decisions in a nondiscriminatory manner. The Plan monitors to prevent and affirm the Committee's decisions have been nondiscriminatory via an annual audit of denied files conducted by the Director of Provider Relations.

Rights and Duties of the 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 applicable to the Practitioner, pursuant to said contract. Notification of Practitioner Rights are in the Provider Manual and in this policy PR-06 Practitioner Credentialing Policy, both found on the Plan's website.

Practitioners will comply with the Plan's policies and procedures and participate in the Plan's Utilization Review and Quality Improvement program as developed by the Plan's Board and committees to improve quality of care, services, and Member experience. Practitioners must allow the Plan to use Practitioner performance data from quality improvement activities and permit Plan representatives to have access to his/her office and medical records, for the purpose of conducting on-site surveys. Practitioners shall also maintain the confidentially of Member information and records and allow the Plan to use Practitioner practice data relevant to Plan participation.

Burden of Providing Information:

The Applicant shall have the burden of providing evidence that all statements made, and information given on the Application are factual and true. 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. Until the Plan has received and verified all information requested by the Application, the Application will be deemed incomplete and will not be processed. An Application may become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing

process.

Scope of Practice and Information Regarding Clinical Privileges:

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 VPMO. The approved scope of practice shall be based upon the Applicant's recent and relevant education, training, experience, demonstrated competency and judgment, references and other applicable information, and conformance with Plan criteria regarding qualifications for performance of such procedures.

The Practitioner shall have the burden of establishing his/her qualifications and competencies to exercise the scope of practice he/she requests. This will include submitting information to the Plan regarding his/her qualifications and credentials as may be requested by the Plan. Such information may include, but not be limited to:

- A copy or listing of privileges currently exercised at each Plan Participating hospital where he/she is appointed to the medical staff or granted permission to practice.
- A listing of any procedures for which clinical privileges were not granted in a hospital where he/she practices but are exercised in his/her private office setting.
- Procedures that he/she regularly performs in his/her private office setting.
- Other information regarding the aspects of private office practice related to his/her participation in the Plan.

When a Practitioner is applying to exercise clinical privileges at a Participating Hospital, the Plan has the option to request the hospital to provide copies of documents in the hospital's credentialing files that specify the qualifications to perform procedures and verify compliance of the Practitioner with the criteria set forth. The Plan may accept as primary source verification when provided by and certified by the Hospital that the information is current and correct.

Right to Notification:

Practitioners will be notified in writing of any information obtained during the credentialing process that varies substantially from the information provided by the Practitioner. This may include actions on a license, malpractice claims history or Board Certification status. (See also Procedure Section 4.)

Right to Correct Erroneous Information:

Practitioners will have the right to correct erroneous information. The Practitioner will be sent a written communication identifying the erroneous information and will be afforded ten (10) business days to provide corrected information. The Provider will be informed that he/she has one opportunity to correct the information requested in the written notification. If the discrepancy can be explained by the Practitioner, the file will continue to be processed. If no response is received, if not all questions are responded to, or if information provided is unable to be verified by Primary Source, the Practitioner will be notified that the file remains incomplete and cannot be processed. The Practitioner will not be eligible to re-apply for a period of one year. (See also Procedure Section 4.)

Right to Inquire about Credentialing Status:

Each contracted Practitioner with the Plan retains the right to at any time inquire about their credentialing status. The Practitioner may contact any representative of Sanford Health Plan Provider Relations Department, and the Provider Relations representative will obtain the exact status from Credentialing Services. The Provider Relations representative will then respond to the Practitioner in a timely fashion with information regarding their credentialing status. The Practitioner may be given information regarding outstanding verifications. No Peer Review related information will be shared.

Right to Review:

Practitioners have the right to review information submitted in support of their credentialing Applications, however, the Plan respects the right of the Peer Review protections that are integral in the credentialing process.

Practitioners will not be allowed to review references, recommendations or any other information that is Peer Review protected. Information obtained from malpractice insurance carriers, state licensing boards, board certification verification or similar agencies may be reviewed by the Practitioner. In the event the Practitioner discovers an error in the credentialing file, he/she has the right to request a correction of the information in question. Such correction must be Primary Source Verified or otherwise validated.

Confidentiality:

All Practitioner Credentialing Information obtained in the credentialing process will remain confidential, except as otherwise provided by law. Practitioner Credentialing Information means that all information gathered either in the Practitioner's credentialing Application or through primary source verifications will be accessible only to authorized personnel and

shared only with the Credentials Committee, except where required by State and/or Federal laws. Staff will secure confidential information as per SHP Policy PR-023, Credentialing System Controls. The Credentialing Committee will uphold the established principles and written procedures pertaining to physician confidentiality and individual privacy. The Plan collaborates with Sanford Credentialing Services for exchange of data to ensure the protection of privacy and confidentially.

Provisional Credentialing:

The Plan does not provisionally credential Practitioners. All Practitioners are fully approved.

Claims Release:

Practitioners are not published in the Plan Directory until after Credentials Committee approval. However, when allowed by contracts, other payors or when required by state law (for example Iowa code chapter 514) the Plan will provide for retrospective payment of clean claims for covered services provided during the Practitioner's credentialing period (defined as the time-period between the Plan's receipt of the credentialing Application and approval by the Credentials Committee). In these circumstances, the Plan will have a process in place to hold claims during the credentialing period and release claims once the Practitioner has been approved.

PROCEDURE:

Section 1: Application Submission and Acceptance

To initiate the Application process, the Practitioner will complete an online initial Application request form found on the Plan's website. An email with a link to the online Application will be sent within 10 business days to the Practitioner, and to a credentialing contact or administrator if requested by the Practitioner. The Practitioner must complete and submit an Application online via the link provided on the Sanford Hub. Electronic signatures and dates will be accepted with online completion. Practitioners may request the ability to submit a paper Application, which will be considered on a case-by-case basis.

Once the online Application is received, an initial check-in process will be completed within 48 hours. This is a precursory review to ensure appropriate sections are completed, required supplemental materials are provided, disclosure questions are responded to, with explanations when indicated, and all signatures are present. The Practitioner will be notified of any missing information needed to complete submission of the Application. The Application will not be accepted into the system until missing information is provided. The date the Application is accepted into the system is

recorded as the date the Application is received.

The Application includes, at minimum:

1. reasons for any inability to perform the essential functions of the position, with or without accommodation;
2. absence of present illegal drug use;
3. history of loss of license and felony convictions;
4. history of loss or limitation of privileges or other disciplinary activity;
5. current malpractice insurance coverage; and,
6. signed attestation as to the correctness and completeness of the Application.

The attestation must be signed and dated within 180 days of the Credentials Committee decision date. Electronic, faxed, digital, scanned or photocopied signatures are accepted. Signature stamps are not accepted unless the Practitioner is physically impaired. The disability will be documented in the Practitioner's credentialing file allowing the stamp signature to be accepted.

Section 2: Re-Credentialing Application

Each Participating Practitioner will be responsible for providing the Plan with updated information at least every three (3) years. The look-back for re- credentialing is current to previous cycle. Participants will be sent a notice and provided a link to submit a pre-populated re-credentialing Application approximately 5 months prior to their due date. If not received, a minimum of three subsequent reminder notices will be sent. On the third notice, the Practitioner will be informed that the updated Application is needed within 30 calendar days of their expiration date and without receipt, their Participation status will be administratively terminated.

Practitioners must be re-credentialed at least within 36 months from the previous credentialing date. However, the Plan may extend a Practitioner's re-credentialing cycle time frame (beyond 36 months) if the Practitioner is: on active military assignment; on a medical leave of absence; or on sabbatical. The reason for the extension will be documented in the Practitioner's credentials file and re-credentialing will be completed within 60 days of the Practitioner's return to practice.

All efforts will be made to maintain the credentialing and re-credentialing schedules of Sanford employed Practitioners or Practitioners credentialed through contract with Sanford Credentialing and Verification Office (CVO) to minimize the number of Applications required.

Section 3: Verification Procedure:

Once an Application is accepted into the credentialing data system, verification of the

Applicant's credentials may begin and continue until it is determined the Application is complete.

Verifications must be obtained within 180 days of the Credentials Committee decision date from one of the following sources: the primary source, a contracted agent of the primary source or another NCQA accepted source listed for the credential. License and DEA must be current at the time of the Credentials Committee decision.

Information that shall be primary source verified is listed on Appendix C of this policy. Verifications will be placed in the Applicant's electronic file and documented in the credentialing data system in accordance to PR-023, Credentialing System Controls.

Once all verifications have been received, a Credentialing Services staff member will review the file to ensure the verifications are within the appropriate timeframe. If for any reason a primary source verification becomes older than 180 days, re- verification will be completed. The CVO Manager or designee will review credentialing information to determine if the Application is complete (See Section 4).

Section 4: Determination of Complete Application

A complete Application means that all of the following have been affirmed: all applicable verifications pertaining to the Application have been received (Appendix C); eligibility criteria are met (in accordance to Appendix A and B); there are no unresolved omissions, commissions or discrepancies between information provided on the Application and information obtained during the credentialing process; all verifications and signatures are within the appropriate timeframe; there are no issues or concerns requiring additional explanation or clarification; and, all available information or substantiation needed to evaluate an issue or concern has been obtained.

Practitioners will be notified, in writing, when information obtained in the credentialing process varies from the information provided in the Application. The Practitioner will be afforded ten (10) business days to provide clarification of conflicting information or provide correction of erroneous information. A written response will be required, with the exception that verbal correction of employment/affiliation dates may be accepted. Written responses must be provided directly to the recipient identified in the request for information. Receipt of the correction or clarification will be documented in the Practitioner's credentialing file. All new or corrected information will be incorporated into the credentialing process and verified through the appropriate Primary Source. If the discrepancy or error can be explained or corrected by the Practitioner, the file will continue to be processed.

If Credentialing Services personnel feel the discrepancy is unresolved by the clarification or correction provided; or if the discrepancy is substantial and raises additional questions or concerns regarding the Practitioner's qualifications, the CVO Manager will be informed, and further evaluation will ensue to include any additional verifications needed to resolve the issue. This may include affiliation references, peer references, and any additional verifications applicable to the area of concern.

If within 30 days further evaluation does not resolve the issue or concern in question and additional new information is needed from the Practitioner, the Practitioner will be notified that the file is incomplete and be requested to provide any additional explanation, clarification, information or substantiation required, with notice that failure to respond within 30 days will result in the Application being considered automatically withdrawn, with a one-year waiting period for re-application.

If no response is received, the Practitioner will be notified their application is automatically withdrawn and that they may submit a complete Application, addressing all noted issues or concerns, after a one-year period of time.

If a response is received, the CVO Manager will review the information received to determine if additional verifications are needed to Primary Source verify or validate. Once it is determined that information needed to consider the merits of the Application has been received, the Application will be considered complete and advance for processing. The date when it is determined that all information has been obtained will be recorded as the file completion date within the Credentialing database.

Section 5: Determination of Clean File versus Committee File:

Following determination of a complete Application, the file will be evaluated within three (3) business days to determine if criteria are met for a Clean File. All files initially determined to be a Clean File will undergo a second quality review for confirmation.

A Clean File is a credentialing file whereby there is no information found throughout the verification process that requires additional review to determine if the Practitioner is qualified for Plan participation. Criteria for determination of Clean File versus Committee File are further defined in Appendix D of this policy. A Clean file will be processed following the Clean File Medical Director approval (Section 7) with determination made most commonly within 30 days of file completion, but at least within 45 days of file completion.

A Committee File is a credentialing file that did not meet criteria as a Clean File or a file with issues or concerns identified that require additional evaluation and/or

review by the Credentials Committee to determine if the Practitioner meets all qualifications as a Plan Participant. If it is determined a credentialing file does not meet criteria as a Clean File, the Practitioner will be notified of such within 3 days from file completion and the Committee File will be placed on the next Credentials Committee agenda. Refer to Section 7 for Sanford Health Plan Committee Approval proceedings. The Credentials Committee will make determination most commonly within 30 days of file completion. However, the Committee may request additional information to consider at their next meeting which extends this timeline to 75 days of file completion.

Section 6: Sanford Health Plan Credentials Committee

The Credentials Committee is a peer review committee facilitated by the VPMO. The VPMO will chair or delegate the role of chair to a Senior Director of Medical Services. The VPMO will appoint members of the SHP Credentials Committee. Membership is comprised of Participating Practitioners with a variety of different specialties and practice backgrounds. The VPMO may request attendance of an ad hoc member when additional subject matter expertise is needed. Credentialing Services and SHP support staff may be assigned to attend, however, only Practitioner members will vote on the participation status of each Practitioner.
Quorum is 50% of the voting members with decisions made by majority rule. The Committee will meet monthly, usually the first Monday of the month, from 12:00 to 1:00 p.m. via video conference.

The Credentials Committee shall examine the evidence of the character, professional competence, qualifications, prior behavior and ethical standing of the Applicant. Based upon information provided by the Applicant, from references, through verifications and from any other sources available, the Credentials Committee will determine whether the Applicant meets all of the necessary qualifications for a Plan contract to perform the clinical services and procedures requested.

During the re-credentialing cycle, the Credentials Committee will also review any additional factors and information including, but not limited to quality complaints, adverse events or auditing/monitoring findings. The VPMO will evaluate any available information from the Plan's Quality program relevant to the Participating Practitioner and make report to the Credentials Committee.

The Credentials Committee may delegate the approval of Clean Files to the VPMO to act on the Credentials Committee's behalf. The VPMO may approve or designate approval authority to a Senior Director of Medical Services**.** Refer to Section 7 below. When there is delegation of Clean File approval, the Credentials Committee will receive minutes from the weekly Clean File review.

All files that do not meet Clean File criteria or files where issues or concerns have been identified and additional evaluation is needed to determine a Practitioner's qualifications will be reviewed by the Credentials Committee. Refer to Section 8 below.

The Committee will review findings of ongoing credentials monitoring activity and evaluate if there are concerns for quality deficiencies or changes in Practitioner qualifications that may raise questions relating to continued participation. The Committee will determine if additional information or evaluation is needed or if the status of the Practitioner needs to be altered. (See also PR-024 Monitoring.)

The Committee will review and approve credentialing related policies and procedures on an annual basis and note such approval in the Committee minutes.

Section 7: Procedure for Clean File Review

Sanford Credentialing Services will run a weekly report of Clean Files. The Credentialing Manager, or designee, will review all Clean Files to validate each file is complete and has met the Plan's Clean File criteria. A listing of Clean Files ready for approval will be presented to the VPMO or designee. The VPMO, or designee, has the authority to sign off Clean Files on behalf of the Credentials Committee, signifying the credentialing file is complete, without identified issues or concerns and approved. The date of signature is considered the Credentials Committee approval date. The VPMO, or designee, may use a handwritten signature or handwritten initials as documentation of sign-off. An electronic signature will not be accepted. If all Clean Files on the weekly listing are approved, one signature may suffice for the full listing. Minutes will be created, listing those Practitioners approved. Minutes will be presented to the next Credentials Committee.

Section 8: Procedure for Committee File Review

The Credentials Committee receives a report with supporting materials for all Committee Files. Each Committee File is reviewed by the Credentials Committee to determine if the Practitioner meets qualifications as a Participating Practitioner. The Credentials Committee will make its determination by majority vote. The Plan does not conduct provisional credentialing. Actions of the Credentials Committee may include the following:

1. Approve the Application for a full cycle (most commonly 2 years but may be up to, but not exceeding 36 months). The re-credentialing date may be established to coincide with the Practitioner's additional credentialing cycles, when applicable.

2. Approve the Application for a shortened cycle to allow specified follow-up or a more timely review of potential issues or concerns. This may include specific recommendations for monitoring or auditing. Most commonly shorted cycles are recommended between the timeframe of 6 months and 18 months.

3. Determine the Application is incomplete due to new issues or concerns identified or due to insufficient information to resolve issues or concerns presented for Committee review. The Credentials Committee may take action in one of the three following ways:
    a. Pend the Application and ask the Practitioner for additional (new) information. In this case, the VPMO will send a letter to the Applicant informing them additional information is required for review. The Applicant will be given 30 days to supply the additional information with notice that failure to respond will result in the Application being considered automatically withdrawn. Any response received, to include verification of the information provided, and when possible, will be brought to the next Credentials Committee for review and to make determination on the file within 75 days of the file completion date.
    b. Defer the Application and request Credentialing Services to obtain additional verifications or credentialing information for review and evaluation. The Credentials Committee will allow an additional 30 days of evaluation but will make determination on the file within 75 days of the file completion date.
    c. If additional information has already been requested from the Practitioner and has not been provided in full, is determined to be insufficient to resolve issues and concerns, or is unable to be substantiated, the Application will be deemed incomplete. The Applicant will be notified by the VPMO that the file is incomplete, cannot be processed and is automatically withdrawn. The Practitioner and will be apprised that he/she will not be eligible to re-apply for a period of one year.

4. Deny the Application based on the clinical competence or professional behavior of the Applicant. The VPMO will notify the Applicant of the denial, to include the stated reason(s) for denial and will be apprised of their right to a hearing pursuant to the Plan's Hearing Procedures. All subsequent actions shall be governed by those procedures, which shall comply with the minimum due process requirements set forth in the Federal health Care Quality Improvement Act of 1986. (Refer PR-015 Provider Appeal Rights and Section 9 below if denial decision is made at re-credentialing.)

Minutes of the Credentials Committee will document the discussions and decisions voted upon by the members at each meeting. The Senior Medical Services Director who chaired the meeting and the VPMO will review and sign the minutes. Minutes are forwarded to the Sanford Health Plan Board of Directors for ratification.

The Plan Provider Relations Department will send a letter notifying Practitioners of all initial and re-credentialing decisions for approval within 10 business days. All other Credential Committee decisions will be communicated by the VPMO to the Practitioner by letter within ten (10) business days of the Credentials Committee's decision.

Section 9: Discontinuation of Participating Practitioner Status for reasons Related to Clinical Competence or Professional Conduct

If the Plan has determined to discontinue a Practitioner's Participating status after initial credentialing 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).

Applicants are notified of their appeal rights through the Provider Manual, which is available on the Plan website. The Provider Appeal Rights Policy or policy link will be sent along with the termination letter to the Practitioner.

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. Reports will be made to delegated payors as per contract requirements.

Section 10: Practitioner Termination and Reinstatement

If the Plan should terminate a Practitioner and the later want to reinstate Participation, the Practitioner will have to reapply and go through initial credentialing if the lapse was more than 30 calendar days. The Application may be pre-populated for update. Primary source verifications will be re-verified to meet necessary timeframes for initial credentialing.

Section 11: Delegated Credentialing

The Plan will, in certain circumstances, enter into an agreement to delegate credentialing and re-credentialing responsibilities to large Practitioner groups and/or rental networks. In such cases, the Plan follows the NCQA guidelines along with any relevant State regulations, including regulations issued by the Board of Registration of Medicine at 243 CMR 3.13 in regard to delegation. A complete pre-assessment and file review of the organization would be completed and reviewed against the NCQA Standards along with any relevant State regulations. If the organization meets the necessary standards, a delegation agreement would be offered. The agreement would indicate what standards would be delegated (NCQA Standards CR 1-8) based upon those elements passing the pre-assessment review. The Plan retains the responsibility for ensuring that all credentialing functions are performed according to the Plan's expectations and NCQA Standards. A summary report of delegated credentialing monitoring activity will be provided to the VPMO on an annual basis, and as issues or concerns are identified. For further explanation on Delegated Credentialing refer to Policy PR-25 Delegated Credentialing Process.

Section 12: File Retention

Sanford Credentialing Services will retain all initial credentialing and re- credentialing files for each Practitioner credentialed. If a Practitioner should leave the Plan's network, the whole credentialing file will be scanned or sent to off-site storage (Record Keepers). If scanned, the paper file will be shredded appropriately.

DEFINITIONS:

"Applicant" means a Practitioner who has submitted an Application (initial or re-credentialing Application) to participate as a Participating Practitioner.

"Application" means and initial or re-credentialing Application.

"Credentials Committee" or "Committee" means the Sanford Health Plan Credentials Committee.

"Credentialing Services" means Sanford Professional Practice personnel (enterprise and regional) authorized to support credentialing, privileging, peer review and support medical review committees. This includes but is not limited to Sanford Central Verification Services (CVS) and Credentialing & Verification Office (CVO) personnel.

"Member" means any individual who is covered by the Plan.

"Participating" means that the Practitioner or someone on the Practitioner's behalf has signed a contract with the Plan to provide services to covered Members and has been approved by the Credentials Committee.

"Plan" means Sanford Health Plan.

"Practitioner" means any individual who is 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, occupational therapists, audiologists, physical therapists, MSWs, diabetic educations, registered dieticians, physician assistants, nurse Practitioners, certified nurse midwives, nurse anesthetists, and dentists. (Refer to PR-010 Criteria for Participating Practitioners for a complete listing.)

"Vice President Medical Officer" or "VPMO" means the Sanford Health Plan Vice President Medical Officer or the Senior Director of Medical Services Director. Any responsibilities of the VPMO may be designated to be performed by a Senior Director of Medical Services.

REFERENCES

- NCQA CR 1 and CR 2
- Social Security Act, Section 1852
- 42 CFR 422.204

POLICY IS SUBJECT TO THE FOLLOWING AUDITS:

- NCQA
- Minnesota Department of Health
- Iowa Division of Insurance/Department of Health
- NDME EQRO
- CMS for Marketplace

Appendix A
Sanford Health Plan Scope of Credentialing

Section A –Practice Setting Inclusion Criteria

Practitioners who provide care* in are within the Scope of Credentialing if all three of the following criteria are met:

1. Practitioners must be licensed, certified or registered by their state(s) to practice independently (without supervision).
2. Practitioners have an independent relationship with Sanford Health Plan (SHP). This may include hospital-based Practitioners who see SHP Members as a result of their independent relationship with SHP.
    - An independent relationship exists when SHP selects and directs its Members to see a specific Practitioner or group of Practitioners, including Practitioners whom Members can select as primary care Practitioners.
3. Practitioners provide care to Members under SHP's medical benefits. This may include non-physician Practitioners.

*The above listed criteria apply to Practitioners in the following settings:

- Individual or group practices (inclusive of Practitioners who see Member outside of the inpatient or free-standing ambulatory facilities).
- Facilities
- Rental Networks**
    - That are part of the SHP's primary network, and the organization has Members who reside in the rental network area.
    - Specifically, for out-of-area care and Members may see only those Practitioners or are given an incentive to see rental network Practitioners.
- Telemedicine
    - Practitioners providing medical care to patients located in another state are subject to the licensing and disciplinary laws of that state and must possess an active license in that state for their professions.

**SHP will rent a network if necessary to provide adequate coverage for Members. Rental Networks are used for Members who reside outside SHP's service area and for out of area coverage. Most often the Plan will delegate credentialing with the Rental Network as these networks usually have a large

quality of Practitioners with a small number of Members accessing the Rental Network. If delegated credentialing is not an option or if the Rental Network does not meet delegation requirements, the Plan will credential the Rental Network.

Locum Tenens Providers fall within the scope of credentialing if they have practiced in the same location or on a contracted period of more than 60 consecutive days.

Section B –Practice Setting Exclusion Criteria

Practitioners who practice exclusively within the inpatient setting and who provide care for SHP Members only as a result of the Members being directed to the hospital or other inpatient setting do not need to be credentialed by SHP. The following are examples; however, the list is not all inclusive:

- Pathologists
- Radiologists
- Anesthesiologists
- Neonatologists
- Emergency Room Physicians
- Hospitalists
- Board Certified Consultants (for example, board certified consultants who may provide a professional opinion to the treating practitioner)
- Hospital-Based CRNAs
- Pharmacists who work for pharmacy benefits management (PBM)

Locum Tenens Practitioners who have not practice at the same facility for 60 days or more consecutive calendar days and do not have an independent relationship with the Plan do not need to be credentialed by SHP.

Practitioners who practice exclusively within a free-standing facility and who provide care for SHP Members only as a result of Members being directed to the facility do not need to be credentialed. The following are examples; however, the lists in not all-inclusive:

- Mammography Centers
- Urgent Care Centers
- Ambulatory Surgical Centers
- Ambulatory Behavioral Health Centers
    - Such as psychiatric and addiction disorder clinics

Section C – Eligible Professional Disciplines

The following professional disciplines are eligible for Participating Practitioner status

provided that they meet inclusion criteria (Section A) do not meet exclusion criteria (Section B), and possess and provide satisfactory evidence of qualifications as required through the Plan's Credentialing process:

- Doctors of Medicine
- Doctors of Osteopathy
- Oral/Maxillofacial Surgeons
- Dentists
- Chiropractors
- Optometrists
- Podiatrists
- **Physician Assistants
- **Advanced Practice Registered Nurses (Masters or higher education with national certification and state licensure)
    - **Certified Nurse Practitioners (CNP)
    - **Certified Nurse Midwives (CNM)
    - **Certified Registered Nurse Anesthetists (CRNA)
    - **Clinical Nurse Specialists (CNS)
- Behavioral Health Practitioners:
    - Psychiatrists and other physicians
    - Psychologists (Doctoral or Masters prepared who are certified and licensed)
    - **CNSs or CNPs specializing in psychiatric/behavioral health services who are certified and state licensed.
    - Social Workers (Masters or higher education who are state certified or licensed)
    - Addiction Medicine Specialists
    - Other behavioral health specialists who are licensed and certified or registered by the state to practice independently.
- Audiologists
- Physical Therapists
- Speech Pathologists
- Occupational Therapists
- Registered Dieticians
- Certified Diabetic Educators
- Acupuncturists who possess current National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) certification and current (full, active and unrestricted) acupuncture license in each state the Practitioner is practicing.

**Advanced Practice Professionals must have an agreement with a licensed

physician or physician group unless the state law allows the Practitioner to practice independently. This is in reference to H.R. 3590 – Patient Protection and Affordable Care Act C.2706, nondiscrimination in health care and 42 U.S.C. 300gg-5 - non-discrimination in the health care. State laws requiring collaborative agreements will be required by the Plan.

Section D – Ineligible Professional Disciplines

The following list of professional disciplines are not accepted by SHP and therefore credentialing Applications for these types of Practitioners will not be accepted:

- Registered Nurses
- Licensed Practical Nurses
- State certified, lay or direct entry midwives
- Naturopathic Doctor (ND)
- Acupuncturists who do not possess NCCAOM certification or current (full, active and unrestricted) state licensure

Appendix B
Threshold Eligibility Criteria

Practitioners must meet all of the following threshold eligibility criteria to apply for and maintain SHP participation.

1. *Meet practice setting Scope of Practice eligibility criteria as defined in Appendix A, Section A of this policy.
2. Possess a current license in the state(s) in which they practice in an eligible professional discipline (see Appendix A, Section C of this policy).
    - In the case of resident moonlighting, all of the following criteria must be met:
        i. The resident holds a permanent or temporary license/certification that permits the resident to practice unsupervised medicine outside of the resident's authorized training program in each state where he/she moonlights.
        ii. Resident must be at minimum midway through his/her second year (PGY2) of residency training to be eligible for credentialing.
        iii. A letter from the Residency Program Director must be submitted allowing the resident to moonlight outside of the residency training.
        iv. The credentialing cycle will end 60 days after the estimated residency completion date. A re-credentialing cycle will be completed to include residency verification.
3. Must not currently be excluded or precluded from participation in the Federal Medicare program.
4. *Must not have applied for Sanford Health Plan Participation and had the Application automatically withdrawn as an incomplete file within the prior year. (In extenuating circumstances, the Credentials Committee may shorten or waive the one year waiting period.)
5. *Possess a current Certificate of Insurance or Medical Insurance Face Sheet verifying professional liability insurance coverage at a minimum of $1 million occurrence/$3 million aggregate or $2 million occurrence/$2 million aggregate unless another amount is required by applicable state law.
6. *When applicable to the professional discipline, possess a current state CDS Certificate and Federal Drug Enforcement Agency Certificate for all schedules unless such a certificate is not needed for the practice of the Applicant's specialty. A waiver, for Credentials Committee consideration, must be completed and signed by the Practitioner that does not have nor need a Federal DEA in a particular state in which he/she practices in.

7. *Possess hospital privileges at a SHP Participating and contracted hospital if the Practitioner performs procedures, provides services or admissions that have to be performed in a hospital facility.

Appendix C
Verifications

The following information shall be primary source verified, placed in the Applicant's electronic file and documented in the credentialing data system as follows:

1. Valid current state licensure in each state that the Practitioner provides care for the Plan's Members. The state licensure is primary source verified directly with the state licensure board by letter, phone, fax, web crawl or via state web site. Credentialing Services personnel will verify whether there are state sanctions, restrictions or limitations on the Practitioner's scope of practice with the licensing agency.

2. Current Federal DEA in each state in with the Practitioner practices in regard to Plan's Members or a signed Sanford Health Plan waiver indicating why the Practitioner does not need a state specific Federal DEA or indicating the Practitioner/Practitioner Group that will write for the Member. The Federal DEA will be primary source verified through web crawl, phone verification or inspection of current copy. CSR Certificate will be verified via current copy, phone verification, email or website of the CSR Certificate, if applicable, in each state the Practitioner practices in regard to the Plan's Members. Refer to a copy of the Sanford Health Plan Waiver for Controlled Substances/Federal DEA/State Controlled Substances.

3. Primary Source verification of the highest level of Medical/Professional education, residency training or board certification achieved. Medical/professional school and residencies will be primary source verified by letter, phone, web crawl or fax directly with the institution and/or by the AOA (American Board of Osteopathic Association) or the AMA (American Medical Association). Education/training beyond residency will be verified if the Applicant is practicing in that specialty unless they are Board certified, in which case Board Certification will be verified.

4. Board Certification status will be primary source verified by the American Board of Medical Specialties or an official ABMS display agent via website, letter, fax, web crawl or telephone.

5. Board Certification can also be verified by the AMA, AOA or confirmation

from the appropriate specialty board by letter, phone website, web crawl or fax. Expiration must be present with the verification and noted in the credentialing system. If an expiration date is not provided by the Board, the Plan will verify and document that the Board Certification is current within 180 days of the credentialing approval date. Board Certification will be verified at re-credentialing, including lifetime certifications. Board Certification is not required by the Plan.

6. ECFMG, is applicable, primary source verified directly with the Educational Commission for Foreign Medical Graduates by letter, fax or website electronic verification.

7. Hospital affiliations and the primary admitting facility will be gathered from the credentialing Application or CV provided by the Practitioner as applicable.

8. Work History:
    - For initial credentialing, a minimum of five-year-relevant work history must be provided on the Application. Any time gaps exceeding six months will require an explanation via 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. Credentialing Services personnel will review the work history in the credentialing system and document their review within the appropriate electronic workflow (checklist) in the credentialing system.
    - For re-credentialing verify any changes in work history since previous credentialing cycle. Any time gaps exceeding six months will require an explanation via letter, phone or fax. Any gaps over a year must be explained by the Practitioner in writing.

9. Malpractice history primary source 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 required.

10. Current professional liability coverage is supplied in the form of a photocopy of the Certificate of Insurance requested from the Applicant. Current professional liability insurance information is also requested

within the Application. The coverage limits and effective and expiration dates must be present. Minimum limits are $1 million per occurrence and $3 million aggregate or $2 million per occurrence and $2 million aggregate. If the Practitioner is covered under a federal tort policy, a copy of the letter or attestation from the provider of the federal tort coverage will be accepted.

11. Medicare/Medicaid sanctions primary source verified through report from the National Practitioners Data bank and EPStaff Check. The EPStaff Check contract verifies the following data bases (Refer to Policy PR-24 Monitoring Policy):
    - Iowa Medicaid Provider Sanctions List
    - Minnesota Excluded Providers
    - North Dakota Medicaid Exclusion List
    - Nebraska Medicaid Exclusion List
    - Office of Inspector General- List of the Excluded individuals/entities
    - Office of Inspector General – Most Wanted Fugitives
    - System for Award Management Excluded Parties
    - Office of Foreign Assets Control
    - Wyoming Medical Sanctioned Providers
    - Montana Medicaid Exclusions

12. Sanctions, limitations, restrictions on licensure primary source verified with state medical board or other licensing agency, as appropriate. All state licenses will be queried for the recent five year look back period. (Refer to Policy PR-24 Monitoring Policy.) 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.
    - Federation of State Medical Boards.
    - State licensure or certification board

13. In addition, the following databases shall be queried as appropriate:
    - Medicare Opt Out websites for Practitioners
    - Social Security Death Master File

- National Plan and Provider Enumeration System (NPI Registry)
- CMS Preclusion Lists

Appendix D
Clean File Criteria

If all of the following criteria are met, a complete file may advance for approval following the Clean File process defined in Section 7 of this policy – Process for Clean File Review. If one or more of the criteria are not met, the file will require review by the Sanford Health Plan Credentials Committee (see Section 8 of this policy – Process for Committee File Review).

Clean File Criteria includes certification by the Applicant of all of the following in addition to supporting findings by primary sources verification:

1. Possess a current, unrestricted and unencumbered license to practice in the state in which they practice, and past history of certify that his/her license to practice, has never been revoked or suspended by any state licensing board.

2. Have never been excluded or precluded from participation in Medicare, Medicaid or another federal or state governmental health care programs.

3. Have never had his/her medical staff appointment, clinical privileges or permission to practice denied, revoked or terminated by any health care facility.

4. Have never been convicted of Medicare, Medicaid or other governmental or private third-party payor fraud or program abuse, or have been required to pay civil penalties for the same.

5. Medical Malpractice History must <u>not</u>:
   - Exceed 3 claims with pay-out of any amount within the most recent 10-year period.
   - Have any claims with pay-out of $1,000,000 or more.
   - Have any claims, excluding those closed or dismissed without any payment, involving unexplained death or serious injury. (Examples of serious injury include loss of limb, permanent loss of mobility, loss of significant cognitive function, change from ability to live independently to dependent living).
   - Have pending litigation in the presence of any other red flags on the file.

6. A gap in work history of 6 months or greater in the last five years if there is concern that the explanation provided is not plausible, is insufficient or gives rise to quality of care or practitioner qualification concerns.

7. Have never been convicted of a felony or of any criminal misdemeanor relating to the practice of his/her profession, other health care related matters, third-party reimbursement, controlled substances violations, child/adult abuse charges, or any other matter which may adversely affect or bring into question quality of care, medical judgment, or professional ethics or conduct.

8. Must not have had a DUI within the most recent 5 years.