Sanford Health Plan	PR-006-Practitioner Credentialing Policy
CURRENT REVIEW: 12/01/2018	**REVISION:** 12/01/2018
WRITTEN BY: Manager, Professional Practice	**APPROVED BY:** Sanford Health Plan Credentialing Committee

SCOPE:	All
AFFECTED DEPARTMENT(s):	Provider Relations, Provider Contracting, Credentialing, Medical Management
IMPLEMENTED: 01/01/98	**ISSUED:** 01/01/98
REVIEW COORDINATOR:	Manager, Provider Relations
NCQA REVIEW:	Yes-direct
Provider Manual Publication	Yes

1
2 **REPLACES:** Conversion from PR-06 Practitioner Credentialing Policy
3
4 **VENDORS:**
5
- ***Sanford Credentialing Services = Sanford Health Credentialing Department***

6 **RELATED POLICY(IES) –**
7
- **Sanford Health Plan**
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  - MM-041
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  - MM-056
10
  - MM-049
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  - PR-006
12
  - PR-024
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  - PR-025
14
- **ENTERPRISE**

15 **APPENDICES AND ATTACHMENTS -**
16
- **Sanford Health Plan**

17 **PURPOSE:**
18 To promulgate a policy related to practitioner credentialing
19
20 **POLICY:**
21 (a) Nondiscrimination Policy
22 No Practitioner shall be denied Participating Practitioner status on the basis of
23 gender, race, creed, color, ethnic/national origin, age, disability, sexual orientation
24 or the types of procedures or patients in which the practitioner specializes.

25 Sanford Health Plan does not discriminate against particular practitioners that
26 serve high-risk populations or specialize in conditions that require costly
27 treatment. Sanford Health Plan monitors and prevents discrimination on an
28 ongoing basis and at least annually. Monitoring and preventing is done by
29 completing audits of denied files by the Director of Provider Relations. Also, all
30 Credentialing Committee members will sign an affirmative statement to make
31 decisions in a nondiscriminatory manner annually. Also, the Credentialing
32 Committee is given only the practitioners name and specialty when reviewing the
33 file. Gender, age, race, etc. is not given to the Committee at the time of reviewing
34 the file therefore preventing discriminatory decisions.
35 (b) Rights and Duties of Participating Practitioner
36 The Practitioner shall only have such rights and duties as are set forth in the
37 Practitioner's contract with the Plan and in other Plan policies and documents
38 which are applicable to the Practitioner pursuant to said contract. Practitioners
39 shall cooperate with Quality Improvement activities to improve the quality of care
40 and services and member experience. Cooperation includes collection and
41 evaluation of data and participation in the organization's QI programs.
42 Practitioners shall also maintain the confidentiality of member information and
43 records, and allow the Plan to use practitioner performance data.
44 (c) Burden of Providing Information
45 The Applicant shall always have the ultimate burden of producing adequate
46 information for a proper evaluation of his or her competence, character, ethics and
47 other qualifications, and of resolving any doubts about such qualifications. The
48 Applicant shall also have the burden of providing evidence that all the statements
49 made and information given on the application are factual and true. Until the Plan
50 has received and verified all information requested by the Application, the
51 Application will be deemed incomplete and will not be processed.
52 (d) Right to Inquire About Credentialing Status
53 Each contracted practitioner with the Sanford Health Plan retains the right
54 to at anytime inquire about their credentialing status. The practitioner may
55 contact any representative of the Sanford Health Plan Provider Relations
56 department, and the Provider Relations department will contact Sanford
57 Credentialing Services to obtain the exact status. The Provider Relations
58 representative will then respond to the practitioner in a timely fashion with the
59 information requested through the inquiry with regards to the status of their
60 credentialing. The practitioner may be given the outstanding verifications. No
61 peer related information will be shared.
62 (e) Right to Review
63 Practitioners will have the right to review the information submitted in support of
64 their credentialing applications however, Sanford Health Plan respects the right of
65 the Peer Review aspects that are integral in the credentialing process. Therefore,
66 practitioners will not be allowed to review references, recommendations or any
67 other information that is peer review protected. The information obtained from
68 malpractice insurance carriers, state licensing boards, board certification
69 verification, etc may be reviewed by the practitioner. In the event that through
70 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.

(f) 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. Examples include but not limited to actions on licenses, malpractice claims history or board certification. The Credentialing Specialist will send written communication to the practitioner requesting clarification of the conflicting information. The practitioner will be given 10 business days to respond with a written or verbal explanation. If the discrepancy can be explained by the practitioner the file will continue to be processed. If the Credentialing Specialist feels the discrepancy was substantial the VP Medical Officer or Senior Director Medical Services will be notified to determine on how to proceed.

(g) 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. Sanford Health Plan will accept corrected information over the phone, in person, or via voice mail if it is related to employment/affiliation dates otherwise it must be a written response from the practitioner. Corrected information must be returned to the appropriate Credentialing Specialist who is processing the file. The Credentialing Specialist will document the receipt of corrected information in the practitioner's credentialing file and the credentialing database. 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 application is incomplete. Primary Source Verification will be used for the purpose of credentialing.

(h) Notification of Practitioner Rights

Practitioner rights are in the Provider Manual and in this policy PR-06 Practitioner Credentialing Policy which both can be found on the Plan's website.

(i) 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 visitors must report at the front desk and will be escorted throughout the office. (Refer to Code of Conduct, Compliance Enterprise policy)

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

117 staff and shared only with the Credentialing Committee, except where required by
118 State and/or Federal laws. A practitioner may view their credentialing file upon
119 request. Refer to Section 2 of this policy for detailed information of this process.
120 Sanford Health Plan collaborates with Sanford Credentialing Services for
121 exchange of data to ensure the protection of privacy and confidentiality.
122
123 Section 3. Criteria
124 (a) Eligibility

125 In order to be eligible to be considered as a Participating Practitioner, a
126 Practitioner must meet the applicable criteria set forth in the Plan's Criteria for
127 Participating Practitioners (Policy PR-010 Criteria for Participating Practitioners).
128 The Credentialing Committee may, in its discretion, waive any of the criteria if it
129 determines that to do so would be in the best interests of the Plan or its Covered
130 persons. Practitioners are not published on the Sanford Health Plan directory until
131 after Credentialing Committee approval.

132
133 (b) For Iowa physicians: Insurance Division's Omnibus Bill, House File 2555. The
134 bill has been signed by the Governor. Section 28 adds a new subsection 514F.6 to
135 Iowa Code chapter 514, "Utilization and Cost Control," that reads as follows: The
136 commissioner shall adopt rules to provide for the retrospective payment of clean
137 claims for covered services provided by a physician during the credentialing
138 period, once the physician is credentialed. For purposes of this section,
139 "physician" means a licensed doctor of medicine and surgery or a licensed doctor
140 of osteopathic medicine and surgery, and "credentialing period" means the time
141 period between the health insurer's receipt of a physician's application for
142 credentialing and approval of that application by the health insurer.
143 "Credentialing" means a process through which a health insurer makes a
144 determination based on criteria established by the health insurer concerning
145 whether a physician is eligible to provide health care services to an insured and to
146 receive reimbursement for the health care services provided under agreement
147 entered into between the physician and the health insurer. "Clean claim" means
148 the same as defined in section 507B.4A, subsection 2, paragraph"b."
149

150 Sanford Health Plan has a process in place to hold claims for physicians that fall
151 into this category. Once the physician has been approved, claims will be released
152 for processing.

153 (c) Obtaining Information from Hospital
154 When the Applicant is applying for or exercises clinical privileges at a
155 Participating Hospital, the Plan has the option to request the hospital to provide
156 copies of documents in the hospital's credentialing files that verify compliance by
157 the applicant with the criteria set forth above. When this information is forwarded
158 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.

PROCEDURE:

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 VP Medical Officer or Senior Director Medical Services. 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.

Process and Procedure for Application

(a) Submission of Application

Applications shall be submitted on forms prescribed by the Plan. The Application shall be submitted by the Applicant to tSanford Credentialing Services. After collecting current certificate of insurance and other information or materials deemed pertinent, the Plan shall determine the Application to be complete and credentialing process may begin.

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 unless the practitioner is physically impaired. The disability will be documented in the practitioner's credentialing file allowing the stamp signature to be accepted.

(b) Verification Procedure

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

Appropriate documentation for primary source verifications:

(a) All verifications will be printed and placed in the practitioners credentialing file or the verifications will be scanned into the credentialing system. The verifications are also entered into the credentialing system and which identifies the person that verified the document and the date. Our system will automatically print an

206 electronic signature for some of the primary source verifications
207 from websites which will include the staff member verifying the
208 information, date, source and report date, if applicable.
209 (b) Oral or verbal verification – the Credentialing Specialist who
210 verified the credentials must date, sign or initial and note the
211 credentialed verified if it is not in the electronic system. Written
212 verification – the date of the letter or report is used to assess
213 timeliness of the verification. The Credentialing Specialist will
214 initial and date stamp the receipt of the verification if it is not in
215 the electronic system.
216 (c) Internet or electronic verification – The date generated by the source
217 when the information is retrieved is the verification date. If the
218 source does not list a date, the date will be the person verifying the
219 information. The Credentialing Specialist who verifies the
220 credentials must sign/initial and date the verification if the
221 information is not generated by electronic source or automated by
222 the computer system and if it is not in the electronic system.
223 (d) Pencils will not be used for credentialing documentation.
224
225
226 The information supplied by the applicant shall be primary source verified, placed
227 in the applicant's file either paper or electronic and documented in the
228 credentialing system as follows:
229 1. Valid, current state licensure in each state that the practitioner
230 provides care for the Plan's members. The state licensure is
231 primary source verified directly with the state licensure board by
232 letter, phone, fax or via state web site. The Credentialing
233 Specialist will verify whether there are state sanctions, restrictions
234 or limitations on the practitioner's scope of practice with the
235 licensing agency.
236 2. Current Federal DEA in each state in which the practitioner
237 practices in regards to Plan's members or a signed Sanford Health
238 Plan waiver indicating why the practitioner does not need a state
239 specific Federal DEA. The Federal DEA will be primary source
240 verified through NTIS, phone verification or inspection of current
241 copy. CSR certificate will be verified via current copy, phone
242 verification, email or website of the CSR certificate, if applicable,
243 in each state the practitioner practices in regards to the Plan's
244 members. Please refer to a copy of the Sanford Health Plan
245 Waiver for Controlled Substances/Federal DEA/State Controlled
246 Substances.
247 A practitioner that has a pending DEA or CSR, may be approved if
248 the practitioner submits a letter stating what practitioner will write
249 all prescriptions requiring a DEA or CSR number until the
250 practitioner has a valid DEA or CSR certificate.
251 3. Medical/professional school education, residency training or board

252 certification verified depending on the highest level achieved. The
253 Plan verifies the highest level achieved. Medical/professional
254 school and residencies will be primary source verified by letter,
255 phone or fax directly with the institution and/or by the AOA
256 (American Board of Osteopathic Association) or the AMA
257 (American Medical Association). Education/training beyond
258 residency will be verified if the applicant is practicing in that
259 specialty unless they are board certified. If they are board certified
260 in that specialty, we will verify the board certification. The Plan
261 may obtain at least annually, written confirmation from the state
262 licensing agency, specialty board or registry stating the entity
263 performs primary source verification of practitioner education and
264 training.
265 4. Board certification status will be primary source verified by the
266 American Board of Medical Specialties or an official ABMS
267 display agent via website, letter, fax, or telephone . Board
268 certification can also be verified by the AMA, AOA or
269 confirmation from the appropriate specialty board by letter, phone,
270 website or fax. Expiration date must be present with the
271 verification and noted in the credentialing system. If an expiration
272 date is not provided by the Board, the Plan will verify and
273 document that the board certification is current within 180 days of
274 the credentialing approval date. Board certification will be verified
275 at recredentialing including lifetime certifications. Board
276 certification is not required by the Plan.
277 5. ECFMG (if applicable) primary source verified directly with the
278 Educational Commission for Foreign Medical Graduates by letter,
279 fax or website electronic verification.
280 6. Hospital affiliations and the primary admitting facility will be
281 gathered from the credentialing application provided by the
282 practitioner as applicable.
283 7. Work History
284 i. For Initial Credentialing a minimum of five-year relevant work
285 history must be provided on the application. Any time gaps
286 exceeding six months will require an explanation via letter, phone
287 or fax. Any gaps over a year must be explained by the practitioner
288 in writing. All work history must have a month and year
289 beginning date and month and year end date. If the practitioner
290 has practiced fewer than five years the relevant work history
291 begins at the time of initial licensure. A time gap report is ran out
292 of the credentialing system to verify any time gaps. The
293 credentialing specialists will initial and date the report.
294 ii. For Recredentialing a work history (from previous approval
295 date) to verify any gaps in history exceeding six months will
296 require an explanation through letter, phone or fax. Any gaps
297 exceeding one year will need to be verified in writing by the

practitioner.

8. 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 obtained.
9. Present 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. 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.
10. Medicare/Medicaid sanctions primary source verified through report from National Practitioners Data Bank and EPStaff Check. The EPStaff Check contract verifies the following databases:
    - Iowa Medicaid Provider Sanctions List
    - Minnesota Excluded Providers
    - North Dakota Medicaid
    - 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 Medicaid Sanctioned Providers
    - Montana Medicaid Exclusions (Refer to Policy PR-24 Monitoring Policy)
11. Sanctions, limitations, restrictions on licensure primary source verified with state medical board or other licensing agency, as appropriate, Federation of State Medical Boards or the NPDB. All state licenses will be queried for the recent five year look back period. (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.
- Federation of State Medical Boards.
- State licensure or certification board
- Medicare Opt Out websites for practitioners practicing in South Dakota, Minnesota, North Dakota and Iowa

- Social Security Death Master File
- National Plan and Provider Enumeration System (NPI Registry)

12. Once all verifications have been received, the file is reviewed by a Credentialing staff member to ensure the verifications are within the appropriate timeframe, to review the file against the established criteria to determine if it is a clean or non clean file and to verify the file is complete.

(c) <u>Credentialing Committee</u>

(1) The Credentialing Committee is facilitated by the VP Medical Officer or the Senior Director Medical Services. The committee is made up of participating practitioners with a variety of different specialties. (refer to Policy PR-18 Credentialing Committee Policy) During the meetings, only the Committee Practitioner Members discuss and vote on the participation status of each "unclean" practitioner. The 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, through verifications 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. 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.

(2) During the Recredentialing cycle, the Committee shall review those qualities above as well as additional factors including, but not limited to Quality complaints and adverse events. The VP Medical Officer or Senior Director Medical Serviceswill review information available from the Quality improvement program relative to the Participating Practitioner, when available and will make a recommendation.

(d) <u>Decision Process</u>

(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 VP Medical Officer or Senior Director Medical Services. The Committee receives a report of "clean" and all "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 based off the credentialing criteria found in policy PR-010. As for an "unclean" file, information was obtained that the Committee would need

390 to review as the file did not meet the established criteria or issues were
391 discovered. (See policy PR-10 for specific criteria) Examples include but
392 not limited to: malpractice claims, peer reference unsatisfactory, OIG or
393 NPDB with information on the report or health status that may limit or
394 enable a practitioner to perform his/her specific duties. The VP Medical
395 Officer or Senior Director Medical Services has the authority to determine
396 that a file is "clean" and may sign off on it as complete, clean and
397 approved which is considered the committee review date. The VP
398 Medical Officer or Senior Director Medical Services may use a
399 handwritten signature or handwritten initials as documentation of sign-off;
400 an electronic signature will not be accepted.
401 (2) If the recommendation of the Credentialing Committee is delayed longer than
402 180 days, the VP Medical Officer or Senior Director Medical Services
403 shall send a letter to the Applicant, VP Medical Officer. If for any reason
404 a primary source verification becomes older than 180 days, re-verification
405 will be completed.
406 (3) If the Credentialing Committee recommends that an Application be denied
407 for stated reasons based on the clinical competence or professional
408 conduct of the Applicant, the Applicant may request a hearing pursuant to
409 the Plan's Hearing Procedures, and all subsequent actions shall be
410 governed by those procedures. Said procedures shall comply with the
411 minimum due process requirements set forth in the Federal Health Care
412 Quality Improvement Act of 1986. (Refer to Policy PR-15 Provider
413 Appeal Rights)
414 (4) The Credentialing Committee may decide to pend an Application to ask the
415 practitioner for additional information. In this case, the VP Medical
416 Officer or Senior Director Medical Services or designated credentialing
417 staff member will send a letter to the Applicant requesting the additional
418 information. The Applicant will be given 30 days to supply additional
419 information. The new information will be included in the original file
420 which is brought back to the next Credentialing Committee meeting.
421 (5) The decisions on appointment made by the Plan's Credentialing Committee
422 are approved by the Sanford Health Plan Board of Director's.
423 (6) The Sanford Health Plan does not conduct Provisional Credentialing.
424 (7) The Sanford Health Plan Provider Relations Department will send
425 a letter notifying the practitioner of his/her credentialing/recredentialing
426 decision within ten (10) business days of the Committee's decision. In
427 case of a denial, the VP Medical Officer or Senior Director Medical
428 Services will send the letter.
429
430 Section 6. Recredentialing Cycle Length
431 (a) Each Participating Practitioner shall be responsible for providing the Plan with
432 updated information at least every three years pertaining to his or her credentials.
433 Practitioners must be recredentialed at least within 36 months from previous
434 credentialing date.
435

(b) Sanford employed practitioners: 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.

Section 7. Procedure for Clean File Review

(a) Sanford Credentialing Services will run a weekly report of clean files that are at Committee status. The designated person will review all profiles to confirm each file has meet the Plan's clean criteria, is complete and ready for the VP Medical Officer or Senior Director Medical Services to review. The VP Medical Officer or Senior Director Medical Services will review and if approves will sign off on the full clean list. Minutes will be created, listing those practitioners approved.

Section 8. 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 available on our website. The Provider Appeal Rights Policy would be sent along with the termination letter to the practitioner.

Section 9. 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 Director of Provider Relations 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 Director of Provider Relationsof 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

482 may be necessary, and recommend such corrective action (if any) as it deems
483 appropriate to the Board.
484 (c) The Board shall take such action, as it deems appropriate upon receipt of the
485 recommendation of the Committee. The Practitioner shall be notified of the
486 disposition of the grievance and any corrective action taken with respect to the
487 grievance. The decision of the Board shall be final and binding on both the Plan
488 and the Practitioner.
489
490 Section 10: Delegated Credentialing
491 The Plan will in certain circumstances enter into the process of delegating
492 the credentialing and recredentialing responsibilities to large practitioner groups
493 and/or rental networks. In such cases, the Plan follows the NCQA guidelines
494 along with any relevant State regulations, including regulations issued by the
495 Board of Registration of Medicine at 243 CMR 3.13 in regards to delegation. A
496 complete pre assessment and file review of the organization would be completed
497 and reviewed against the NCQA standards along with any relevant State
498 regulations as specified above. If the organization meets the necessary standards
499 a delegation agreement would be offered. The agreement would indicate what
500 standards that would be delegated which may include all NCQA standards CR 1 –
501 8 which would be based off of those elements passing the pre-assessment review.
502 The Plan retains the responsibility for ensuring that all credentialing functions are
503 being performed according to the Plan's expectations and NCQA standards. For
504 further explanation on Delegated Credentialing refer to Policy PR-25 Delegated
505 Credentialing Process. Sanford Health Plan does currently have delegated
506 agreements in place.
507 Section 11: Practitioner Termination and Reinstatement
508 If the Plan should terminate a practitioner and then later want to reinstate a
509 practitioner the practitioner will have to go through initial credentialing if the
510 lapse was more than 30 calendar days.
511
512 Section 12: File Retention
513 Sanford Credentialing Services will keep all initial credentialing and
514 recredentialing files for each practitioner credentialed. If a practitioner should
515 leave the Plan's network the whole credentialing file will be scanned or sent off
516 site to Record Keepers. If scanned, the paper file will be shredded appropriately.
517
518 **FLOW DIAGRAM (Attachment A)**
519
520 **WORK INSTRUCTIONS:**
521
522 **DEFINITIONS:**
523 (a) "Applicant" means a practitioner who has submitted an initial application to
524 participate as a Participating Practitioner with the Plan or a Recredentialing
525 Application with the Plan.
526 (b) "Application" means an initial or recredentialing application.
527 (c) "VP Medical Officer" or "Senior Director Medical Services" means the
528 physician(s) directly responsible for facilitating the credentialing process and

529 during the committee meetings. The VP Medical Officer or Senior Director
530 Medical Services has the authority to sign off on "clean" files. The VP Medical
531 Officer or Senior Director Medical Services submits a report and verbal
532 recommendation to the Board in circumstances of non-renewals.
533 (d) "Covered Services" means those medically necessary health services to which
534 Covered persons are entitled under a health agreement when provided or
535 authorized in accordance with Plan Policy.
536 (e) "Member" means any individual who is covered by the Plan.
537 (f) "Health Care Services" mean any procedures, diagnoses, facilities or supplies
538 furnished to a human being for the treatment of illness or injury.
539 (g) "Health Contract" means a contract whereby the Plan agrees to provide
540 comprehensive health services to Covered persons.
541 (h) "Participating." All Practitioners are either "Participating" or "Non-
542 Participating."
543 (i) "Participating" means that the Practitioner or someone on the
544 Practitioner's behalf has signed a contract with the Plan to provide
545 services to Covered persons and has been approved by the Credentialing
546 Committee.
547 (ii) "Non-Participating" means that the Practitioner has not signed such a
548 contract with the Plan.
549 (i) "Physician" means an individual licensed to practice medicine or osteopathy in
550 any state where the Plan is legally authorized to operate.
551 (j) "Practitioner" means any individual or group of individuals licensed to practice
552 the healing arts in any state where the Plan is legally authorized to operate. This
553 includes physicians, podiatrists, psychologists, chiropractors, optometrists, speech
554 pathologists, occupational therapists, audiologists, physical therapists. MSWs,
555 Ed.Ds, physician assistants, nurse practitioners, nurse midwives, nurse
556 anesthetists, dentists.
557 (k) "Practitioner Group" shall mean a partnership, professional corporation, nonprofit
558 corporation or other entity that employs or contracts with Practitioners and in turn
559 enters into a contract with the Plan to provide Covered Services to Covered
560 persons.
561 (l) "Primary Care Physician" means a family practice physician, internist,
562 pediatrician, or obstetrician/gynecologist who is a Participating Practitioner and
563 has chosen to be designated as a Primary Care Physician as indicated in the
564 Provider Directory and who may be responsible for providing, prescribing,
565 directing and/or authorizing all care and treatment required by Covered persons.
566 (m) "Provider" hospital or any other institution that furnishes health care services and
567 is licensed or otherwise authorized to render such services in any state where the
568 Plan is legally authorized to operate.
569 (n) "The Plan" shall mean Sanford Health Plan.
570
571 **REFERENCES**
572 NCQA Standard QI 3, CR 1, CR 2,CR 3, CR 4
573 Medicaid Expansion 42 CFR Standards 438.214
574 Medicaid Expansion 42 CFR 438.214 Provider Selection
575 Medicaid Expansion 42 CFR 438.230 Subcontractual Relationships and Delegation

576 Minnesota Administrative Rule 4685.1110 Subp. 11 Provider Selection and Credentialing
577
578 **POLICY IS SUBJECT TO THE FOLLOWING AUDITS:**
579 - NCQA
580 - NDME-External Quality Review Organization (EQRO)
581 - Minnesota Department of Health
582 - CMS for Marketplace

583 **EXTERNAL PROGRAM REVIEWER:** N/A
584 **PUBLICATION or WEB PRESENTATION:**
585 Published in Manual and Portal