Sanford Health Plan	PR-020-Organizational Provider Credentialing Policy
CURRENT REVIEW: 11/01/17	**REVISION:** 11/01/17
WRITTEN BY: Manager, Professional Practice	**APPROVED BY:** Sanford Health Plan Credentialing Committee

SCOPE:	ALL
AFFECTED DEPARTMENT(s):	Provider Relations
IMPLEMENTED: 01/01/98	**ISSUED:** 01/01/98
REVIEW COORDINATOR:	Manager, Provider Relations
NCQA REVIEW:	**Yes - Direct**
Provider Manual Publication	**Yes**

REPLACES: Conversion from PR-20 Institutional Provider Credentialing Policy

VENDORS: N/A

RELATED POLICY(IES) –

- **Sanford Health Plan**
  - N/A
- **ENTERPRISE**
  - N/A

APPENDICES AND ATTACHMENTS –

- **Sanford Health Plan**

PURPOSE: N/A

POLICY: Organizational Provider Credentialing Policy

PROCEDURE:

1. Organizational providers that wish to contract with the Plan must first complete a Facility/Agency Credentialing Application and return it with all supporting documentation to the Plan.

2. Once the application is returned, the Plan shall verify that the organizational provider has met and currently meets all applicable state and federal licensing and regulatory requirements and is in good standing with those regulatory bodies by receiving a current copy of the facility license or directly from the applicable state or federal agency. In addition, the Plan shall identify those organizational providers that have been approved by a recognized accrediting body, and are in good standing with those accrediting and regulatory bodies by receiving a copy of the current accreditation or directly from the applicable accrediting body. Accrediting bodies include, but are not limited to, The Joint Commission (TJC), American Osteopathic Association (AOA), Accreditation Association for Ambulatory Health Care (AAAHC), Commission on Accreditation of Rehabilitation Facilities (CARF), and Continuing Care Accreditation Commission

(CCAC). Hospitals shall not be required to be accredited by The Joint Commission. Sanford Health Plan will also query OIG/Mediregs and SAM for each organizational provider to verify there are no sanctions.

3. If the organizational provider has not been accredited, the Plan shall substitute a CMS or state review in lieu of the required site visit. The Plan will review the CMS or State survey and follow up with the organizational provider to insure any deficiencies have been corrected. The organizational provider will not be approved by the Plan's Committee until all deficiencies have been corrected and approved by the CMS or State Reviewers. The Plan may accept a copy of the CMS or State agency approval letter that states the organizational provider was reviewed and passes inspection.

4. An on-site quality assessment review will be completed if an organizational provider does not have a completed CMS or State review and a site visit would be conducted every three years for a non CMS or State reviewed organization provider. The Sanford Health Plan Provider Relations department will conduct the onsite visit assessing the organizational provider with the Sanford Health Plan Site Visit tool. A review of credentialed practitioners will be conducted during the site visit. Exceptions to the onsite quality assessment review include: unaccredited organizational providers that are classified by the U.S. Census Bureau as rural healthcare facilities.

5. The organizational provider must furnish 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.

6. The organizational provider shall be responsible for providing the information to satisfy the process and to resolve any difficulties in verifying or obtaining information.

7. When all information provided on the application form has been verified, all requested documents have been submitted and the CMS or state survey have been reviewed or (if necessary) an on-site quality assessment completed, the application and all supporting documentation shall be reviewed against Sanford Health Plan requirements. The Credentialing Committee decision may include the:
   a. approval of the application;
   b. denial of the application; or
   c. return of the application for clarification or further investigation of any aspect of the application that is unclear or of concern.

a. The Committee decision will be made within 180 days of the collected documents. The VP Medical Officer or Senior Director Medical Services may approve and sign off on organizational provider credentialing files that are complete and without identified concerns.

8. At least every three years, the Plan shall confirm that any organizational provider with which it contracts continues to be in good standing with the applicable state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body. An onsite visit will be conducted if an organizational provider has not been reviewed by an accrediting body or CMS/state governing body within the past three years.

9. Organizational providers shall cooperate with Sanford Health Plan's QI activities including collection of performance measurement data and participation in the Sanford Health Plan's clinical and service measure QI programs.

10. Organization providers maintain the confidentiality of Sanford Health Plan member information and records.

11. Organizational providers must allow Sanford Health Plan to use their performance data to include: data from quality improvement activities.

FLOW DIAGRAM (Attachment A): N/A

WORK INSTRUCTIONS: N/A

DEFINITIONS:

Sanford Health Plan (the "Plan") shall credential all organizational providers that wish to become participating providers in accordance with this Policy. For purposes of this Policy, organizational providers shall include, but are not limited to, hospitals, home health agencies, skilled nursing facilities and free-standing surgical centers. This policy also includes, but not limited to behavioral health facilities providing mental health or substance abuse services for inpatient, residential and ambulatory settings. The behavioral health facilities include but not limited to psychiatric hospitals and clinics, addiction disorder facilities, residential treatment centers for psychiatric and addiction disorders.

Additional institutions may be credentialed include: hospice, home infusion therapy, ambulance, ambulatory surgery center, end stage renal disease, durable medical equipment, independent lab criteria and radiology/imaging center. Sanford Health Plan will ensure each organizational provider be credentialed and approved.

With regard to the parameters that must be met for an organizational provider to contract with Sanford Health Plan, SHP adopts the standards and regulations of the appropriate CMS and/or state review for each specific type of organizational provider.

REFERENCES

- NCQA Standard QI 3, CR 7

POLICY IS SUBJECT TO THE FOLLOWING AUDITS:

- NCQA
- NDME-External Quality Review Organization (EQRO)
- Minnesota Department of Health
- CMS for Marketplace
- CMS for Medicare Supplement
- CMS for Medicare Cost

EXTERNAL PROGRAM REVIEWER: N/A

PUBLICATION or WEB PRESENTATION: Published in Portal, Referenced in Manual.