

Policy and Procedure

Title: Credentialing and Re-credentialing/HEDIS Process
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PURPOSE:

The purpose of this policy is to document the Credentialing and Re-credentialing /HEDIS Process for Assessment of Practitioner Board Certification at Group Health Cooperative of South Central Wisconsin (GHC-SCW).

POLICY:

1. In order to promote the highest quality of care for Group Health Cooperative of South Central Wisconsin (GHC-SCW) members, GHC-SCW ensures that all employed and contracted practitioners and providers meet minimum standards relative to licensure, education, and board certification, if applicable. The licensure, educational, and board certification is verified by the collection of specific credentials on a routine basis.
2. Medical practitioners requiring credentialing are defined as Medical Doctor (MDs), Doctor of Osteopathic Medicine (Dos), Oral Surgeons, Doctor of Podiatric Medicine (DPMs), Doctor of Chiropractic (DCs), Nurse Practitioners (NPs), Physician Assistants (PAs), Optometrist (ODs), Physical Therapists (PTs), Occupational Therapists (OT), Certified Nurse Midwives (CNM) and Speech/Language Therapists. Behavioral Health practitioners requiring credentialing are defined as physicians and psychiatrists (MD or DO); masters or doctorate level psychologist who are state licensed (PhD or PsyD); licensed Advanced Practice Nurse Prescribers (APNP); masters or doctorate level Licensed Clinical Social Workers (LCSW); Licensed Marriage & Family Therapists (LFMT); Licensed Professional Counselors (LPC); and licensed Clinical Substance Abuse Counselors (CSAC) who are certified to practice independently.
3. Providers are defined as Hospitals, including Behavioral Health inpatient services; Home Health agencies; Skilled Nursing facilities; Free Standing Surgical Centers and Behavioral Health Residential and Ambulatory facilities.
4. **OVERSIGHT, PRACTITIONER RIGHTS, AND CONFIDENTIALITY**

a. **OVERSIGHT AND ACCOUNTABILITY**

- 1) As part of the GHC-SCW Quality Improvement Program, GHC-SCW has adopted standards for credentialing. These standards are described in Policy Items 5a, 5b, and Procedure Item 3 of this Attachment.
- 2) The GHC-SCW Board of Directors through the Health Services Committee has delegated the responsibility of practitioner credentialing to the Medical Director. The Medical Director, in turn, delegates the credentialing process to the GHC-SCW Peer Review/Credentialing Committees. GHC-SCW's Credentialing Committee is the same body as the GHC-SCW Peer Review Committee which reviews all credentialing/re-credentialing applications with or without exceptions (malpractice, sanctions, pending claim, etc) Final approval for credentialing all practitioners is done by the Medical Director after reviewing recommendations from the Credentialing Committee and the information obtained during the credentialing process.

Review Date										
Revision Date	3/95	1/97	5/97	2/98	3/99	2/00	2/01	7/02	7/03	1/04
	1/05	1/07	2/08	1/09	12/09	2/11	1/12	2/13		

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- 3) The GHC-SCW Medical Director or the Quality Management MD Liaison chairs the Credentialing Committee which approves the credentialing & re-credentialing of the staff model MDs and DCs, all PCPs in the Department of Family Medicine and in the UW Health Clinics, direct contract psychiatrists, and all behavioral health practitioners.
- 4) GHC-SCW's Credentialing Committee makes credentialing and re-credentialing decisions based solely on the verified information provided on the practitioner's applications. GHC-SCW does not discriminate against an applicant based on race, ethnic/national identity, gender, age, sexual orientation, or types of procedures or types of patients (e.g. Medicaid) the practitioner specializes in.
- 5) GHC-SCW recognizes the need to expedite the approval of clean credential files and may approve clean credential files outside of the regularly scheduled Credentialing meetings. Clean credential files are defined as initial or re-credential files whose primary source verification elements (outlined on the GHC-SCW Initial and Re-Credentialing Checklists) are complete and without questions or concerns and the files meet the necessary requirements eligible to be approved by the GHC-SCW Credentialing Committee. Clean files may be approved by the GHC-SCW Medical Director or the Quality Management MD Liaison or designee outside of the regularly scheduled Credentialing Committee meeting. The Medical Staff Coordinator (MSC) is responsible for completing the GHC-SCW Initial and/or Re-Credentialing Checklist and will present clean files to either the Medical Director or the Quality Management MD Liaison or designee for review and approval. The Medical Director or the Quality Management MD Liaison or designee will sign and date the GHC-SCW Checklist as indication of approval. A list of the files approved outside of the regularly scheduled meeting will be presented at the next Credentialing Committee meeting.
- 6) GHC-SCW's Credentialing Committee receives and reviews the credentials of all practitioners, including those who do not meet the organization's established criteria. GHC-SCW's Medical Director or Quality Management MD Liaison monitors for nondiscriminatory credentialing and re-credentialing by reviewing every file that is denied in the credentialing process to ensure that there has been no discrimination. The Medical Director or Quality Management MD Liaison performing the review will be the one who did not chair the Credentialing Committee meeting when the application was denied. GHC-SCW's Medical Director or Quality Management MD Liaison will forward the result of their review to the Credentialing Committee, and the result of his/her review will be documented in the Credentialing Committee minutes.
- 7) In addition, all applications that are received by the MSC but are not taken to the Credentialing Committee will be reviewed by the Medical Director or Quality Management MD Liaison. The individual conducting the review for potential discrimination will be the one not involved in the processing of the application.
- 8) Annually, all Credentialing Committee members are required to sign an affirmative statement that they will make decisions in a non-discriminatory manner.
- 9) GHC-SCW prevents discrimination of credentialing and re-credentialing by maintaining a heterogeneous credentialing committee and requiring those responsible for credentialing decisions to sign a statement affirming that they do not discriminate applicants and re-applicants on the basis of race, ethnicity/national identity, age, gender, sexual orientation, disability status, type of procedures or type of patients.
- 10) Appropriate documentation for a GHC-SCW credential file must include primary source verification documentation in one of two ways:

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- a) A detailed, signed/initialed and dated checklist where the checklist contains the name of the source used, the date of the verification, the signature or initials of the credentialing professional who performed the primary source verification and the date of the report, if applicable; or
 - b) Copies of credentialing information and a checklist. GHC-SCW may use an electronic signature or unique electronic identifier of staff to document verification if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information, the date of verification, the source and the report date, if applicable.
- 11) GHC-SCW will maintain credential and re-credential files for all practitioners that are not delegated for not less than a six (6) year period to ensure the current credentialing and previous credentialing cycle are available.
 - 12) The decision making process for initial and re-credentialing of GHC-SCW practitioners and providers is achieved through the use of a standardized and objective set of criteria set forth in Policy Items 5a and 5b and Procedure Item 3 below.

b. PRACTITIONER RIGHTS

- 1) Practitioners have the right to review the information submitted in support of their credentialing applications with the exception of references, recommendations or other peer-review protected information. Should any information obtained during the credentialing and re-credentialing process vary substantially from the information provided by the practitioner, the MSC will notify the practitioners in writing within 10 days of becoming aware of the discrepancy. The practitioner has the right to correct erroneous information and is requested to respond, in writing, with additional information to support a correction. Practitioners have up to 30 days to submit written corrections to the MSC. The MSC will respond by telephone, United States Postal Service or by email to the practitioner within seven (7) calendar days of receiving the corrections.
- 2) Practitioners have the right, upon request in writing to the MSC, to be informed of the status of their credentialing or re-credentialing applications. The MSC will respond by telephone, United States Postal Service or by e-mail to the practitioner within seven (7) calendar days of the status of their credentialing or re-credentialing application.
- 3) In the event an application and attestation must be updated, only the practitioner may attest to the update, a staff member may not sign on behalf of the practitioner.
- 4) Practitioners have the right to receive notification of the above rights. GHC-SCW notifies applicants of their Practitioner Rights at the time of initial and re-application in a statement on the initial application form and in the letters that accompanies the initial and re-credentialing application.
- 5) MSC will notify practitioners in writing of credentialing decisions (decisions include acceptance, denial or if additional information is required to process the application or re-application) within 60 calendar days of the Credentialing Committee decision.

c. CONFIDENTIALITY OF INFORMATION

- 1) The information obtained in the credentialing process is confidential. Access to information obtained throughout the credentialing process will be carefully monitored and will not be released to outside parties

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without permission of the practitioner involved or by legal responsibility, including the Health Care Quality Improvement Act of 1986.

- 2) The credentialing files will only be available to GHC-SCW's Credentialing Committee, Credentialing Staff and GHC-SCW's Medical Director. Credentialing files and minutes will be maintained in a locked, secure location. The individual practitioner may read information contained in his/her file upon request of a scheduled appointment. The file review will take place in the presence of GHC-SCW MSC.

5. **CREDENTIALING OF STAFF (EMPLOYED) PHYSICIANS, DANE COUNTY PCPs, BEHAVIORAL HEALTH PRACTITIONERS, CHIROPRACTORS**

- a. The credentialing verification activities for these practitioners are performed by GHC-SCW.

b. INITIAL CREDENTIALING (See Checklist)

- 1) The following is a listing of the items that must be present and will be verified. The criteria and the source of verification is listed below:
- 2) GHC-SCW requires that the eligible practitioner holds a **valid, current, unrestricted license** in the State of Wisconsin. Primary source verification is completed by receipt of written verification directly from the appropriate state licensing agency or verification via the WI State licensing web page at <http://online.drl.wi.gov/LicenseLookup/LicenseLookup.aspx> is acceptable.
- 3) GHC-SCW requires that the eligible practitioner, if applicable, holds a valid, **current DEA in the State of Wisconsin**. Primary source verification of **DEA** is completed by query of the Drug Enforcement Administration (DEA) Registration File from NTIS (CD ROM received quarterly) OR by the MSC viewing a photocopy of the DEA. The DEA must be valid in the state where the practitioner provides care to GHC-SCW members. If practitioner type is eligible for a DEA (i.e. MD, DO, DPM, APNP, PA-C or OD) but does not have a DEA, the practitioner must explain why no DEA AND provide explanation of arrangements for his/her patients who need prescriptions requiring DEA certification. If a practitioner's DEA is pending, a written plan will be documented in the provider's credential file, which allows a practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner until the practitioner has a valid DEA.
- 4) GHC-SCW's requirement for completion of education is based on the practitioner type. Primary verification of **highest level of education is outlined by the following provider types:**
 - a) ***MD and DO***
 - (1) Board Certification is preferred, but not required by GHC-SCW. If the physician is board certified, primary source verification of board certification satisfies the verification of highest level of education.
 - (2) For MDs, GHC-SCW will verify board certification via the American Board of Medical Specialties (ABMS) thru CeriFACTS on line (password protected). GHC-SCW only recognizes those board associated with the ABMS. For those ABMS Boards who do not provide an expiration date, GHC-SCW will verify the board certification within 180 days of the initial or re-credentialing decision date.
 - (3) For DOs, GHC-SCW will verify board certification via the American Osteopathic Association (AOA)

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Board Certification. GHC-SCW will contact the Board, in writing, online, or by phone for primary source verification.

- (4) For practitioners who are not board certified, GHC-SCW requires the physician to complete a residency program. Acceptable residency programs include only those residency programs that have been accredited by the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada. GHC-SCW will contact the residency program in writing or by phone for primary source verification OR verification of licensure from the State of Wisconsin Department of Safety & Professional Services website satisfies the verification of highest level of education.
- (5) For practitioners who did not complete a residency, primary source verification is completed by contacting the medical school

b) ***DPM***

- (1) Board Certification is preferred, but not required by GHC-SCW. If the physician is board certified, primary verification of board certification satisfies the verification of highest level of education. Verify via the American Board of Podiatric Surgery Board Certification. GHC-SCW MSC will contact the Board, in writing for primary source verification
- (2) If the physician is not board certified, GHC-SCW requires the physician to complete his/her education from a podiatry college. Primary source verification is completed by contacting the Podiatry school OR verification of licensure from the State of Wisconsin Department of Safety & Professional Services website satisfies the verification of highest level of education.

c) ***DCs***

- (1) GHC-SCW requires physician to complete his/her education from a Chiropractic College. Primary source verification is completed by contacting the Chiropractic College OR verification of licensure from the State of Wisconsin Department of Safety & Professional Services website satisfies the verification of highest level of education.

d) **NP, PA-C, OD, PT, Speech and Language Therapists and other Credentialed Providers**

- (1) GHC-SCW's requirement for practitioner education is based on practitioner type.
- (2) Professional School –or-
- (3) Primary Source verification is completed by confirmation from the WI Licensing Department, which performs primary source verification of education for all licensed practitioner types.
- (4) If the healthcare professional is board certified, primary source verification from the appropriate specialty board is completed.

e) **Oral Surgeon**

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- (1) Board certificated is preferred, but not required by GHC-SCW. If the provider is board certified, primary verification of board certification is obtained from the appropriate specialty board if the board performs primary source verification of graduation from a CODA accredited training program. At least annually, the organization must obtain written confirmation from the specialty board that it performs primary-source verification of graduation from a CODA accredited training program.
 - (2) For providers not board certified, verification of completion of a residency training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). GHC-SCW will contact the residency program in writing or by phone for primary source verification OR verification of licensure from the State of Wisconsin Department of Safety & Professional Services website satisfies the verification of highest level of education.
- 5) Annually, MSC obtains written confirmation from the WI Licensing agency that it performs primary source verification of education.
- 6) GHC-SCW requires the applicant to complete an application and attest to its correctness and completeness. The following questions must be addressed:
 - a) Physical and mental health status and reasons for inability to perform essential functions of the position, with or without accommodations
 - b) Chemical dependency or lack of illegal drug use
 - c) History of loss of license and/or felony convictions
 - d) History of loss or limitation of clinical privileges or disciplinary action
 - e) Work history for the last five years in mm/yy to mm/yy format, and any gaps six (6) months or greater must be explained, in writing.
 - f) Malpractice history
 - g) Current coverage for malpractice insurance, including dates and amounts, even if the coverage amount is \$0.
 - h) Signature attesting to the correctness and completeness of the application
- 7) GHC-SCW requires a National Practitioner Data Bank (NPDB) report to be run on all applicants for verification of malpractice history and initial sanction information. The Committee will review all adverse NPDB reports. The MSC will obtain a query of the NPDB at <https://www.npdb-hipdb.com/login.html>.
- 8) The MSC will enroll all practitioners in the Proactive Disclosure Service (PDS) for NPDB and HIPDB. All enrolled practitioners are renewed annually.
- 9) If employment is terminated, the enrollment is canceled 30 days after termination date.
- 10) Any notifications from the PDS are sent via e-mail to the MSC including malpractice claims, Office of the Inspector General sanctions, and Department of Regulation and Licensing orders

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- 11) Review of Medicare/Medicaid sanctions through the NPDB-HIPDB
 - 12) Review of the Disciplinary Actions by the Medical Examining Board through the NPDB-HIPDB for MD, DO, Oral Surgeons, non-physician, and behavioral health care professional.
 - c. For Chiropractors, GHC-SCW requires a query of the disciplinary actions from the National Practitioner Data Bank. The Committee will review all adverse NPDB-HIPDB reports. The MSC will obtain the query.
 - d. For Podiatrists, GHC-SCW requires a query of the disciplinary actions through the **State Board of Podiatric Examiners, The Federation of Podiatric Medical Boards**, or the National Practitioner Data Bank. The Committee will review all adverse reports. The MSC will obtain the query.
 - e. Verification and completion of all of the above must be within 180 days prior to the date of the initial credentialing decision.
 - f. The Credentialing Committee reviews the application and credentialing documents and makes recommendations to the Medical Director. A practitioner from the specialty of a practitioner being credentialed participates on the Credentialing Committee.
 - g. Credentialing process is completed prior to a practitioner providing services to GHC-SCW members.
 - h. If GHC-SCW terminates a practitioner and later wishes to reinstate the practitioner, GHC-SCW will credential and re-verify credentialing requirements, if the break in service is 30 days or more. GHC-SCW's Credentialing Committee will review all credentials and make a final determination prior to the practitioner's reinstatement.
6. **RE-CREDENTIALING (See Checklist)**
- a. GHC-SCW employed physicians; Dane County PCPs, Oral Surgeons, NPs, PA-Cs, ODs, PTs, OTs, Speech and Language Therapists, behavioral health practitioners, DCs and other credentialed providers are re-credentialed every three years.
 - b. The following is a listing of the items that must be present and will be verified. The criteria and the source of verification is listed below:
 - 1) GHC-SCW requires that the eligible practitioner holds a **valid, current, unrestricted** license in the State of Wisconsin. Primary source verification by receipt of written verification directly from the appropriate state licensing agency or verification via the WI State licensing web page:<http://online.drl.wi.gov/LicenseLookup/LicenseLookup.aspx>.
 - 2) GHC-SCW requires that the eligible practitioner, if applicable, holds a valid, **current DEA in the State of Wisconsin**. Primary source verification of **DEA** is completed by query of the Drug Enforcement Administration (DEA) Registration File from NTIS (CD ROM received quarterly) OR by the MSC viewing a photocopy of the DEA. The DEA must be valid in the state where the practitioner provides care to GHC-SCW members. If practitioner type is eligible for a DEA (i.e. MD, DO, DPM, APNP, PA-C or OD) but does not have a DEA, the practitioner must explain why no DEA AND provide explanation of arrangements for his/her patients who need prescriptions requiring DEA certification. If a practitioner's DEA is pending, a written plan will be documented in the provider's credential file, which allows a practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner until the practitioner has a valid DEA.

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- 3) GHC-SCW does not require board certification; however if a re-applicant is board certified, GHC-SCW must verify the board certification. Verify via the American Board of Medical Specialties (ABMS) thru CeriFACTS on line (password protected). GHC-SCW only recognizes those board associated with the ABMS or the AOA. For those ABMS Boards who do not provide an expiration date, GHC-SCW will verify the board certification within 180 days of the initial or re-credentialing decision date.
- 4) GHC-SCW requires continuous monitoring of adverse events through the NPDB/HIPDB and this is maintained through the PDS.
- 5) The MSC will maintain continuous enrollment of all practitioners in the Proactive Disclosure Service (PDS) for NPDB and HPDB.
- 6) All enrolled practitioners are renewed annually.
- 7) If employment is terminated, the enrollment is canceled 30 days after termination date.
- 8) Any notifications from the PDS are sent via e-mail to the MSC including malpractice claims, Office of the Inspector General sanctions, and Department of Regulation and Licensing orders.
- 9) Review of Medicare/Medicaid sanctions through the NPDB-HIPDB/PDS
- 10) Review of the Disciplinary Actions by the Medical Examining Board through the NPDB-HIPDB for MD, DO, Oral Surgeons, non-physician, and behavioral health care professionals
- 11) At the time of re-credentialing, GHC-SCW requires re-applicants to submit a current, signed attestation by the applicant regarding:
 - a) Physical and mental health status and reasons for inability to perform essential functions of the position, with or without accommodations
 - b) Chemical dependency or lack of illegal drug
 - c) History of loss of licensure since last appointment
 - d) Any felony convictions since last appointment
 - e) History of loss or limitation of clinical privileges or disciplinary activity since last appointment
 - f) Current coverage for malpractice insurance, including dates and amounts, even if the coverage amount is \$0.
 - g) Signature attesting to the correctness and completeness of the statement
- 12) GHC-SCW requires a monthly review of the Disciplinary Actions by the State of Wisconsin Medical Examining Board. The MSC queries the report monthly and presents the report to the Committee.
- 13) GHC-SCW reviews all Quality of Care and Service complaints for any practitioner being re-credentialed.

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- 14) Verification and completion of all of the above must be within 180 days prior to the date of the re-credentialing decision.
- 15) Review of all of the above information by the Credentialing Committee with re-credentialing recommendations to the Medical Director.
- 16) If GHC-SCW terminates a practitioner and later wishes to reinstate the practitioner, GHC-SCW will credential and re-verify credentialing requirements, if the break in service is 30 days or more. GHC-SCW's Credentialing Committee will review all credentials and make a final determination prior to the practitioner's reinstatement.

7. DELEGATED CREDENTIALING OF PHYSICIANS AND OTHER PRACTITIONERS AT HOSPITALS OR OTHER ENTITIES

- a. GHC-SCW considers delegating to another organization only after performing a pre-delegation audit, which ensures the delegate candidate is compliant with GHC-SCW's credentialing and re-credentialing policies described in this document. The available elements for delegation are described in Procedure Items 1 and 2 below. It is the Medical Director's responsibility to determine if the delegated entities meet the standards established by Group Health Cooperative of South Central Wisconsin. The delegation agreement must be in place before delegated activities are performed.
- b. Upon successful completion of a pre-delegation audit, GHC-SCW prepares a written delegation agreement which includes the following elements:
 - 1) The delegation document is mutually agreed upon
 - 2) The delegation document describes the responsibilities of GHC-SCW and the delegated entity
 - 3) The delegation document describes the delegated activities (as described in Procedure Items 1 and 2 below).
 - 4) The delegation document describes the reporting process, which includes at least semiannual reporting from the delegated entity. GHC-SCW prefers monthly reports, but requires at least semiannual reports.
 - 5) The delegation document describes the process by which GHC-SCW annually performs an evaluation of the delegated entity's performance
 - 6) The delegation document describes remedies to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.
 - 7) The delegation agreement includes the use of protected health information (PHI) by the delegated entity and the following PHI provisions:
 - a) A list of the allowed uses of PHI
 - b) A description of delegate safeguards to protect the information from inappropriate use or further disclosure
 - c) A stipulation that the delegate will ensure that sub delegates have similar safeguards

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- d) A stipulation that the delegate will provide individuals with access to their PHI
 - e) A stipulation that the delegate will inform the organization if inappropriate uses of the information occur
 - f) A stipulation that the delegate will ensure that PHI is returned, destroyed or protected if the delegation agreement ends
- 8) Credentialing activity is delegated to University of Wisconsin Medical Foundation (UWMF) and to Dean Health Plan for practitioners not employed by GHC-SCW who have privileges at area hospitals or are credentialed by Dean Health Plan.
- 9) GHC-SCW retains the right to approve, suspend and terminate individual practitioners, providers and sites for any delegated practitioner, provider and site.
- 10) GHC-SCW MSC performs annual reviews of credentialing policies and files at the delegated entities. GHC-SCW uses the current NCQA credentialing and re-credentialing Data Collection Tools. GHC-SCW is using NCQA's 8/30 methodology to review delegate files.

8. INITIAL CREDENTIALING by DELEGATED ENTITY

a. ELEMENTS PERFORMED BY DELEGATED ENTITY:

- 1) Primary source verification of a valid State of Wisconsin license
- 2) Primary source verification of a **current DEA**. The DEA must be valid in the state where the practitioner provides care to GHC-SCW members. If practitioner type is eligible for a DEA (i.e. MD, DO, DPM, APNP, PA-C or OD) but does not have a DEA, the practitioner must explain why no DEA AND provide explanation of arrangements for his/her patients who need prescriptions requiring DEA certification.
- 3) Primary source verification of the highest level of education (board certification satisfies residency or professional school) will be completed. For practitioners who are not board certified, primary source verification is completed by contacting the residency-training program. Acceptable residency programs include only those residency programs that have been accredited by the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.
- 4) Review of a completed application, including the following:
 - a) Physical and mental health status and reasons for inability to perform essential functions of the position, with or without accommodations
 - b) Alcohol or chemical dependency and lack of current illegal drug use
 - c) History of loss of license
 - d) History of any felony convictions
 - e) History of loss or limitation of clinical privileges or disciplinary action

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- f) Work history for the last five years in mm/yy to mm/yy format, and any gaps six (6) months or greater must be explained in writing
 - g) Malpractice history
 - h) Current coverage for malpractice insurance, including dates and amounts, even if the coverage amount is \$0.
 - i) Signature attesting to the correctness and completeness of the application
- 5) National Practitioner Data Bank (NPDB-HIPDB) inquiry, to include
- a) Professional liability claims history
 - b) Medicare/Medicaid sanctions
 - c) Disciplinary Actions by the Medical Examining Board
- 6) Verification and completion of all of the above must be within 180 days prior to the date of the initial credentialing decision.
- 7) The Credentialing Committee of the delegate reviews the application and credentialing documents, and makes credentialing decisions. A practitioner from the specialty of a practitioner being credentialed participates on the Credentialing Committee.
- 8) Credentialing process completed prior to practitioner providing services to GHC-SCW members.
- 9) Delegates provide to GHC-SCW a monthly report, which includes lists of credentialed practitioners, analysis of data, and committee meeting minutes.
- 10) If a delegate terminates a practitioner and later wishes to reinstate the practitioner, the delegate will credential and re-verify credentialing requirements, if the break in service is 30 days or more. The delegate's Credentialing Committee will review all credentials and make a final determination prior to the practitioner's reinstatement.
- b. ACTIVITIES PERFORMED BY GHC-SCW (in relation to delegated contracts)**
- 1) GHC-SCW performs annual site visit audits at each delegated entity.
 - 2) Review of credentialing policies and practitioner files at each delegated entity, to assure compliance with GHC-SCW credentialing requirements. GHC-SCW uses NCQA's 8/30 methodology to review delegate files.
 - 3) Evaluation of the file review by the GHC-SCW Medical Director or Quality Management MD Liaison . If any deficiencies are noted, a recommendation for an action plan will be sent. Credentialing Staff send the Audit Report to the delegate and, within 30 days, conduct follow-up with the delegate as indicated in the corrective action plan.

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- 4) Credentialing Staff conduct re-evaluations of the delegate's performance annually or more frequently if indicated in a corrective action plan.

9. RE-CREDENTIALING by DELEGATED ENTITY

ELEMENTS PERFORMED BY DELEGATED ENTITY

- a. Primary source verification of valid State of Wisconsin license
- b. Primary source verification of a **current DEA**. The DEA must be valid in the state where the practitioner provides care to GHC-SCW members. If practitioner type is eligible for a DEA (i.e. MD, DO, DPM, APNP, PA-C or OD) but does not have a DEA, the practitioner must explain why no DEA AND provide explanation of arrangements for his/her patients who need prescriptions requiring DEA certification.
- c. Primary source verification of the highest level of education (board certification satisfies residency or professional school) will be completed. For practitioners who are not board certified, primary source verification is completed by contacting the residency-training program. Acceptable residency programs include only those residency programs that have been accredited by the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.
- d. National Practitioner Data Bank inquiry, to include:
 - 1) Professional liability claim history
 - 2) Review of Medicare/Medicaid sanctions
 - 3) Disciplinary Actions by the Medical Examining Board
- e. Current, signed attestation by the applicant regarding:
 - 1) Physical and mental health status and reasons for inability to perform essential functions of the position, with or without accommodations
 - 2) Alcohol or Chemical dependency and lack of current illegal drug use
 - 3) History of loss of licensure
 - 4) History of any felony convictions
 - 5) History of loss or limitation of clinical privileges or disciplinary activity
 - 6) Current coverage for malpractice insurance, including dates and amounts, even if coverage amount is \$0.
 - 7) Signature attesting to the correctness and completeness of the statement
 - 8) Monthly review of member complaints by GHC-SCW for all practitioners.
- f. Verification and completion of all of the above must be within 180 days prior to the date of the re-credentialing

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decision.

- g. The Credentialing Committee of the delegate reviews the application and credentialing documents, and makes credentialing decisions. A practitioner from the specialty of a practitioner being credentialed participates on the Credentialing Committee.
- h. Delegates provide to GHC-SCW a monthly report, which includes lists of re-credentialed practitioners, analysis of data, and/or committee meeting minutes.
- i. If a delegate terminates a practitioner and later wishes to reinstate the practitioner, the delegate will credential and re-verify credentialing requirements, if the break in service is 30 days or more. The delegate's Credentialing Committee will review all credentials and make a final determination prior to the practitioner's reinstate activities performed by GHC-SCW.

10. CREDENTIALING OF HEALTH CARE DELIVERY ORGANIZATIONS

- a. GHC-SCW requires that Health Care and Behavioral Health Care delivery organizations meet requirements of Federal and state regulatory bodies, and that the appropriate accrediting body for the respective organization accredits these organizations. These requirements are verified prior to the initial contract being signed by GHC-SCW and every three years thereafter.
- b. GHC-SCW conducts an on-site visit if the provider organization is not accredited. A non-accredited provider organization MAY substitute a CMS or State Review in lieu of the required site visit. (GHC-SCW must obtain the report from the institution to verify that the review has been performed and that the report meets GHC-SCW's standards; however, a letter from CMS or the applicable state agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if GHC-SCW reviewed and approved CMS or State criteria as meeting the standard). The CMS or State review may not be greater than three years old at the time of verification.
- c. GHC-SCW requires specific licensure and accreditation as listed below:
 - 1) **Hospitals (includes Behavioral Health inpatient services)**
 - a) Medicare certification
 - b) Medicaid certification (optional)
 - c) State licensure
 - d) The Joint Commission (TJC) accreditation
 - e) If not TJC accredited, GHC-SCW will evaluate through the following methods:
 - (1) A copy of the hospital's malpractice liability insurance declaration
 - (2) Names of the members and by-laws of the governing body or designated person who functions as the governing body
 - (3) A copy of the hospital's Quality Assurance (QA) plan

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- (4) A copy of the Utilization Review (UR) plan
- (5) A copy of the hospital's medical record keeping policies and procedures
- (6) A site visit by the GHC-SCW Medical Director or his/her designee to review the above **or** GHC-SCW may accept a CMS or state review in lieu of the required site visit. GHC-SCW must obtain the report from the institution to verify that the review has been performed and that the report meets GHC-SCW's standards; however, a letter from CMS or the applicable state agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if GHC reviewed and approved CMS or state criteria as meeting our standards. The CMS or State review may not be greater than three years old at the time of verification.

2) Home Health Agencies (HHA)

- a) Medicare certification
- b) State licensure
- c) Care Accreditation Commission (CCAC)
- d) If not CCAC or TJC accredited, GHC-SCW will evaluate through the following methods:
 - (1) A copy of the HHA's malpractice liability insurance declaration
 - (2) Names of the members and by-laws of the governing body or designated person who functions as the governing body
 - (3) A copy of the HHA's Quality Assurance (QA) plan
 - (4) A copy of the Utilization Review (UR) plan
 - (5) A copy of the HHA's medical record keeping policies and procedures
 - (6) A site visit by the GHC-SCW Medical Director or his/her designee to review the above **or** GHC-SCW may accept a CMS or state review in lieu of the required site visit. GHC-SCW must obtain the report from the institution to verify that the review has been performed and that the report meets GHC-SCW's standards; however, a letter from CMS or the applicable state agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if GHC reviewed and approved CMS or state criteria as meeting our standards. The CMS or State review may not be greater than three years old at the time of verification.

3) Skilled Nursing Facility (SNF)

- a) Medicare certification (if accepting Medicare patients)
- b) State licensure
- c) Medicaid (optional)

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- d) Commission on Accreditation of Rehabilitation Facilities (CARF)
- e) If not Commission on Accreditation of Rehabilitation Facilities (CARF) accredited or TJC, GHC-SCW will evaluate through the following methods:
 - (1) A copy of the SNF's malpractice liability insurance declaration
 - (2) Names of the members and by-laws of the governing body or designated person who functions as the governing body
 - (3) A copy of the SNF's Quality Assurance (QA) plan
 - (4) A copy of the Utilization Review (UR) plan
 - (5) A copy of the SNF's medical record keeping policies and procedures
 - (6) A site visit by the GHC-SCW Medical Director or his/her designee to review the above **or** GHC-SCW may accept a CMS or state review in lieu of the required site visit. GHC-SCW must obtain the report from the institution to verify that the review has been performed and that the report meets GHC-SCW's standards; however, a letter from CMS or the applicable state agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if GHC reviewed and approved CMS or state criteria as meeting our standards. The CMS or State review may not be greater than three years old at the time of verification.

4) **Free Standing Surgicenter**

- a) Medicare certification
- b) TJC or AAAHC (Accreditation Association for Ambulatory Health Care) accreditation
- c) If not AAAHC accredited, GHC-SCW will evaluate through the following methods:
 - (1) A copy of the ASC's malpractice liability insurance declaration
 - (2) Names of the members and by-laws of the governing body or designated person who functions as the governing body
 - (3) A copy of the ASC's Quality Assurance (QA) plan
 - (4) A copy of the Utilization Review (UR) plan
 - (5) A copy of the ASC's medical record keeping policies and procedures
 - (6) A site visit by the GHC-SCW Medical Director or his/her designee to review the above **or** GHC-SCW may accept a CMS or state review in lieu of the required site visit. GHC-SCW must obtain the report from the institution to verify that the review has been performed and that the report meets GHC-SCW's standards; however, a letter from CMS or the applicable state agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey

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report if GHC reviewed and approved CMS or state criteria as meeting our standards. The CMS or State review may not be greater than three years old at the time of verification.

5) Behavioral Health Residential and Ambulatory Facilities

- a) State licensure
- b) TJC accreditation
- c) A site visit by the GHC-SCW Medical Director or his/her designee to review the above **or** GHC-SCW may accept a CMS or state review in lieu of the required site visit. GHC-SCW must obtain the report from the institution to verify that the review has been performed and that the report meets GHC-SCW's standards; however, a letter from CMS or the applicable state agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if GHC reviewed and approved CMS or state criteria as meeting our standards. The CMS or State review may not be greater than three years old at the time of verification.

11. INTERNAL NOTIFICATION OF CREDENTIALING DECISION:

- a. Upon approval by the GHC-SCW Credentials Committee of initial credentialing the MSC sends notification out no later than one week after the Credentialing Committee's decision to GHC-SCW internal departments of:
 - 1) Facilities
 - 2) Enrollment
 - 3) Claims
 - 4) Marketing
 - 5) Member Services
 - 6) Scheduling Coordinator
 - 7) Epic/Cadence Coordinator
 - 8) Clinic Managers
 - 9) Pharmacy
 - 10) Human Resources
 - 11) Coding Department
 - 12) Health Information
 - 13) Compliance

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14) Care Management

15) Quality Management

16) Mental Health Manager/Coordinators

b. This notification includes the following information for all **Staff Model practitioners**:

1) Name

2) Credentials

3) Start Date

4) License Number/Expiration Date

5) Board Certification/Expiration Date (if applicable)

6) NPI

7) DEA/Expiration Date (if applicable)

c. For **Non-Staff Model practitioners**

1) Name

2) Credentials

3) Place of practice

12. ONGOING MONITORING OF SANCTIONS AND COMPLAINTS

GHC-SCW performs ongoing monitoring of sanctions and complaints continuously. If any incident of poor quality relating to the categories below is identified and requires intervention, the processes outlined in Policy ADM.001 (Attachment 4) govern the intervention process. The information below is reviewed at the Peer Review Committee as standing agenda items. On a monthly basis, before the Peer Review/Credentialing Committee meeting, the MSC compiles the following information:

a. **Medicare and Medicaid Sanctions**

1) Review within 30 days of the release of the quarterly reports from the Office of Inspector General for Medicare and Medicaid Sanctions web page at oig.hhs.gov/exclusions_list.asp. MSC also receives notification of Sanctions from the NPDB Proactive Disclosure Service (PDS) of enrolled practitioners as soon as it is posted.

2) If any GHC-SCW practitioner credentialed by the GHC-SCW Peer Review Committee is listed, the practitioner is required to submit an explanation. The Peer Review Committee reviews this information and the pertinent sanctions at the next meeting. If the Committee determines that corrective action or loss of

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privileges are necessary, this is recommended to the Medical Director who communicates to the practitioner. The practitioner may appeal this action as outlined in the description of Peer Review Committee actions.

- 3) If any GHC-SCW practitioner credentialed by a delegate is listed, GHC-SCW will send that information to the delegate in order for the delegate to take appropriate action.

b. Wisconsin State Licensing and Examining Board

- 1) Review of monthly disciplinary reports from the State of Wisconsin Department of Safety & Professional Services web page at online.drl.wi.gov/orders/searchorders.aspx. The MSC also receives notification of sanctions from the NPDB Proactive Disclosure Service (PDS) of enrolled practitioners as soon as they are posted.
- 2) If any GHC-SCW practitioner credentialed by the GHC-SCW Credentialing Committee is listed, the practitioner is required to submit an explanation. The Peer Review Committee reviews this information and the pertinent sanctions at the next meeting. If the Committee determines that corrective action or loss of privileges are necessary, this is recommended to the Medical Director who communicates to the practitioner. The practitioner may appeal this action as outlined in the description of Peer Review Committee actions.
- 3) If any GHC-SCW practitioner credentialed by a delegate is listed, GHC-SCW will send that information to the delegate in order for the delegate to take appropriate action.

c. Member Complaints

- 1) GHC-SCW maintains a log of member complaints by practitioner. The log lists whether the complaint is justified after Peer Review Committee and Medical Director review.
- 2) The GHC-SCW Peer Review Committee reviews the log during their monthly meeting for all GHC-SCW practitioners credentialed by the GHC-SCW Credentialing Committee. If any practitioner has three or more quality of care concerns in the previous 12 months, the Peer Review Committee conducts an additional review of the practitioner. If the Committee determines that corrective action or loss of privileges are necessary, this is recommended to the Medical Director who communicates to the practitioner. The practitioner may appeal this action as outlined in the description of Peer Review Committee actions.
- 3) Site visits at any participating practitioner office including, but not limited to the offices of primary care physicians and obstetricians/gynecologists for facility review and medical record keeping practices review will be performed when complaints dictate.
- 4) If any GHC-SCW practitioner credentialed by a delegate is listed on the complaint log, GHC-SCW will send that information to the delegate in order for the delegate to take appropriate action.

d. Ongoing Monitoring of Adverse events related to injury (Safety):

- 1) GHC-SCW collect reports on a monthly basis from Member Services and Care Management Departments on any adverse events related to injuries that happened while receiving health care services from a practitioner. GHC-SCW also maintains a log of Malpractice Cases by practitioner prepared by the GHC-SCW Medical Director. This log lists all active malpractice claims cases. If any GHC-SCW practitioner credentialed by the GHC-SCW Peer Review Committee is reported, the practitioner is required to submit an explanation. The Peer Review Committee reviews this information and the pertinent sanctions at the next meeting. If the

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Committee determines that corrective action or loss/limitation of privileges are necessary, this is recommended to the Medical Director who communicates to the practitioner. The practitioner may appeal this action as outlined in the description of Peer Review Committee actions.

- 2) If any GHC-SCW practitioner credentialed by a delegate has any adverse event, GHC-SCW will send that information to the delegate in order for the delegate to take appropriate action.

13. **GHC-SCW Directories and Membership Materials:**

- a. The MSC ensures that the information provided in member materials, which include practitioner directories and website listings is consistent with the information contained in the credentialing file. On a monthly basis the MSC sends an e-mail to the Marketing Communication Specialist, Member Services Manager, Enrollment Manager, and Claims Manager, of the newly approved practitioners which includes name, education, training, specialty, license number, board certification status, DEA number and location. The MSC monitors license, DEA, and Board Certification status on a monthly basis and would notify the Marketing Communication Specialist of any changes.
- b. Before printing the GHC-SCW's Provider Directory, the Marketing Communication Specialist contacts the MSC to review and verify the correctness of all published information about a practitioner based on credentialing and primary source verification.

14. **Initial and Re-credentialing PROCESS for HEDIS:**

- a. GHC-SCW complies with HEDIS Standards for Board Certification and Practitioner Turnover by utilizing the credentialing data obtained in the initial and re-credentialing processes explained above in Procedure Items 1 and 2.
- b. The MSC maintains a database for all credentialed practitioners. This database is in the MSC's G:drive.
- c. Information from those practitioners credentialed in-house and information from delegates is maintained in the database.
- d. The data in the database can only be modified by the MSC.
- e. An overview of the credentialing/re-credentialing process is outlined below:
 - 1) **For Initial Credentialing: Application Process is outlined as follows:**
 - a) Application is sent, allowing two weeks for completion by practitioner
 - b) Two applications and a follow-up phone call will be made in an effort to obtain the initial credentialing application.
 - c) Review of the application for completeness, including signature and date. Fax, digital and photocopied signatures are acceptable.
 - d) Review of the current signed attestation statement regarding physical and mental health status, limitation of privileges and status regarding drug or alcohol use is reviewed.

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- e) Primary source verification of Board Certification status is performed as part of the credentialing/re-credentialing process outlined in above Procedure Items 1 and 2.
- f) Initial applicants are presented to the GHC-SCW Credentialing Committee for approval/denial.

2) **For Re-Credentialing: Reapplication Process is outlined as follows:**

- a) Reapplication is sent, allowing two weeks for completion by practitioner.
- b) Two reapplications and a follow-up phone call will be made in an effort to obtain the re-credentialing application.
- c) Review of the reapplication for completeness, including signature and date. Fax, digital and photocopied signatures are acceptable.
- d) Review of the current signed attestation statement regarding physical and mental health status, limitation of privileges and status regarding drug or alcohol use is reviewed.
- e) Primary source verification of Board Certification status is performed as part of the credentialing/re-credentialing process outlined in above Procedure Items 1 and 2.
- f) Re-applicants are presented to the GHC-SCW Credentialing Committee for approval/suspension/denial.

f. **Board Certification Calculation for HEDIS:**

At least annually, the MSC will report the board certification percentage rates of the following practitioners:

- 1) Primary Care Practitioners (PCP)
- 2) OB/GYN Practitioners
- 3) Pediatric Practitioner Specialties
- 4) Geriatrics
- 5) All other Practitioner Specialties
- 6) The MSC manually calculates the board certification status based on information in the credentialing database and in accordance with the most current HEDIS Guidelines.

g. **Practitioner Turnover Calculation for HEDIS:**

- 1) At least annually, the MSC reports the practitioner turnover rate.
- 2) Termination dates are entered into the database.
- 3) The MSC manually calculates the practitioner turnover rate based on the credentialed/termination dates in the credentialing database in accordance with the most current HEDIS Guidelines.

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h. Audit for Accuracy:

- 1) At least annually, the MSC and Director of Claims provide each other with reports of data in their systems on the practitioners entered into each system for comparison.
- 2) The reports must contain the following information:
 - a) Name
 - b) Credentials
 - c) Start Date
 - d) License Number
 - e) Board Certification
 - f) NPI
 - g) DEA
- 3) Any discrepancies are identified, researched and resolved in both systems.