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- 4c. The PRC 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, or make credentialing decisions, based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the patient population (e.g., Medicaid) in which the practitioner may specialize. Annually, all PRC members are required to sign an affirmative statement that they will make decisions in a non-discriminatory manner. GHC-SCW prevents discrimination of credentialing and re-credentialing by maintaining a heterogeneous PRC and requiring those responsible for credentialing decisions to affirm that they do not discriminate.
- 4d. GHC-SCW recognizes the need to expedite the approval of clean credential files and may approve clean credential files outside of the regularly scheduled PRC meetings. Clean credential files are defined as initial or re-credentialing files whose primary source verification elements as outlined on the organization's Initial and Re-Credentialing checklists are complete and without concerns and meet the necessary requirements to be approved by the PRC. Clean files may be approved by the Chief Medical Officer or designee outside of a regularly scheduled PRC meeting. The Medical Staff Administrator (MSA) is the sole individual responsible for completing the Initial and/or Re-Credentialing checklist and will present clean files to the Chief Medical Officer or designee for review and approval. The Chief Medical Officer or designee will sign and date the checklist as indication of approval. A list of the files approved outside of a regularly scheduled meeting will be presented at the next PRC meeting.
- 4e. The PRC receives and reviews the credentials of all practitioners, including those who do not meet the organization's established criteria. GHC-SCW's Chief Medical Officer or the Chair of the PRC monitors for non-discriminatory credentialing and re-credentialing by reviewing every file that is denied in the credentialing process to ensure that there has been no discrimination. The Chief Medical Officer or designee performing the review will be a PRC member who did not chair the meeting when the application was denied. The Chief Medical Officer or designee will forward the result of their review to the PRC, and the result of his/her review will be documented in the minutes. All applications that are received by the MSA but are not taken to the PRC will be reviewed by the Chief Medical Officer or designee in the same manner described above.
- 4f. Appropriate documentation for a GHC-SCW credential file must include primary source verification documentation in one of two ways:
- i. 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
  - ii. 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.
- 4g. 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. 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 as defined within this policy under **Credentialing of Practitioners**.

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## PRACTITIONER RIGHTS

- 5a. Practitioners have the right to review the information submitted in support of their credentialing applications except for 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 MSA will notify 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 MSA. The MSA will respond by telephone, United States Postal Service or by e-mail to the practitioner within seven (7) calendar days of receiving the corrections.
- 5b. Practitioners have the right, upon request to the MSA, to be informed of the status of their credentialing or re-credentialing applications. The MSA 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.
- 5c. 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 letter that accompanies the initial and re-credentialing application.
- 5d. The MSA 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 PRC decision.

## CONFIDENTIALITY OF INFORMATION

- 6a. The information obtained in the credentialing process is confidential. Access to information obtained throughout the credentialing process is carefully monitored and will not be released to outside parties without permission of the practitioner involved or by legal responsibility, including the Health Care Quality Improvement Act of 1986.

Credentialing files are only available to the MSA, the Chief Medical Officer, the Senior Medical Director, and the credentialing committee members for review. The credentialing packet is stored in secure electronic format or if non-electronic in locked file cabinets inside a locked office when the MSA is not present. An individual practitioner may read information contained in his/her file upon request in the presence of the MSA.

## CREDENTIALING SYSTEM SECURITY CONTROLS AND OVERSIGHT

- 6b. See MED.ADM.071

**CREDENTIALING OF PRACTITIONERS:** Credentialing verification for all practitioners employed and contracted by GHC-SCW are performed by the organization.

**Initial Credentialing:** The following is a list of the criteria that must be present and will be primary source verified.

- 7a. GHC-SCW requires 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 webpage of the Wisconsin State licensing agency at [licensesearch.wi.gov](http://licensesearch.wi.gov)
- 7b. GHC-SCW requires the eligible practitioner, if applicable, holds a valid, current DEA in the State of Wisconsin. Primary source verification of DEA is completed online at the DEA website [deaddiversion.usdoj.gov](http://deaddiversion.usdoj.gov) OR by the MSA viewing the DEA certificate. The DEA must be valid in the state where the practitioner provides care

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to GHC-SCW members. Should the practitioner be eligible for a DEA (i.e., MD, DO, APNP, PA-C etc.) but does not have a DEA, the practitioner must explain why AND provide explanation of arrangements for his/her patients who need prescriptions requiring a DEA. If a practitioner's DEA is pending, a written plan will be documented in the practitioners' credentialing file, which allows a practitioner with a valid DEA to write all prescriptions requiring a DEA number for the prescribing practitioner until the practitioner has a valid DEA.

7c. GHC-SCW verifies the highest of the three levels of education & training obtained by the practitioner as appropriate:

- Board certification
- Residency
- Graduation from medical school or professional school

GHC-SCW uses any of the following sources to verify education & training:

- i. Directly from the school at which the education and training took place (primary source)
- ii. The state licensing agency, specialty board or registry, if it performs primary source verification. GHC-SCW will annually obtain written confirmation from the State of WI Department of Safety & Professional Services that it performs primary source verification of education & training, or provide a printed, dated screenshot of the state licensing agency, specialty board or registry website displaying the statement that it performs primary source verification of practitioner education and training information.
- iii. AMA Physician Masterfile (MD, DO)
- iv. American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File (MD, DO)
- v. ECFMG

GHC-SCW uses the following sources to verify board certification:

- Directly from the appropriate specialty board (primary source)
- For physicians (MD, DO):
  - American Board of Medical Specialties (ABMS) thru CertiFACTS (<https://certifacts.abms.org/Login.aspx>) on-line, password protected.
  - AMA Physician Masterfile
  - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File

7d. GHC-SCW requires the practitioner to complete an application and attest to its correctness and completeness. The following must be addressed:

- Physical and mental health status and reasons for inability to perform essential functions of the position, with or without accommodations
- Chemical dependency or lack of illegal drug use
- History of loss of license and/or felony convictions
- History of loss or limitation of clinical privileges or disciplinary action
- Work history for the last five years in mm/yy to mm/yy format. Any gaps one year or less must be explained verbally or in writing. A verbal clarification will be documented by the MSA. Any gaps greater than one year must be explained in writing.
- Malpractice history
- Current coverage for malpractice, including dates and amounts, even if the coverage amount is \$0.
- Signature attesting to the correctness and completeness of the application

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- 7e. GHC-SCW enrolls all credentialed practitioners in the National Practitioner Data Bank (NPDB) Continuous Query. An initial report will be generated for verifications of malpractice history and sanction information. The PRC will review all adverse NPDB reports. The MSA will obtain a query of the NPDB at <https://www.npdb.hrsa.gov>. Any notifications from the NPDB are sent via e-mail to the MSA including malpractice claims, Office of the Inspector General sanctions, WI Department of Safety & Professional Services and Medicare/Medicaid sanctions. All enrolled practitioners are renewed on an annual basis. If employment is terminated, the enrollment is canceled no later than 30 days after termination.
- 7f. Verification and completion of all the above must be within 180 days prior to the date of the initial credentialing decision. The credentialing process is completed prior to a practitioner providing services to GHC-SCW members.
- 7g. The PRC reviews the application and credentialing documents and makes recommendations to the CMO.
- 7h. If GHC-SCW terminates a practitioner and later wishes to reinstate the practitioner, GHC-SCW will credential and re-verify all credentialing requirements, if the break in service is 30 days or more. The PRC will review all credentials and make a final determination prior to the practitioner's reinstatement.

### Re-Credentialing

*All credentialed providers are re-credentialed at a minimum of every three years. The items that must be present and that will be verified are current license, DEA (if applicable), board certification (if applicable), malpractice insurance coverage, and NPDB query. The processes followed and verification sources used for re-credentialing are identical to the initial credentialing criteria outlined above.*

### DELEGATED CREDENTIALING

8a. GHC-SCW considers delegating credentialing to another organization only after performing a pre-delegation evaluation to ensure the capacity of the delegate organization to meet NCQA requirements and any planned delegated activities. The evaluation must be performed within 12 months prior to implementing delegation and will include a review of the organizations structure or credentialing policies including if the delegate is NCQA Accredited or sub-delegates to an NCQA Certified Credentialing Verification Organization (CVO) to help solidify the terms of the final written agreement.

Potential delegates policies and procedures will be collected by GHC-SCW's Medical Staff Administrator (MSA) and evaluated by the Peer Review Committee (PRC). The result of the pre-delegation assessment will be documented in the minutes of these PRC meetings. The Chief Medical Officer will have final authority to accept or reject potential delegates.

- 8b. A delegation agreement must be in place before delegated activities are performed. Upon successful completion of the pre-delegation evaluation, GHC-SCW will execute a written agreement that will be mutually agreed upon by signatures of both parties. The agreement will describe:
- the delegated activities and responsibilities of both GHC-SCW and the delegate entity and/or the sub-delegate
  - the process, for at least semi-annual reporting by the delegate to GHC-SCW.
  - the delegate or sub-delegates credentialing system, security controls in practice and an annual monitoring and reporting process by the delegated entity that meets NCQA requirements
  - an annual evaluation process of delegate performance which includes reviewing the delegates or sub-delegates credentialing systems security controls monitoring reports
  - remedies if the delegate does not fulfill its obligations, including revocation of the agreement.
- 8c. GHC-SCW retains the right to approve, suspend and terminate individual practitioners, providers' and sites for any delegated practitioner, provider or site.

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- 8d. GHC-SCW requires all delegates to monitor and report on their credentialing systems security controls at least annually to evaluate for unauthorized credentialing modifications consistent with the delegated agreement or delegate policies describing the security controls in place to protect from unauthorized access or if the system has advanced capabilities, as well as the methods the delegate uses to monitor for unauthorized modifications as they apply.
- 8e. The Medical Staff Administrator is responsible for the following delegate monitoring activities:
- i. annual review of the appropriate sections of the credentialing policies and procedures of all current delegates of 12 months duration or longer. The MSA will report to the Peer Review Committee; PRC minutes will document the discussion and/or committees' recommendation.
  - ii. annual credentialing and recredentialing file audits to monitor the performance of any delegate not NCQA Accredited using current NCQA review tools and the 8/30 sampling methodology for file review . This includes any delegate who sub-delegates to an NCQA Certified Credentialing Verification Organization (CVO).
    - o NCQA recognizes Certified CVO's only for applications and primary source verifications for which organizations can claim automatic credit. If decision making is delegated in the agreement to be performed by the delegates committee, GHC-SCW's annual audit must assess the delegate for timeliness of the credentialing decision only.
    - o If any deficiencies are noted during a delegate's audit, a recommended action plan will be sent to the delegate contact by the MSA within 30 days. Follow-up, at a minimum, will be re-evaluation annually.
  - iii. annual collection and review of each delegate's or sub-delegates systems security controls monitoring reports as per the delegated agreement. If any deficiencies are noted upon review of the report, a quarterly monitoring process will be expected of the delegate until improvement is observed over three consecutive quarters.

### **INITIAL CREDENTIALING PERFORMED BY A DELEGATED ENTITY**

- 9a. Primary source verification of a valid State of Wisconsin license
- 9b. 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 a practitioner type is eligible for a DEA (i.e., MD, DO, APNP, PA-C etc.) but does not have a DEA, the practitioner must explain why AND provide explanation of arrangements for his/her patients who need prescriptions requiring a DEA.
- 9c. 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.



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9d. Review of a completed application, including the following:

- Physical and mental health status and reasons for inability to perform essential functions of the position, with or without accommodations
- Alcohol or chemical dependency and lack of current illegal drug use
- History of loss of license
- History of any felony convictions
- History of loss or limitation of clinical privileges or disciplinary action
- Work history for the last five years in mm/yy to mm/yy format. Any gaps one year or less must be explained verbally or in writing. A verbal clarification will be documented by the MSA. Any gaps greater than one year must be explained in writing.
- Malpractice history
- Current coverage for malpractice, including dates and amounts, even if the coverage amount is \$0.
- Signature attesting to the correctness and completeness of the application

9e. National Practitioner Data Bank (NPDB) query, to include

- Professional liability claims history
- Medicare/Medicaid sanctions
- Disciplinary actions by the Medical Examining Board

9f. Verification and completion of all the above must be within 180 days prior to the date of the initial decision. The credentialing committee of the delegate reviews the application and credentialing documents, and makes credentialing decisions. The credentialing process is completed prior to any practitioner providing services to GHC-SCW members.

9g. Delegates provide the MSA with reports, at least semiannually, that lists recently credentialed practitioners. Should a delegate terminate 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 reinstatement.

### **RE-CREDENTIALING PERFORMED BY A DELEGATED ENTITY**

*All credentialed providers are re-credentialed at a minimum of every three years. The items that must be present and that will be verified are identical to the criteria outlined, source of verification and processes defined above in items 9a through 9g per Initial Credentialing Performed by a Delegated Entity.*

### **CREDENTIALING AND ASSESSMENT OF ORGANIZATIONAL PROVIDERS**

10a. GHC-SCW requires that Medical and Behavioral Health Care provider 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 and, at a minimum, every three years thereafter as long as the contract remains in effect.

10b. Sources used to confirm that providers are in good standing with state and federal requirements include A) the applicable state or federal agency B) the agent of the applicable state or federal agency or C) copies of credentials obtained (e.g., state licensure) from the provider.

10c. Sources used to confirm the provider's accreditation status include A) the applicable accrediting body B) the agent of the applicable accrediting body, or C) copies of credentials (i.e., the accreditation report, certificate, or decision

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letter) from the provider.

10d. GHC-SCW conducts an on-site visit if the provider 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 a 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 provider 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.

10e. GHC-SCW requires the specific licensure and accreditation as listed below for:

**Hospitals (includes Behavioral Health inpatient services)**

- Medicare certification
- Medicaid certification (optional)
- State licensure
- A copy of the hospital's malpractice liability insurance declaration
- The Joint Commission (TJC) or Healthcare Facilities Accreditation Program (HFAP) accreditation
- If not TJC or HFAP accredited, GHC-SCW will evaluate through the following methods:
  - (1) A copy of the hospital's Quality Assurance (QA) plan
  - (2) A copy of the Utilization Review (UR) plan
  - (3) A copy of the hospital's medical record keeping policies and procedures
  - (4) A site visit by GHC-SCW 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 per item 10d.

**Home Health Agencies (HHA)**

- Medicare certification
- State licensure
- Care Accreditation Commission (CCAC) or TJC accredited
- A copy of the HHA's malpractice liability insurance declaration
- If not CCAC or TJC accredited, GHC-SCW will evaluate through the following methods:
  - (1) A copy of the HHA's Quality Assurance (QA) plan
  - (2) A copy of the Utilization Review (UR) plan
  - (3) A copy of the HHA's medical record keeping policies and procedures
  - (4) A site visit by GHC-SCW 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 per item 10d.

**Skilled Nursing Facility (SNF)**

- Medicare certification (if accepting Medicare patients)
- State licensure
- Medicaid (optional)
- A copy of the SNF's malpractice liability insurance declaration
- Commission on Accreditation of Rehabilitation Facilities (CARF), TJC or HFAP accredited
- If not CARF, TJC, or HFAP accredited GHC-SCW will evaluate through the following methods:
  - (1) A copy of the SNF's Quality Assurance (QA) plan
  - (2) A copy of the Utilization Review (UR) plan
  - (3) A copy of the SNF's medical record keeping policies and procedures



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- (4) A site visit by GHC-SCW 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 per item 10d.

### **Free Standing Surgery Center (FSSC)**

- Medicare certification
- A copy of the malpractice liability insurance declaration
- TJC, HFAP or AAAHC (Accreditation Association for Ambulatory Health Care) accreditation
- If not AAAHC, TJC or HFAP accredited, GHC-SCW will evaluate through the following methods:
  - (1) A copy of the Quality Assurance (QA) plan
  - (2) A copy of the Utilization Review (UR) plan
  - (3) A copy of the FSSC's medical record keeping policies and procedures
  - (4) A site visit by GHC-SCW 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 per item 10d.

### **Behavioral Health Residential and Ambulatory Facilities**

- State licensure
- A copy of the malpractice liability insurance declaration
- TJC or HFAP accreditation
- If not TJC or HFAP accredited, GHC-SCW will evaluate through the following methods:
  - (1) A copy of the Quality Assurance (QA) plan
  - (2) A copy of the Utilization Review (UR) plan
  - (3) A copy of the Facilities medical record keeping policies and procedures
  - (4) A site visit by GHC-SCW 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 per item 10d.

### **INTERNAL NOTIFICATIONS REGARDING CREDENTIALING**

*Notification of credentialing and recredentialing decisions is sent by the MSA to all applicable internal departments no later than one week after the PRC meeting. Notification includes the following:*

#### **11a. GHC-SCW Employed Practitioners**

- Name
- Credentials
- Start Date
- License Number
- Board Certification (if applicable)
- NPI

#### **Contracted Practitioners**

- Name
- Credentials
- Place of practice

### **ONGOING MONITORING OF SANCTIONS AND COMPLAINTS**

*GHC-SCW conducts ongoing monitoring of sanctions and complaints. If any incident of poor quality is identified and requires intervention, the processes outlined in policy ADM.COM.001 governs the intervention process. The information outlined below is reviewed by the PRC as standing agenda items. On a monthly basis, before the PRC meeting, the MSA compiles the following information:*

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## Medicare and Medicaid Sanctions

12a. Review within 30 days of the release of the quarterly reports from the Office of Inspector General for U.S Department of Health and Human Services Medicare and Medicaid Sanctions at <https://exclusions.oig.hhs.gov> The MSA also receives notification of Sanctions from the NPDB Proactive Disclosure Service (PDS) of enrolled practitioners as soon as it is posted.

If any practitioner credentialed by the PRC is listed in these reports, the practitioner will be required to submit an explanation. The Peer Review Committee reviews this information and the pertinent sanctions at the next meeting. Should the PRC determine that corrective action or loss of privileges are necessary, the Chief Medical Officer communicates this with the practitioner. The practitioner may appeal this action as outlined in ADM.COM.001. In the event any practitioner credentialed by a delegate is listed, GHC-SCW will provide that information to the delegate to take appropriate action.

## Wisconsin State Licensing and Examining Board

12b. Review of monthly disciplinary reports from the State of Wisconsin Department of Safety & Professional Services web page online. The MSA also receives notification of sanctions from the NPDB Proactive Disclosure Service (PDS) of enrolled practitioners as soon as it is posted. If any practitioner credentialed by the PRC 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. Should the PRC determine that corrective action or loss of privileges are necessary, the Chief Medical Officer or designee communicates this with the practitioner. The practitioner may appeal this action as outlined in ADM.COM.001. In the event any practitioner credentialed by a delegate is listed, GHC-SCW will provide that information to the delegate to take appropriate action.

## Member Complaints

12c. The PRC maintains a log of patient/member complaints related to quality of care or service by practitioners. The log lists the disposition of the complaint and the determination of the PRC. The PRC reviews the log during monthly meetings to monitor for concerning trends. If trends are identified, additional chart review may be conducted by the PRC. Should the committee determine that corrective action or loss of privileges are necessary, the Chief Medical Officer or designee will communicate with the practitioner. The practitioner may appeal this action as outlined in ADM.COM.001. If any practitioner credentialed by a delegate receives a complaint, GHC-SCW will provide information to the delegate to take appropriate action.

12d. Site visits of any participating practitioner office will be performed when complaints dictate.

## Ongoing Monitoring of Adverse Events

An occurrence or safety event is an event or situation that results in actual or potential adverse outcomes.

13a. The PRC is routinely notified via Care Management, Member Services or GHC-SCW's internal occurrence reporting system ([occurrencereporting@ghcscw.com](mailto:occurrencereporting@ghcscw.com)) of any adverse events that have occurred. The PRC reviews events or concerns documented in the reporting system such as, but not limited to, patient injuries, medication or immunization errors etc. If any practitioner credentialed by a delegate has an adverse event reported to GHC-SCW, the organization will provide the information to the delegate to take appropriate action.

13b. GHC-SCW also maintains a log of active malpractice cases by practitioner. Should any GHC-SCW practitioner credentialed by the Peer Review Committee be reported, the practitioner is required to submit an explanation. The PRC reviews all pertinent sanctions and determines if corrective action or loss/limitation of privileges are necessary and informs the Chief Medical Officer or designee who communicates with the practitioner. Practitioners may appeal this action as outlined in ADM.COM.001.

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## **GHC-SCW DIRECTORIES AND MEMBERSHIP MATERIALS**

- 14a. The MSA ensures that the information provided in member materials, which include practitioner directories and website listings are consistent with the information contained in the credentialing file. On a monthly basis, the MSA communicates with applicable internal staff or departments newly approved practitioners and notifies appropriate staff of any changes in practitioner information.
- 14b. GHC-SCW reviews and verifies the correctness of all information about a practitioner prior to publication.