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Owner	Janet Krajnovic: Mgr-Credentialing
Area	Provider Network Management
Applicability	Health Alliance Plan
Document Types	Policy

Credentialing Policy

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APPLIES TO:	X	COMMERCIAL	X	MMP	X	MEDICARE ADVANTAGE	X	MEDICAID	X	OTHER

PURPOSE:

The policy is to ensure that Health Alliance Plan (HAP) ensures that all practitioners applying for affiliation meet rigorous credentialing standards prior to approval for participation. All credentialing and re-credentialing decisions are non-discriminatory and not based upon an applicant's race, ethnic/national identity, gender, age, or sexual orientation.

POLICY:

Failure to comply with the requirements of this policy may result in disciplinary action, up to and including termination of employment.

- NCQA - CR 1 Credentialing Policies
- MCL 500.3528 - Credentialing and Recredentialing process
- 42 CFR 438.214 - Credentialing and Recredentialing process
- 2.7.3.11.2 – Credential providers
- 2.7.3.11.5 – Credential providers prior to becoming network providers
- 2.7.3.11.1 – Regarding the selection, retention and exclusion of providers, and non-discrimination
- 2.8.3.11.3 – Recredentialing Performance Monitoring process

DEFINITIONS:

Credentialing: The process of obtaining and verifying credentials.

Recredentialing: The process of reassessing and revalidating the qualifications of an existing provider.

CAQH: Provider Data Portal.

Primary Source Verification: The process by which the credentialing departments validate credentialing information.

NCQA: National Committee on Quality Assurance, a non-profit organization dedicated to improving health care quality.

CMS: Centers for Medicare and Medicaid Services

MDHHS: Michigan Department of Health and Human Services

DIFS: Michigan Department of Insurance and Financial Services

PROCEDURE:

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HAP has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. This policy is put into place that HAP will comply with regulatory and accreditation standards in the development and management of Credentialing.

Responsible Party (Who)	Step	Action Taken (Does What)
Manager, Credentialing Department	A	**Types of practitioners to credential and recredential:** This policy applies to practitioners who have an independent relationship including Allopath's (MD), Osteopaths (DO), Dentists (DDS) (only oral and maxillofacial surgeons providing care under medical benefits), Podiatrists (DPM), Chiropractors (DC), Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Optometrists (OD), fully licensed Psychologists (PhD/PsyD), Master Level Psychologists (LLP), and Master Level Social Workers (LMSW), Licensed Professional Counselors (LPC), and Genetic Counselors (CGC). Board Certified Behavior Analysts (BCBA) and Acupuncturists are credentialed as an exception, based on the health plan's need. PCP availability: A PCP is described as a MD or DO who is listed as a General Practice, Family Medicine, Pediatrician, or Internal Medicine Practitioner. OB/Gyn practitioners and other

		specialists may be designated as a PCP if they agree to provide care for all medical conditions. PCPs must provide or arrange for coverage of services 24 hours per day, 7 days per week. PCPs must be available to see patients a minimum of 20 hours per practice location per week. Practitioners who do not need to be credentialed are those who practice exclusively within the inpatient setting and provide care for organization members only as a result of members being directed to the hospital or another inpatient setting, Hospitalists, Pathologists, Radiologists, Anesthesiologists, Certified Registered Nurse Anesthetists, Neonatologists and Emergency Department physicians, practitioners who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility, locum tenens, and general dentistry.
Credentialing Department	B	**Credentials System Controls:** Primary source verification (PSV) is documented using a checklist which includes the name of the primary source, the date of verification, the signature or initials of the Credentialing Coordinator who verified the information and the report date, if applicable. If the PSV is obtained via the internet the verification will contain the URL address. The credentialing application which includes PSV documentation, the CAQH application and other documents which complete the file is saved electronically. The credentialing file is saved on a secure drive only accessible by the Credentialing Department. The Credentialing Coordinator is responsible for maintaining the security of the credentialing documents while processing the file. Documents may not be altered.
Credentialing Department	C	**Primary source verifications used, how information is received, dated, and stored for credentialing and recredentialing:** **Application:** The CAQH application must include a signed current attestation confirming that the application is to be accurate and complete within the required time frame of 180 calendar days prior to the Credentialing Committee's decision. If the

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		signature attestation exceeds 180 calendar days before the credentialing decision, the practitioner must re-attest that the information on the application is current and complete. The CAQH application is received electronically and saved in an electronic format with the date of receipt. The Credentialing Coordinator is responsible for maintaining the security of the document. The application must also include the following: • Reasons for inability to perform the essential functions of the position. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage. **Licensure:** HAP verifies a current, valid license to practice and a controlled-substance license as applicable in states where the practitioner provides care to its members is present, is within the prescribed time limit of 180 calendar days and is active at the time of the Credentialing Committee's decision. Practitioner names will be recorded in the credentialing database as verified on the practitioner's state license. The names must match the name as displayed on the state license. Degrees must match what has been verified through primary source verification. • Obtains internet verification, oral or written verification directly from the State of Michigan Department **of Licensing and Regulatory Affairs (LARA)** or certification agency. • Obtains either oral, written, or Internet verification for all other state licenses utilizing the appropriate state-licensing agency. • Review of information of sanctions, licensures, or scope of practice covers

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the most recent five-year period available through the data source.

- Information on state sanctioning activity from the State of Michigan Department of Consumer and Industry Services Bureau of Health Services at the time of license verification.

DEA or CDS Certificates:
HAP verifies a current and valid DEA or CDS certificate with no restrictions or limitations (if applicable) in each state where the practitioner provides care to members through one of the following. Verification is obtained prior to the credentialing decision. Recent graduates, or fellows applying for initial credentialing or practitioners who move from another state, may have a HAP covering practitioner for up to six months until they obtain their DEA. Documentation will be included in the credentialing file who the designated HAP provider will be writing prescriptions on their behalf.

- Confirmation with the state pharmaceutical licensing agency, where applicable
- A copy of DEA or CDS certificate
- Documented visual inspection of the original certificate
- Confirmation with the DEA or CDS agency
- Confirmation with the American Medical Association (AMA) Physician Master File
- American Osteopathic Association Official Osteopathic Physician Profile Report
- The DEA and CDS certificate are not applicable to chiropractors.

Education and Training:
Practitioners must have completed at least three years of post-graduate medical education in an approved internship and/or residency program (MD

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		or DO) or DO's with only one-year post-graduate training before 1989 in an approved program and board certification. Verification of board certification meets the requirement for verification of education and training since medical specialty boards verify both. HAP verifies the highest of the three levels of education and training obtained by the practitioner prior to the credentialing decision. Graduation from medical or professional school, residency, if appropriate, and board certification, if appropriate. The agencies/authorities recognized at the time of this policy are the following: • The Accreditation Council for Graduate Medical Education (ACGME) • American Medical Association (AMA) Physician Master Profile • The American Osteopathic Association (AOA) • Royal College of Physicians and Surgeons of Canada • The American Podiatric Medical Association (AMPA) Council on Podiatric Medical Education • Graduation from a Commission on Dental Accreditation (CODA) accredited training program – Oral Surgeons • Completion of an accredited psychologist program with an approved internship/clinical practice requirement • Completion of an accredited nurse midwife program, nurse practitioner, clinical nurse specialists with an approved internship/clinical practice requirement • Chiropractic College • Graduate from an optometry program that is accredited by the Accreditation Council on Optometric Education (ACOE) of the American Optometric Association (AOA). Optometrists must complete a four-year post-baccalaureate Doctor of Optometry Degree program.

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- Completion of a master's degree in social work (MSW) with a major focus of study in the treatment of Behavioral Medicine or equivalent field, as defined by the Michigan Board of Examiners of Social Work.
- Master's Degree from a program approved by the State of Board of Counseling
- Master's or doctoral degree in Psychology (LLP's)
- Doctoral degree in Psychology (Psychology)
- Possession of a minimum of a bachelor's and a master's degree that was conferred in behavior analysis or other natural science, education, human services, engineering, medicine, or a field related to behavior analysis and approved by the Behavior Analyst Certification Board and must obtain the Board-Certified Behavior Analyst Certification.

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Board Certification:

HAP verifies board certification and documents the expiration date within the 180-calendar daytime limit including lifetime certification status. If the medical board does not provide the expiration date for a practitioner's board certification, verification of the board certification status and date of verification is documented within the practitioner's file.

Board Certification is verified by one or more of the following HAP recognized agencies/authorities are:

- American Board of Medical Specialties (ABMS Certifacts)
- American Osteopathic Association (AOA) Physician Profile Report
- Royal College of Physicians and Surgeons of Canada
- American Board of Addiction Medicine

- American Board of Genetic Counseling (ABGC)
- American Board of Medical Genetics and Genomics (ABMGG)
- American Board of Sleep Medicine
- American Board of Oral and Maxillofacial Surgery
- American Podiatric Medical Association (APMA)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Lower Extremity Surgery (ABLES)
- American Board of Multiple Specialties in Podiatry (ABMSP)
- American Board of Podiatric Medicine (ABPM)
- American Midwifery Certification Board (AMCB)
- National Commission on Certification of Physician Assistants
- Nurse Practitioners meet the advanced practice certification standards of one of the following certification organizations:

a. American Nurses Credentialing Center (ANCC)
b. American Academy of Nurse Practitioners
c. National Certification Board of Pediatric Nurse Practitioners and Nurses, Inc.
d. National Certification Corporation (NCC) for obstetric, gynecologic, and neonatal nursing specialties
e. Oncology Nursing certification corporation
f. Pediatric Nursing Certification Board
g. American Association of Critical-Care Nurses

Work History:

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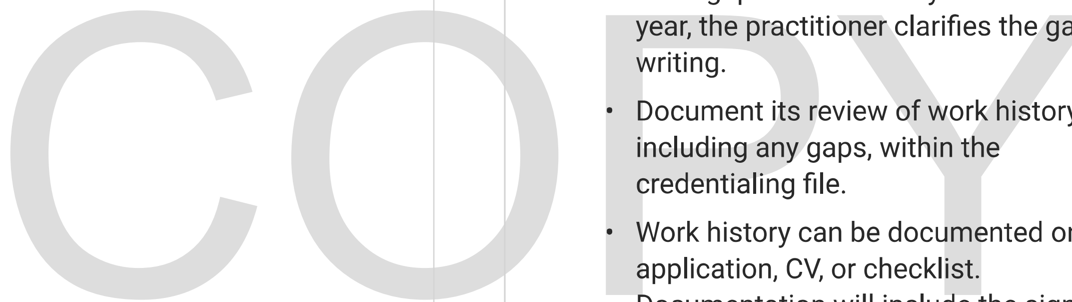
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		HAP obtains a minimum of the most recent five years of relevant work history through the practitioner's application or curriculum vitae within 180 calendar daytime limit. Relevant experience includes work as a health professional. If the practitioner has practiced fewer than five years from the date of verification of work history, the time frame starts at the date of initial licensure. The application or curriculum vitae must include the beginning and ending month and year for each position the practitioner's employment experience. If the practitioner has had continuous employment for five years or more with no gaps in work history providing the year is acceptable. • Clarify either verbally or in writing each gap in employment that exceeds six months. • If the gap in work history exceeds one year, the practitioner clarifies the gap in writing. • Document its review of work history, including any gaps, within the credentialing file. • Work history can be documented on the application, CV, or checklist. Documentation will include the signature or initials of staff who reviewed work history and the date of review. **Malpractice History:** HAP obtains confirmation of the past five years of history of malpractice settlements from the malpractice carrier or the National Practitioner Databank (NPDB) within 180 calendar daytime limit. The five-year period may include residency or fellowship years. HAP does not need to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship. **Hospital Affiliation:** HAP verifies all current hospital affiliations as attested to on the application. In the event of a "red

		flag," previous hospitals affiliations are also verified. **Sanction Information:** HAP reviews and evaluates State sanctions, restrictions on licensure, limitations on scope of practice, and Medicare and Medicaid Sanctions prior to making a credentialing/recredentialing decision. The practitioner's file will contain sufficient documentation to demonstrate that the credentialing information is present at the time of the credentialing decision within the 180-calendar daytime limit from the following agencies/sources: • NPDB • State Medicaid agency or intermediary and the Medicare intermediary • List of Excluded Individuals and Entities (maintained by the Office of Inspector General (OIG), available over the Internet • Medicare Exclusion Database • Michigan Department of Health and Human Services (MDHHS) Sanction Provider List, available over the Internet • Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General • The System for Award Management (SAM) web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of federal financial and non-financial assistance and benefits • The American Medical Association (AMA) Physician Master File entry • Federation of State Medical Board (FSMB) • Centers for Medicare and Medicaid Service (CMS) Preclusion Provider List
Credentialing Coordinators, Credentialing Leads and Credentialing Manager	D	**Authorization to Modify Information:** The Credentialing Coordinators and/or Credentialing Leads in the Credentialing

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		Department are authorized to data enter, review, and modify credentialing data in accordance with existing procedures. The credentialing information is gathered from PSV's, application, and documents to support the credentialing application. Only the Credentialing Manager and/or Credentialing Lead are authorized to delete credentialing information. Deletions are only made once data is reviewed, verified to be incorrect or duplicated. The credentialing software allows which fields can be added, modified, and/or read only according to the user. All requests for access to the credentialing database and/or secured shared drive are reviewed by the Credentialing Manager to evaluate appropriateness and to determine the security group the individual shall be assigned based on job responsibilities. Each user has a unique identifier and password. These ID's and passwords shall not be shared, or the user may be subject to disciplinary action, including possible termination. If access is not granted, the Credentialing Manager will communicate the denial to the requestor, including the reason for the denial. The credentialing software system tracks the adds, modifications and/or changes with an audit log. The audit log identifies the staff member who made the data entry, what change was added, modified, and/or deleted, identifies the time the change was made and date the change was made. The report is run monthly. The Credentialing Manager and/or Credentialing Lead review the report regularly. If there is a discrepancy between the information provided by the applicant and the PSV, the Credentialing Coordinator will follow the policy and process for resolving discrepancies in information which may include contacting the applicant and/or the PSV for clarification. Notations may be made in the credentialing file and must contain the date of the entry and the name/initials of the staff member who made the entry.
Credentialing Coordinator, Credentialing Lead, and Credentialing Manager	E	**Credentialing Process Audit:** At the time that the credentialing files are completed, the Credentialing Coordinator who was responsible for completing the file attests that the information is accurate and complete and is documented on the credentialing tracking sheet.

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		The file is then peer reviewed by another Credentialing Coordinator prior to the Credentialing Meeting to ensure all credentialing is completed according to the credentialing policy and signs the credentialing tracking sheet indicating the name and date of the review. Prior to the Credentials Committee meeting, the Credentialing Manager and/or Credentialing Lead will review any applications (initial or recredentialing) that is not considered clean to ensure the file is processed in accordance with existing policies and procedures. For any files that were not approved by the Credentialing Committee the file is reviewed by the Credentialing Manager and/or Credentialing Lead to ensure credentialing decisions were made in accordance with existing policies and procedures. To ensure the integrity and security of the practitioner data contained in the credentialing database, to identify areas of non-compliance and ensure policy adherence, various auditing activities will be performed on an ongoing basis. Reviewing job roles and user access annually to ensure system access is still appropriate for scope of job responsibility. An audit log report is generated monthly, which identifies the username, the credentialing data field, the audit date and time, the code, and the field name for all adds and modifications made to the credentialing data. The audit report is reviewed by the Credentialing Manager and Credentialing Lead to ensure all policies and procedures are followed and to identify any unusual or inconsistent activity. An audit of all modifications made to the credentialing data to confirm appropriateness of action. In the event of a discrepancy, appropriate steps shall be taken by the Credentialing Manager. Any evidence of inappropriate modifications or deletions made to the credentialing database or information that is not outlined in the policy, the Credentialing Manager will immediately address and take appropriate actions.
Credentialing Department	F	**Criteria for credentialing and recredentialing:** HAP assures that all practitioners applying for affiliation meet rigorous credentialing standards prior to providing care to members. The provider

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		must submit information and documentation of his/her education, qualification and certification which qualifies them to be identified as a specialist in a particular field of medicine. It is anticipated that the services to HAP members, performed by that credentialed specialist, would be consistent with the medical specialty for which the provider applied for and was evaluated and credentialed by HAP. Credentialed specialists are accordingly expected to provide covered services to HAP members that are within the scope of the specialty credentialed by HAP after review of the providers' application. Practitioners will go through the recredentialing process within 36 months of the previous credentialing decision. The recredentialing process will incorporate recredentialing activities as part of the assessment: • Member appeal and grievances • Quality of Care (QOC) and quality of service events • Medical records review at recredentialing and on a continuous basis Recredentialing process incorporates various forms of data, including, but not limited to: • Grievance data • Results of quality reviews • Utilization Management (UM) information • Member satisfaction survey results • Performance indicators obtained through your organizations quality improvement plan (QIP) The recredentialing cycle begins with the date of the initial credentialing decision. HAP counts the 36-month cycle to the month, not to the day. If HAP cannot recredential a practitioner within the 36-month time frame because the practitioner is on

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		active military assignment, maternity leave, or a sabbatical, but the contract between HAP and the practitioner remains in place, HAP will recredential the practitioner upon his or her return. HAP will document the reason for the delay in the practitioner's file. It is acceptable to recredential practitioners on leave. HAP will verify that a practitioner who returns from military assignment, maternity leave or a sabbatical has a valid license to practice before he or she resumes seeing patients. Within 60 days of when the practitioner resumes practice, HAP will complete the recredentialing cycle. If a practitioner is given administrative termination for reason beyond HAP's control (e.g., the practitioner failed to provide complete credentialing information), and is then reinstated within 30 calendar days, HAP may recredential the practitioner as long as it is documented that the practitioner was terminated for reasons beyond HAP's control and was recredentialed and reinstated within 30 calendar days of termination. HAP will initially credential practitioners if reinstatement is more than 30 calendar days after termination. • Completion of a CAQH application. • Completion of at least three years of post-graduate training in an approved internship and/or residency program (MD or DO) or DOs with only one-year post-graduate training before 1989 in an approved program and board certification. • Completion of an accredited physician assistant program with an approved internship/clinical practice requirements and hold a current active certification by the National Commission on Certification of Physician Assistants. • Completion of an accredited nurse midwife program, nurse practitioner, clinical nurse specialists or CRNA program with an approved internship/ clinical practice requirement.

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		• Nurse Practitioners and Physician Assistants must submit evidence of collaborative or practice agreement between applicant and a designated HAP credentialed physician. • Graduate from an optometry program that is accredited by the Accreditation Council on Optometric Education (ACOE) of the American Optometric Association (AOA). Optometrists must complete a four-year post-baccalaureate Doctor of Optometry Degree program. • Completion of a master's degree in social work (MSW) with a major focus of study in the treatment of Behavioral Medicine or equivalent field, as defined by the Michigan Board of Examiners of Social Work. • **Acupuncturists:** Current Michigan license to practice as an Acupuncturists. • **Licensed Professional Counselor:** Current Michigan license to practice as a Licensed Professional Counselor Master's degree from a program approved by the State Board of Counseling. • **Fully Licensed Psychologist:** Current Michigan license to practice as a Licensed Psychologist. Doctoral degree in psychology from an institution approved by the State of Michigan Board of Psychology • **Limited License Psychologist/LLP:** Current Michigan license to practice as a Limited License Psychologist. Master's or doctoral degree in psychology from an institution approved by the Michigan Board of Psychology. • **Board Certified Behavior Analyst (BCBA):** Possession of a minimum of a bachelor's and a master's degree that was conferred in behavior analysis or other natural science, education, human services, engineering, medicine, or a field

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		related to behavior analysis and approved by the BACB and must obtain BCBA Certification. • Board certification in the requested area of practice is recommended. Board certification does not apply to chiropractors or psychologists. • Recent graduates of residency programs who are not board certified at the time of application are encouraged to **attain board certification within four years of completing the training program.** • Specialties such as OB/GYN and all surgery related specialties are encouraged to **attain board certification within six years of completing the training program.** • Non-boarded practitioners see Section 4; Process for making credentialing and recredentialing decisions. • Unrestricted Licensure in the State of Michigan. • Unrestricted DEA in the State of Michigan or arrangements with a HAP contracted/credentialed provider with a valid DEA for required prescriptions will be considered for approval or denial at the discretion of the Credentialing Committee. For initial practitioners or practitioners who move from another state, they may have a covering practitioner for up to six months until they obtain their DEA. • Affiliation with a hospital, as applicable. Select specialists including Physical Medicine & Rehab, Dermatology, Ophthalmology and Psychology are not required to have an affiliation with a hospital. All others must have hospital affiliations. For PCPs, hospital affiliation is not required if they are able to identify a credentialed contracted practitioner to oversee the care of their members. • Current malpractice insurance, with at

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		least $100,000/$300,000 coverage. Verify malpractice coverages and amounts from the CAQH application or obtain a copy of the face sheet from practitioner. • Federal Torte Coverage - In lieu of malpractice insurance for practitioners delivering care at federal facilities, the file must include a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage. • For practitioners requesting assignment of a dual PCP and specialist, each designation must be assigned to a separate network. • Eligible to participate in Medicare and Medicaid and must not be excluded from participation in any governmental healthcare program. • Participate in Medicare and does not appear on the Medicare Opt-Out List. • Lack of current sanction and/or suspension from Medicare or Medicaid, or Federal Employees Health Benefits (FEHB). Exclusion or sanctions from a federal health care program shall cause an automatic termination as an affiliated practitioner. • Cooperation with Quality Management and Utilization Management programs, including a credentialing site visit and medical record-keeping practices review if requested. • Accept the HAP fee schedule as payment in full. • Accept new patients for all contracted product lines. • Favorable professional liability history including malpractice claims history with no more than $500,000 per claim or no more than 5 claims within the past five years. • Not excluded from System for Award Management (SAMS) Exclusion list.

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		• Lack of present illegal drug use. • Attest to any felony convictions. • No unexplained gaps in work history. • Obtain disclosure of Ownership and control of network provider • Lack of fraud, waste, and abuse documentation from Audit Department or FWA Response Team.
Credentialing Manager, and/or Credentialing Lead and Credentialing Committee Chair	G	**Process for making credentialing and recredentialing decisions:** Decision-making is governed by a majority vote of the Credentialing Committee for practitioners who do not meet minimum HAP standards and is nondiscriminatory. Each decision is based upon information, documents and/or evidence created, collected, maintained, or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies Committee decisions will be kept confidential by all participants except as required by law or at the discretion of the Credentialing Committee in order to encourage candor and careful assessment necessary to effect peer review and quality assurance. All credentialing activities are in compliance with NCQA, State of Michigan Department of Consumer and Industry Services Bureau of Health Services, and all other applicable laws and regulatory bodies. The Credentialing Committee considers all applicants, including those who have been granted waivers in the context of all available information. In the case of waivers, the Committee must weigh the lack of adherence to standards with factors such as: • Perceived value to HAP which merits approval despite failure to meet the standard, and/or • Perceived professional qualities, which may not be appropriately reflected in the HAP standard requiring board certification and residency training, including:

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a. Demonstrated motivation to participate in HAP and follow managed care procedures
b. Special need for practitioners in the geographic area/network
c. Reputation in the community
d. Prominence in the network's managed care organization
e. Professional experience/Continuing Medical Education experience
f. Partnership with current HAP practitioners of perceived exceptional quality

Board certification waivers are reviewed for **initial** applicants only. To be considered for a board certification waiver, the practitioner must submit a letter of recommendation including network need from their (hospital) department chair or three letters of recommendation from HAP contracted and credentialed practitioners. Board certification waivers will be considered for approval or denial at the discretion of Credentialing Committee.

Board certification extensions are granted to recredentialing applicants who provide proof from the board stating they are scheduled to sit for the exam. The Credentialing Committee reserves the right for approval or denial of Board certification extensions.

Practitioners certificates that expired and who fail to become recertified, or those practitioners whose board eligible period expired or lapsed and have no plans of certifying or recertifying must provide a written explanation to Credentialing Committee to continue their affiliation. The Credentialing Committee reserves the right for approval or denial.

- The Credentialing Committee may determine that some applicants who meet minimum HAP standards should not be approved for participation, for example:

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		• Lack of demonstrated motivation to participate cooperatively as a practitioner and follow the managed care/quality management procedures • Lack of perceived need for practitioners in the geographic area/network • Unfavorable reputation in the community • Lack of good standing at affiliated hospital • Perceived lack of quality of medical school/residency experience • Failure to comply with the ethics of the profession
Credentialing Manager, and/or Credentialing Lead and Credentialing Committee Chair	H	**Process for managing credentialing files that meet the organization's established criteria:** All credentialing files that do not meet minimum credentialing standards must be reviewed by the Credentialing Committee. Credentialing files that meet minimum credentialing standards, "clean files," are reviewed and approved by the Chair of the Credentialing Committee or an equally qualified practitioner. Medical Director's Review of Clean Files. • The Medical Director reviews and approves all practitioners that meet minimum requirements. • The Medical Director's approval is obtained through a handwritten signature or an electronic identifier. • The list of initial and recredentialing clean files is documented in the meeting minutes and the total number of clean files is presented to the Credentialing Committee.
Credentialing Department	I	**Process for delegating credentialing or recredentialing:** The credentialing process for affiliation with HAP may be delegated to another credentialing body if the potential delegate passes the pre-delegated evaluation, along with the approval from the Credentialing Committee and a signed executed mutually agreed upon delegated agreement.

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		In all cases, HAP retains ultimate authority over the process and engages in oversight activities to ensure that minimum standards are applied (Refer to Delegated Credentialing Policy).
Credentialing Committee, Credentialing Committee Chair	J	**Process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner:** The Credentialing Committee does not base credentialing decisions on the applicant's race, ethnicity, nationality/country of origin, gender, age, sexual orientation, or types of procedures or patients cared for by the practitioner. All members and guests of the Credentialing Committee sign a statement of confidentiality and nondiscriminatory decision-making on an annual basis as part of their Committee participation requirements. On an annual basis the Credentialing Committee reviews credentialing files (in-process, denied and approved files) to ensure that there is no pattern of discrimination or evidence of individual discrimination.
Credentialing Department	K	**Process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization:** If the information received varies substantially from the information provided on the application, the credentialing staff requests clarification from the practitioner and provides the practitioner an opportunity to amend the erroneous information. Notification of erroneous information is sent to the provider by certified mail or secured e-mail.
Credentialing Department	L	**Process for ensuring that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision:** Practitioners are notified within 60 calendar days of the Credentialing Committee's decision. Approval notices are sent by a Credentialing team member to the practitioner notifying the practitioner of the committee's decision. Denial notices for initial and recredentialing, with the reason for the denial are sent by a Credentialing team member to the practitioner via certified mail.

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Credentialing Committee Chair	M	**Medical director or other designated physician's direct responsibility and participation in the credentialing program:** The HAP Medical Director is responsible for the Credentialing Committee. The HAP Medical Director ensures that HAP carries out its credentialing activities in the most efficient, effective way possible and that all credentialing activities are in compliance with the Credentialing Policies, NCQA standards, State of Michigan Department of Consumer and Industry Service Bureau of Health Services, and all other applicable laws and regulations. The Medical Director may approve initial and recredentialing files that meet all credentialing criteria or may determine that additional review is necessary by the Credentialing Committee.
Credentialing Department, Credentialing Committee Chair	N	**Process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law:** The Credentialing Department and all members and guests of the Credentialing Committee sign a statement of confidentiality and nondiscriminatory decision-making on an annual basis. Members and guests of the Credentialing Committee will not discuss or share information that was obtained at this meeting, or in preparation or follow-up to the meeting. Information is to be utilized only as it is originally intended. Information, documents and/or evidence created, collected, maintained, or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies, will be kept confidential by all participants except as required by law or at the discretion of the Credentialing Committee in order to encourage candor and careful assessment necessary to effect peer review and quality assurance. Credentialing Committee members and guests will not discuss, share, or use any peer review information for any purpose other than peer review. Access to credentials documents will be restricted to authorized credentialing staff, Committee members, peer reviewers and reporting bodies as authorized by the Credentialing Committee. Active credentialing files (currently in process) and completed credentialing files may only be accessed by the Credentialing Department to

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		protect the accuracy of information gathered from primary sources and NCQA-approved sources in accordance with existing corporate policies and procedures. All credentialing files are electronic and stored in electronic format on a secure server only accessed by the Credentialing Department, password specific to the user, to prevent unauthorized access, changes to and release of credentialing information in accordance with existing policies. Access to the credentialing database is requested via an online IT request form and approved by the Credentialing Manager. All Credentialing staff are required to change their passwords every 90 calendar days. For maintaining confidentiality, staff will use strong passwords, avoid writing down their password or share their password; but remember it. User ID's and passwords are unique to each user. The Credentialing Department will follow the Password Management Policy, Network Encryption Standard Policy, Confidentiality, and Information Security Policy of Henry Ford Health System, which includes HAP. Upon the termination of a staff member's employment or transfer to another department within the organization that does not require access to the credentialing database the user access shall be inactivated no later than close of the business on the employee's last day of work. The request is sent by the Credentialing Manager to the IT Department to disable immediately. Minutes, reports, and files of Credentialing Committee meetings will be maintained in a confidential manner in the physicians file imaging system. The physician file once it has been imaged is transferred offsite in a secure and restricted environment for the duration of seven (7) years. At the end of seven (7) years, the file is shredded/ destruction in compliance with Offsite Records Storage, Retrieval, Destruction (Office Services Corporate Policy). Copies of the minutes will not be allowed to be removed from the site of the Credentialing Committee. All minutes and documentation will be shredded immediately following the meeting. The identity of a person whose condition or treatment has been studied in the Committee is confidential and the Committee shall remove the

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		person's name and address from the record before the Committee releases or publishes a record of its proceedings, or its report, findings, and conclusions. Except as otherwise provided, the record of proceedings and the reports, findings, and conclusions and data collected by or for this Committee are confidential, are not public records, and are not discoverable and shall not be used as evidence in a civil action or administrative proceeding. Disclosure of credentialing information is limited to information needed (i.e., name, address, network, specialty, education and training, board certification status, hospital affiliation) for provider directory, provider assignment or on-line directory. Physical access to credentialing information maintained in the Credentials Department is limited to staff members who are assigned to fulfill the requirements of the department. Members of the Credentials Committee, the Medical Director/ Credentials Committee Chairman, may view information only in the course of active Credentials Committee reviews.
Credentialing Department	O	**The process for confirming those listings in practitioner directories and other materials for members is consistent with credentialing data.** The practitioner directory excludes all practitioners that are not independently contracted and credentialed who practice in an inpatient setting. The directory may differ based on member's benefit level. Practitioner-specific information, including education and training, board certification status, specialty, hospital affiliation, gender, and language information, that is made available to HAP and its subsidiaries (all products lines), and the general public is derived directly from the Credentialing department's database. All practitioner-specific information (education and training, board certification status, specialty, hospital affiliation, gender, and language information) is verified through the credentialing process and entered into CACTUS. After the Credentialing Committee's approval, this information is entered into the claims database, where practitioner directories and all practitioner-specific information are derived. The Credentialing staff is responsible for entering

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		practitioner specific information into the credentialing database. Any discrepancies are validated and corrected within 30 calendar days. Practitioner-specific information is also validated during the recredentialing process which takes place every three years.
Credentialing Department	P	**Practitioners Rights** **HAP notifies practitioners about their rights to review information submitted to support their credentialing application:** It is the practitioner's right to review information obtained to evaluate the practitioners credentialing application, attestation, or CV. Each practitioner has the right to review certain information obtained during the verification process. Practitioners do not have the right to review information such as peer-review protected information, recommendations or other information that is considered to be peer-review protected. The practitioner may review credentialing policies and procedures upon written request. **Correction of erroneous information:** If the information received varies substantially from the information provided on the application, HAP requests clarification from the practitioner and provides the practitioner an opportunity to amend the erroneous information. Notification of erroneous information is sent to the provider by certified mail or secured e-mail. The practitioner is asked to respond in writing within 14 calendar days of receipt of the certified letter. The practitioner mails the response to the Credentialing Team member or the Manager of Credentialing by certified mail. If the practitioner chooses to exercise his or her right to correct the erroneous information: • HAP Credentialing will further investigate the primary source information. • This information, along with the practitioner's response, is presented to the Credentialing Committee for review

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		and resolution. • The practitioner is notified via certified mail within 14 days of the Credentialing Committee's decision. • If the practitioner chooses **not** to exercise his or her right to correct the erroneous information, or does not respond within 14 days: • The information is presented to the Credentialing Committee for review and resolution, without input from the practitioner. • The practitioner is notified of the committee decision by certified mail.
Credentialing Department	Q	**Upon request, the practitioner receives the status of their credentialing or recredentialing application:** If the practitioner requests the status of his/her application, HAP provides practitioner with the approximate date when the application will be presented to the Credentialing Committee and any outstanding primary source verification letters either by telephone, email, or written correspondence. Practitioners do not have the right to review information such as recommendations, references, or other information that is considered to be peer-review protected.
Credentialing Department	R	**Notification of Practitioner Rights:** Practitioners are notified of these rights upon their initial request for a contract and on an ongoing basis. CR1 is sent along with the initial request for a contract. Credentialing policies and procedures are made available to all HAP contracted practitioners on an ongoing basis on the provider portal of the website and practitioners are notified annually and offered hard copies of the policies and procedures if web access is unavailable.

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MONITORING:

At a minimum, monthly reports are generated from the credentialing system or as needed.

REPORTING:

The policy is reviewed at least annually, or more frequently, for accuracy, quality and as new guidance becomes available. An annual Credentialing department report is submitted to the Clinical Quality Management Committee (CQMC) on credentialing productivity, credentialing audits conducted, changes, and major activities. All updates/changes in the credentialing requirements/processes are reviewed and approved by the Credentialing Committee.

Name of Report	Frequency of Report	Owner	What committee or senior leader(s) receives report
Audit Report	Quarterly	Manager of Credentialing	Credentialing Committee Chair
Clean File Report	Weekly	Credentialing Lead and/or Credentialing Manager	Credentialing Committee Chair
Recredentialing Due Report	Weekly	Credentialing Lead	Credentialing Manager
Credentialing Disenrollment Report	Quarterly	Credentialing Manager	Credentialing Committee Chair

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Approval Signatures

Step Description	Approver	Date
Compliance Final Review	Johnathan Randle: Dir-Gov't Programs Compliance	10/2023
Medical Director-HCM	Yvonne Sesi: Medical Director-HCM	10/2023
Compliance Initial Review	Irina Shikin: Compl Monitorng & Overst Audit	10/2023
Document Owner	Janet Krajnovic: Mgr-Credentialing	10/2023

Standards

No standards are associated with this document