

n05566

Credentialing and Recredentialing Information Collection, Coordination, and Dissemination Process

Values

Accountability • Integrity • Service Excellence • Innovation • Collaboration

Abstract Purpose:

The purpose of this policy is to provide guidance as to how the Network Health Plan/Network Health Insurance Corporation/Network Health Third Party Administrator/Network Health Administrative Services, LLC (NHP/NHIC/NH TPA/NHAS) Credentialing Department fulfills its responsibilities for collecting credentials for all licensed independent practitioners, dependent practitioners, and organizational providers and shows continued competence by education, experience, and continued commitment to high-quality, cost-effective medical care for continued participation in NHP/NHIC/NH TPA/NHAS upon credentialing and recredentialing.

Policy Detail:

Credentialing and recredentialing is conducted in a manner that does not discriminate on the basis of race, ethnicity, ethnic/national identity, gender, age, religion, sex, sexual orientation, patient's insurance coverage (e.g., Medicaid), or the type of procedure or patient in which the practitioner specializes or serves. A complete review will be conducted on every file that is denied by the credentials committee to ensure that the denial was non-discriminatory. The Medical Director or Designated Physician will appoint a peer to review the denial to ensure that the decision was made in a non-discriminatory manner. The proactive steps that the organization uses to protect, prevent, and annually monitor discriminatory practices are as follows: Upon credentialing and/or recredentialing, the Medical Director or Designated Physician attests that the file review was conducted in a non-discriminatory manner and makes a recommendation to the Centralized Credentials Committee. The results of such review will be reported back to the Credentials Committee by the Medical Director or Designated Physician. An annual review of all credentialing decisions is conducted by the Manager of Provider Integration to help prevent discrimination. The annual review includes, but is not limited to:

1. Maintaining a heterogeneous Credentialing Committee membership and requiring for those responsible for credentialing decisions to sign a statement affirming that they do not discriminate.
2. Periodic audits of credentialing files (in-process, denied, and approved files) that suggest potential discriminatory practice in selecting practitioners.
3. Annual audits of practitioner complaints for evidence of alleged discrimination.
4. Tracks and identifies discrimination in credentialing and recredentialing processes.

Practitioners shall be notified within 30 calendar days of the Credentialing decision. NHP/NHIC/NH TPA/NHAS is not required to notify practitioners regarding recredentialing approvals. Practitioners have

the right, upon request, to be informed of the status of their credentialing and recredentialing application. Review of information to evaluate participation or continuation of participation for practitioners is ongoing and periodic. In situations where there is a question regarding any primary source verification or quality issue, or if requested by the Credentialing Committee, additional investigation or review may be initiated. This policy applies to all practitioners, including PPO practitioners when applicable (see related document NHP/NHIC/NH TPA/NHAS PPO "When Applicable" Definition). This policy is consistent with NHP/NHIC/NH TPA/NHAS's mission, vision, and values. All credentialed NHP/NHIC/NH TPA/NHAS practitioners as identified in this policy must successfully complete the recredentialing process within a 36-month timeframe for a continued contract as an NHP/NHIC/NH TPA/NHAS practitioner. Practitioners whose credentialing or recredentialing required special consideration by the Credentials Committee are required to be reevaluated on an annual basis (every 12 months) or as determined by the Credentials Committee. (*See Range of Actions to Improve Performance/Altering the Conditions of Participation*).

All credentialing and recredentialing applications will be returned to the NHP/NHIC/NH TPA/NHAS Credentialing Department no later than 90 days of receipt of application. Only practitioners who are currently credentialed are included in the NHP/NHIC/NH TPA/NHAS Provider Directory. Education, training, and certification relevant to each specialty/subspecialty in which a practitioner desires to practice will be assessed with each recredentialing cycle. NHP/NHIC/NH TPA/NHAS verifies completion of fellowship if the practitioner's fellowship program or completion of fellowship is communicated to members (e.g., in a directory, newsletter, or by member services staff). If a practitioner desires to change his/her specialty/ subspecialty between recredentialing cycles, this change will need to be presented to the Credentialing Committee for approval. No practitioner will be listed individually by name in NHP/NHIC/NH TPA/NHAS's Directory unless they have been approved by the committee for their specialty or subspecialty of practice. All listings in provider directories and other member materials shall be consistent with credentialing data, including education, training, board certification, and specialty. Processes to ensure consistency include (a) obtaining complete information regarding education, training, board certification, and specialty for each specialty or subspecialty in which the practitioner intends to practice, (b) auditing the accuracy of credentialing information in the Echo/QNXT database, which is the source of provider directory information.

- I. Application process for initial credentialing:
 - A. A request for an application packet will be forwarded to the NHP/NHIC/NH TPA/NHAS Credentialing Department via Managed Care Contracting. NHP/NHIC/NH TPA/NHAS Credentialing Department will forward an application packet to the applicant within a timely manner via the Credentialing software, ECHO.
 1. The application packet will include:
 - a. Welcome Letter, including a link to the applicable NHP/NHIC/NH TPA/NHAS Policies and Procedures.
 - b. Application form.
 - c. Criminal Background Check Form.
 - B. The applicant must sign the completed application via handwritten or electronic documentation to support correctness and completeness of the application. Electronic signatures must be generated from a secure site. Handwritten signatures will be recorded in black or blue non-erasable, non-water-soluble ink. Felt tip markers, fountain pens, and signature stamps are only acceptable if the practitioner is physically impaired, and the disability is documented in the practitioner's credentialing file. If a practitioner is using a

CAQH application, NHP/NHIC/NH TPA/NHAS will accept the last attestation date generated by CAQH as the date when the provider signed and dated the application to attest to its completeness and correctness.

1. Signifies a willingness to appear for interviews regarding the application.
 2. Authorizes NHP/NHIC/NH TPA/NHAS representatives to consult with others who have been associated with the applicant and/or have information bearing on his or her competence and qualifications.
 3. Consents to NHP/NHIC/NH TPA/NHAS representatives' inspection of all records and documents that may be material to an evaluation of the applicant's:
 - a) Professional qualifications and competence
 - b) Physical and mental health status
 - c) Professional and ethical qualifications.
 4. Releases from any liability all NHP/NHIC/NH TPA/NHAS representatives for their acts performed in connection with evaluation of credentials and qualifications.
 5. Releases from any liability all individuals and organizations who, in good faith and without malice, provide information to NHP/NHIC/NH TPA/NHAS representatives - including otherwise privileged or confidential information - concerning the applicant's competence, professional ethics, health equity requirements, character, physical and mental health, emotional stability and other qualifications for Network Health Plan participation.
 6. Authorizes and consents to NHP/NHIC/NH TPA/NHAS representatives providing other hospitals, medical associations, licensing boards, and any organizations concerned with all licensed independent practitioners, dependent practitioners, and organization providers' performance and the quality and efficiency of patient care with any relevant information that the organizations may have, and releases NHP/ NHIC/NH TPA/NHAS representatives from liability for so doing.
 7. Understands and agrees that credentialing and peer review information related to their professional qualifications, character, and competence will be released and exchanged among NHP/NHIC/NH TPA/NHAS entities.
 8. Expressly authorizes the sharing of such information between NHP/NHIC/NH TPA/NHAS, both with respect to information that exists today, and information obtained or created in the future (until such time as all licensed independent practitioners, dependent practitioners, and organizational providers revoke this consent).
 9. Signifies that the applicant agrees to be bound by the current NHP/NHIC/NH TPA/NHAS policies and procedures regarding the application for Network Health Plan participation/contracting requirements.
- C. The applicant must submit the following to the NHP Credentialing Department via email, fax, digital, electronic, scanned, or US mail:
1. A completed application or copy of CAQH Provider Data Summary Application will be deemed incomplete if information or documentation requested is not provided, if responses provided require further explanation, if details related to affirmative responses to disclosure questions are not provided, or if any document has expired prior to making the decision to accept or not to accept an applicant.

2. A signed and dated release/attestation form. Application is incomplete without signature and date.
 3. If available, a copy of the letter or certificate from the appropriate American Board of Medical Specialties specialty boards documenting board status - certified, recertified, or eligible, if applicable.
 4. Copy of Federal DEA registration or CDS (Controlled Dangerous Substances) certificate in each state, which is current and effective, if applicant is to prescribe narcotics. If a provider's DEA registration is pending, Network Health must be provided with an alternate practitioner name with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner whose DEA is still pending until the practitioner has a valid DEA certificate.
 5. Information on education, training, work history, hospital affiliations, and health status and health equity requirements.
 6. Copy of current face sheet of current and valid professional liability insurance in which coverage pertains to area of practice or profession, and meets the minimum limit requirement, and completion of malpractice history questions on application form.
 - a) For practitioners with federal tort coverage, the practitioner need not maintain the current amount of malpractice insurance coverage. Practitioner may include a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage and completion of the malpractice history questions on the application form.
 7. Criminal Background Check Form.
 8. Questions posed on the application related to:
 - a) Reasons for inability to perform the essential functions of the position.
 - b) Lack of present illegal drug use.
 - c) History of loss of license and felony convictions
 - d) History of felony convictions
 - e) History of loss or limitations of privileges or disciplinary actions
 - f) Race, gender, age, sexual orientation, ethnicity, and language.
- D. All credentialing files received by either email, fax, digital, electronic, scanned, or paper copy through the US mail, reports, and any other material used shall be treated in a confidential manner at all times and are scanned and stored in a secure electronic site in the credentialing department, except as required by law. Disclosure of such information shall be limited to NHP/NHIC/NH TPA/NHAS. All other requests will require consent for release of information by the applicant. All materials/primary source verifications are performed and reviewed by the credentialing staff for appropriateness and processing per primary source guidelines. Upon receipt of any documents, the Credentialing staff will date-stamp with an electronic stamp and initial all items as they are received. All credentialing information is tracked within the provider's electronic credentialing file via ECHO's electronic checklist. All information added to ECHO/provider file is reviewed and signed off on by another credentialing staff for accuracy before the file may progress.
- E. Recredentialing approval process

The decision to retain or not retain a current practitioner is based on an assessment of the practitioner's ability to deliver care and the information available, including but not limited to the information gathered through a completed recredentialing application and the verification of all collected information. Sanctions, complaints, adverse events, and quality information are also used to evaluate the current practitioner. See Process for Ongoing Monitoring of Sanctions, Complaints, Adverse Events, and Quality Issues. Recredentialing criteria is used to establish consistent, clear objectives for the recredentialing of current practitioners. The following criteria are prerequisites for consideration by the Credentials Committee for continued participation as a practitioner of NHP/NHIC/NH TPA/NHAS.

- 1) Once the complete Credentialing application and primary source information has been assessed against the established criteria, the application and file are forwarded to the Medical Director or Designated Physician. The Chairperson will review the Credentialing file to determine whether it meets Credentialing criteria and recommend the practitioner's approval for participation to the Credentials Committee at the next scheduled meeting or to pend recommendation for further review and discussion by the Credentials Committee.
 - i. A summary of all applications will be presented at the Credentials Committee meeting. Any files of practitioners will be made available and can be reviewed upon request at the Credentials Committee meeting. The Credentials Committee may accept the recommendations made by the Chairperson or pend for further review and discussion. The final decision will be made by the Credentials Committee. In the instance of providers who fail to meet all Credentialing criteria, the Credentials Committee may approve, request submission of an action plan for improvement by the practitioner, limit Credentialing with further review, or terminate.
 - a. Credentialing decisions shall be documented in the practitioner's file and the Credentials Committee meeting minutes.
 - b. The Credentialing Department will notify the practitioner of the Credentialing decision by letter. If a practitioner is terminated for, if, and only if, reasons related to quality of care, competence and professional conduct, NHP/NHIC/NH TPA/NHAS will inform the practitioner of his/her right to a fair hearing/appellate review and may be required to report such findings to the State of Wisconsin Department of Safety and Professional Services, the National Practitioner Data Bank. (*See Range of Actions to Improve Performance/Altering the Conditions of Participation, Fair Hearing and Appellate Review Process, and Reporting to Proper Authorities*).
2. NHP/NHIC/NH TPA/NHAS Board of Directors has delegated accountability for credentialing decisions to the Credentials Committee, the Credentials Committee reports to the Quality Management Committee (QMC). In the case of an appeal, the

Board of Directors makes the final decision. The Medical Director or Designate Physician is directly responsible for the credentialing program and serves as a member/participates in the Credentials Committee. The Medical Director reports through the QMC to the Board of Directors on all recredentialing activities.

II. Application Process for Recredentialing

- A. A recredentialing application packet will be electronically emailed to provider or provider's office 4 months prior to renewal date via the Credentialing software, ECHO.
 - 1. The recredentialing application packet will include:
 - a) Renewal Letter, including a link to the applicable NHP/NHIC/NH TPA/NHAS Policies and Procedures.
 - b) Pre-populated Application form.
 - c) Criminal Background Check Form.
- B. The applicant must sign the completed application via handwritten or electronic documentation to support correctness and completeness of the application. Electronic signatures must be generated from a secure site. Handwritten signatures will be recorded in black or blue non-erasable, non-water-soluble ink. Felt-tip markers, fountain pens, and signature stamps are only acceptable if the practitioner is physically impaired and the disability is documented in the practitioner's credentialing file.
 - 1. Signifies a willingness to appear for interviews in regard to the application.
 - 2. Authorizes NHP/NHIC/NH TPA/NHAS representatives to consult with others who have been associated with the applicant and/or have information bearing on his or her competence and qualifications.
 - 3. Consents to NHP/NHIC/NH TPA/NHAS representatives' inspection of all records and documents that may be material to an evaluation of the applicant's:
 - d) Professional qualifications and competence
 - e) Physical and mental health status
 - f) Professional and ethical qualifications.
 - 4. Releases from any liability all NHP/NHIC/NH TPA/NHAS representatives for their acts performed in connection with evaluation of credentials and qualifications.
 - 5. Releases from any liability all individuals and organizations who in good faith and without malice, provide information to NHP/NHIC/NH TPA/NHAS representatives - including otherwise privileged or confidential information - concerning the applicant's competence, professional ethics, health equity requirements, character, physical and mental health, emotional stability, and other qualifications for Network Health Plan participation.
 - 6. Authorizes and consents to NHP/NHIC/NH TPA/NHAS representatives providing other hospitals, medical associations, licensing boards, and any organizations concerned with all licensed independent practitioners, dependent practitioners, and organization providers' performance and the quality and efficiency of patient care with any relevant information that the organizations may have, and releases NHP/ NHIC/NH TPA/NHAS representatives from liability for so doing.

7. Understands and agrees that credentialing and peer review information related to their professional qualifications, character, and competence will be released and exchanged among NHP/NHIC/NH TPA/NHAS entities.
 8. Expressly authorizes the sharing of such information between NHP/NHIC/NH TPA/NHAS, both with respect to information that exists today, and information obtained or created in the future (until such time as all licensed independent practitioners, dependent practitioners, and organizational providers revoke this consent).
 9. Signifies that the applicant agrees to be bound by the current NHP/NHIC/NH TPA/NHAS policies and procedures in regard to the application for Network Health Plan participation/contracting requirements.
 10. Attests to the correctness and completion of the application.
- C. The applicant must submit the following to the NHP Credentialing Department via email, fax, digital, electronic, scanned, or US mail:
1. A completed application or copy of CAQH Provider Data Summary Application will be deemed incomplete if information or documentation requested is not provided, if responses provided require further explanation, if details related to affirmative responses to disclosure questions are not provided, or if any document has expired prior to making the decision to accept or not to accept an applicant.
 2. A signed and dated release/attestation form. Application is incomplete without signature and date.
 3. If available, a copy of the letter or certificate from the appropriate American Board of Medical Specialties specialty boards documenting board status - certified, recertified, or eligible, if applicable.
 4. Copy of Federal DEA registration or CDS (Controlled Dangerous Substances) certificate in each state, which is current and effective, if applicant is to prescribe narcotics. If providers DEA registration is pending, an explanation why the practitioner does not prescribe medications, and must provide a practitioner name with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner whose DEA is still pending until the practitioner has a valid DEA certificate.
 5. Information on education, training, work history, hospital affiliations, and health status and health equity requirements.
 6. Copy of current face sheet of current and valid professional liability insurance in which coverage pertains to area of practice or profession, and meets the minimum limit requirement, and completion of malpractice history questions on application form.
 - a) For practitioners with federal tort coverage, the practitioner need not maintain the current amount of malpractice insurance coverage. Practitioner may include a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage and completion of the malpractice history questions on the application form.
 7. Criminal Background Check Form.
 8. Questions posed on the application related to:

- a) Reasons for inability to perform the essential functions of the position.
 - b) Lack of present illegal drug use.
 - c) History of loss of license and felony convictions
 - d) History of felony convictions
 - e) History of loss or limitations of privileges or disciplinary actions
 - f) Race, gender, age, sexual orientation, ethnicity, and language.
- D. All recredentialing files received by either email, fax, digital, electronic, scanned, or paper copy through US mail, reports, and any other material used shall be treated in a confidential manner at all times and are scanned and stored in a secure electronic site in the credentialing department, except as required by law. Disclosure of such information shall be limited to NHP/NHIC/NH TPA/NHAS. All other requests will require consent for release of information by the applicant. All materials/primary source verifications are performed and reviewed by the credentialing staff for appropriateness and processing per primary source guidelines. Upon receipt of any documents, the Credentialing staff will date-stamp with an electronic stamp and initial all items as they are received. All credentialing information is tracked within the provider's electronic credentialing file via ECHO's electronic checklist. All information added to ECHO/provider file is reviewed and signed off on by another credentialing staff for accuracy before the file may progress.
- The Network Health Credentialing Department collects recredentialing data and conducts primary source verification. Completed recredentialing applications are required to be completed in via handwritten or electronic documentation. Faxed, digital, scanned, or photocopied signatures are acceptable. Signature stamps are only acceptable if the practitioner is physically impaired and the disability is documented in the practitioner's credentialing file. Electronic signatures must be generated from a secure site. Handwritten signatures will be recorded in black or blue non-erasable, non-water-soluble ink; felt tip markers, fountain pens, and signature stamps may not be used. In so doing, completed recredentialing applications will be forwarded to the Credentialing Department for assessment and are considered by the Medical Director or Designated Physician and/or the Credentials Committee. Information and verification are to be no more than 120 calendar days old at the time of review and decision by the Medical Director or Designated Physician and/or the Credentials Committee.

1) Documentation Process:

- a. Actual copies of credentialing information are kept within the file or electronically.
- b. The name of the source used, the date of verification, the signature or initials of the person who verified the information, and the report date, if applicable, are included on a detailed/signed checklist to be kept in the file or electronically.
- c. An electronic signature, initials, or unique electronic identifier of staff is used to document verification. The electronic signature, initials, or unique identifier can only be entered by the signatory. The system identifies the individual verifying the information, the date of verification, the source, and the report date, if applicable.

2) Confidentiality:

All recredentialing information received and all recredentialing files, minutes, reports, and any other material used to determine a recredentialing decision is confidential and stored in a secure area in the Credentialing Department, except as required by law. Disclosure of such information will not be granted unless a consent for release of information has been signed by the applicant.

3) Practitioner Notification:

- a. The recredentialing application includes a statement that notifies the practitioner of his/her right to review information obtained by NHP/NHIC/NH TPA/NHAS to evaluate their recredentialing application. This evaluation includes information obtained by any outside primary source (e.g., malpractice insurance carriers, state licensing boards). A practitioner is not allowed to review references/recommendations or other information that is peer review protected.
- b. The recredentialing application also notifies the practitioner of his/her right to correct erroneous information obtained from other sources that varies substantially from that provided by the practitioner, e.g., actions on a license, malpractice claims history, or board certification decisions.
- c. Practitioners are informed of their right to request the status of their application. Request for information on the status of the application should be made through the Credentialing Department via e-mail or phone call. This right is found on the attestation page of the application. The Credentialing Department will notify the practitioner by e-mail, mail, or fax within ten (10) calendar days of receipt of information, and this notification will be documented in the practitioner's credentials file. The Credentialing Department is not required to reveal the source of information if the information is not obtained to meet the requirements of the credentialing verification requirements or if disclosure is prohibited by law. The practitioner will be given ten (10) calendar days to correct erroneous information submitted by another party. Corrections and/or additional information to the application must be submitted in writing to the Credentialing Department via e-mail or mail to: NHP/NHIC/NH TPA/NHAS Credentialing Department, 1570 Midway Place, Menasha, WI 54952, and the receipt of such will be documented and retained in the practitioner's credentials file. The Credentialing Coordinators will communicate via e-mail to schedule arrangements with practitioner either electronically, by mail, or in person in the Credentialing Department.
- d. Process for Ongoing Monitoring of Sanctions, Complaints, Adverse Events, and Quality Issues:
NHP/NHIC/NH TPA/NHAS monitors for sanctions and tracks complaints and quality issues against practitioners throughout the 36-month time frame between formal recredentialing. This is consistent with the NHP/NHIC/NH TPA/NHAS's mission, vision, and values. This is done through monthly queries and reports from the Office of the Inspector General, the State of Wisconsin Department of Safety and Professional Services, and NHP/NHIC/NH TPA/NHAS's Complaint Database and Proactive Disclosure Service (PDS). This process is done on an automatic, continuous monitoring basis with reports from the NPDB/HIPDB. This

process means that as new information is received on an enrolled practitioner, NHP/NHIC/NH TPA/NHAS's Medical Director or Designated Physician is alerted and appropriate action is taken in accordance with related NHP/NHIC/NH TPA/NHAS policies. Also queried on a quarterly basis is the Medicare Opt-Out Report. Findings of sanctions are reported to the Credentials Committee or other designated peer review body at the next meeting after the identified occurrence. Significant quality of care issues are reviewed by the Peer Review Committee, which submits biannual reports to the Credentialing Committee for review and discussion. A corrective action plan is approved by the Credentialing Committee as appropriate.

e. Recredentialing approval process

The decision to retain or not retain a current practitioner is based on an assessment of the practitioner's ability to deliver care and the information available, including but not limited to the information gathered through a completed recredentialing application and the verification of all collected information. Sanctions, complaints, adverse events, and quality information are also used to evaluate the current practitioner. See Process for Ongoing Monitoring of Sanctions, Complaints, Adverse Events, and Quality Issues. Recredentialing criteria is used to establish consistent, clear objectives for the recredentialing of current practitioners. The following criteria are prerequisites for consideration by the Credentials Committee for continued participation as a practitioner of NHP/NHIC/NH TPA/NHAS.

1. Once the complete recredentialing application and primary source information has been assessed against the established criteria, the recredentialing application and file is forwarded to the Medical Director or Designated Physician. The Chairperson will review the Recredentialing file, determine whether it meets recredentialing criteria, and recommend the practitioner's approval for continued participation to the Credentials Committee at the next scheduled meeting or to pend recommendation for further review and discussion by the Credentials Committee.
2. A summary of all recredentialing applications will be presented at the Credentials Committee meeting. Any recredentialing files of practitioners will be made available and can be reviewed upon request at the Credentials Committee meeting. The Credentials Committee may accept the recommendations made by the Chairperson or pend for further review and discussion. The final recredentialing decision will be made by the Credentials Committee. In the instance of providers who fail to meet all recredentialing criteria, the Credentials Committee may approve, request submission of an action plan for improvement by the practitioner, limit recredentialing with further review, or terminate.
3. Recredentialing decisions shall be documented in the practitioner's file and the Credentials Committee meeting minutes.

4. The Credentialing Department will notify the practitioner of the recredentialing decision by letter. If a practitioner is terminated for, if, and only if, reasons related to quality of care, competence and professional conduct, NHP/NHIC/NH TPA/NHAS will inform the practitioner of his/her right to a fair hearing/appellate review and may be required to report such findings to the State of Wisconsin Department of Safety and Professional Services, the National Practitioner Data Bank. (*See Range of Actions to Improve Performance/Altering the Conditions of Participation, Fair Hearing and Appellate Review Process, and Reporting to Proper Authorities*).
 5. NHP/NHIC/NH TPA/NHAS Board of Directors has delegated accountability for credentialing/recredentialing decisions to the Credentials Committee; the Credentials Committee reports to the Quality Management Committee (QMC). In the case of an appeal, the Board of Directors makes the final decision. The Medical Director or Designated Physician is directly responsible for the credentialing program and serves as a member/participates in the Credentials Committee. The Medical Director reports through the QMC to the Board of Directors on all recredentialing activities.
- f. The recredentialing application and supporting documents must be kept as a permanent record in the Credentialing Department. The credentialing files on a participating practitioner are retained throughout the time period that the contract with NHP/NHIC/NH TPA/NHAS remains effective. They are kept for a period of ten years after the date of termination. The identity of terminated practitioners will also be retained.
 - g. Participation reinstatement of Practitioners who are terminated with NHP/NHIC/ NH TPA/NHAS
 If a practitioner was successfully credentialed/recruited by NHP/ NHIC/NH TPA/NHAS, leaves NHP/NHIC/NH TPA/NHAS, and then NHP/NHIC/NH TPA/NHAS or the practitioner wants to reinstate participation in NHP/NHIC/NH TPA/NHAS, the following procedure will be conducted:
 1. Practitioner will review and update most current application to include any additional training/work history and explanation of any gaps from time practitioner left NHP/NHIC/NH TPA/NHAS to present.
 2. Practitioner will sign and date attestation form attesting that updated application is complete and correct.
 3. The Credentialing Department will ensure that all previously verified information is still correct and will re-verify any time-limited information.
 4. The complete application, attestation, and primary source information will be assessed against NHP/NHIC/NH TPA/NHAS recredentialing criteria and forwarded to the Credentials Committee Chairperson for review and recommendation.

5. A summary of the practitioner's reapplication will be presented to the Credentials Committee, along with the recommendation by the Chairperson. The Credentials Committee shall make the final decision on the practitioner's participation in NHP/NHIC/NH TPA/NHAS.
6. The practitioner must complete the above process before a contract is executed.
 - a. If leave extends beyond the next scheduled recredentialing cycle, the practitioner will need to complete a credentialing application and complete the credentialing process before a contract is executed.
 - b. If either party terminated the contract or there is a break in service of more than 30 calendar days, NHP/NHIC/NH TPA/NHAS must initially credential the practitioner.
 - c. If the practitioner cannot be recredentialed within 36-month timeframe because the practitioner is an active military assignment, maternity leave, or a sabbatical, but the contract between NHP/NHIC/NH TPA/NHAS and the practitioner remains in place, NHP/NHIC/NH TPA/NHAS may recredential the practitioner upon his or her return and will document the reason the delay in the practitioner's file. At a minimum, NHP/NHIC/NH TPA/NHAS will verify that a practitioner who returns from military assignment, maternity, or a sabbatical has a valid license to practice, including current CME, before he or she resumes seeing patients. Within 60 calendar days of when the practitioner resumes practice, NHP/NHIC/NH TPA/NHAS will complete the recredentialing cycle. On the other hand, if either party terminates the contract or there is a break in service of more than 30 calendar days, NHP/NHIC/NH TPA/NHAS will require the practitioner to begin initial credentialing before the practitioner rejoins the network. NHP/NHIC/NH TPA/NHAS will recredential the practitioner as long as it provides documentation that the practitioner was terminated for reason beyond its control and was recredentialed and reinstated within 30 calendar days of termination. NHP/NHIC/NH TPA/NHAS will initially credential the practitioner if reinstatement is more than 30 calendar days of termination.
7. If NHP/NHIC/NH TPA/NHAS terminates a practitioner for administrative reasons (e.g., the practitioner failed to provide complete credentialing information) and not for quality reasons, it may reinstate the practitioner within 30 calendar days of termination and is not required to perform initial credentialing. (Note: This is not an NPDB reportable event). The organization performs initial credentialing if reinstatement is more than 30 calendar days after termination. If NHP/NHIC/NH TPA/NHAS organization does not have the necessary information for recredentialing, it informs the practitioner that this information is needed at least 30 calendar days before the recredentialing deadline and that without this information, the

practitioner will be administratively terminated. NHP/NHIC/NH TPA/NHAS includes this notification in the practitioner's credentialing file. If the practitioner is subsequently terminated for lack of information, the termination notice should be in the practitioner's file.

III. Verification Process

Primary verification is obtained from the following. The Credentialing Committee, which includes the medical director or a designated physician, makes final determination regarding which practitioners may participate in NHP/NHIC/NH TPA/NHAS network. The application, attestation, and primary source verification information is to be no more than 120 calendar days old at time of the recredentialing decision. If application/attestation becomes older than 120 calendar days, the application is to be returned to the practitioner for any updates, and a new attestation form is to be signed and dated by the practitioner attesting that the application is correct and complete. If primary source verification becomes older than 120 calendar days, the information will be re-verified by the primary source. State license, DEA certificate, and malpractice insurance policy must be current at time of recredentialing decision.

Criteria for Verification	Source	Provider type	Time	When required
<u>Application</u> Practitioner must submit a complete credentialing application via handwritten or electronic documentation. Electronic signatures must be generated from a secure site. Handwritten signatures will be recorded in black or blue non-erasable, non-water-soluble ink. Felt-tip markers, fountain pens, and signature stamps are only acceptable if the practitioner is physically impaired and the disability is documented in the practitioner's credentialing file. Application must include all required attachments. The attestation and release must be signed and dated by the practitioner.	• Every section of the application is complete or designated N/A • Every question is answered, and answers are legible. • The attestation is signed and dated by the practitioner	All Credentialed/Re credentialed practitioners	120 Calendar Days	Initial & Recredentialing

Must show absence of history of any professional disciplinary action, sanctions, or restrictions and limitations by federal, state, and local authorities, including each jurisdiction in which the practitioner practices or previously practiced for the past five years, including, but not limited to: • Being placed on probation, reprimanded, fined, or having medical practice restricted or limited by any agency that disciplines practitioners. • Medicare or Medicaid reprimand, censure, disqualification, suspension, conviction, or indictment for a felony in the case of such history • Must show evidence that this history does not demonstrate probable future substandard professional performance or probable future unacceptable business practices. All practitioners must demonstrate appropriate office and medical recordkeeping standards acceptable to Network Health Plan/Network Health Third Party Administrator/Network Health Insurance Corporation, or must show evidence of compliance to action plan to improve office sites and/or medical/treatment/record-keeping practices and to	• All required attachments are present. • A detailed written response is included for every yes answer on the professional questions	All Credentialed/ Recredentialed practitioners	120 Calendar Days	Initial & Recredentialing
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ultimately meet the standards, should there be a complaint filed. Practitioners must show absence of a chemical dependency or substance abuse problem that might adversely affect practitioner's ability to competently and safely perform the essential functions of a practitioner in the same area of practice and applicant shows absence of physical or mental condition that may impair the practitioner's ability to practice within the full scope of licensure and qualifications or may pose a risk of harm to patients.				
<u>Malpractice Insurance</u> Practitioner must have history and maintain professional malpractice liability insurance with limits that meet NHP and the WI Department of Licensing criteria for the past 5 years. (The five-year period may include residency and fellowship years, however NHP/NHIC/NH TPA/NHAS is not required to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during residency or fellowship.) For practitioners with federal tort coverage, the application does need to contain the current amount of malpractice insurance coverage. Practitioner files that include a copy of the federal tort letter or an attestation from the practitioner of federal tort	A copy of the insurance certificate showing: • The type of coverage is professional liability insurance. • Dates of coverage (must be currently in effect) • Amounts of coverage • Either the specific practitioner's name or the name of the group in which the practitioner works	All practitioner types	Must be in effect at the time of decision and verified within 120 Calendar Days	Initial & Recredentialing

coverage will be included in the practitioner's file.				
<u>License</u> Practitioner must hold an active, current, valid license to practice in their specialty in WI.	Current, valid licensure is verified directly with the appropriate state licensing or certification agency. • Online directly with Licensing Board or appropriate state agency The verification must indicate: • the scope/type of license • the date of original licensure • expiration date • status of license • If there have been or currently are any disciplinary actions or sanctions on the license.	All practitioner types	Must be in effect at the time of decision and verified within 120 Calendar Days	Initial & Recredentialing

<u>DEA/CDS</u> Practitioners must hold a current, valid, unrestricted Drug Enforcement Agency (DEA). Practitioners must have a DEA in every state where the practitioner provides care to NHP members. If provider does not have a DEA, a coverage arrangement will be documented. NHP/NHIC/NH TPA/NHAS will credential a practitioner whose DEA certificate is pending if it has a documented process for allowing a practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner whose DEA is pending until the practitioner has a valid DEA certificate. If providers DEA is pending, an explanation why the practitioner does not prescribe medications, and must provide a practitioner name with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner whose DEA is still pending until the practitioner has a valid DEA certificate.	A copy of the DEA from the practitioner	All applicable practitioner types that have DEA	Must be in effect at time of decision and verified within 120 calendar days	Initial & Recredentialing
<u>Education</u> Practitioner must have graduated from an accredited school with a degree required to practice in their specialty.	The highest level of education is primary source verified by one of the following methods: • Primary source verification of Board Certification by accessing the ABMS website. This verification must indicate the education has been specifically verified. • The American Medical Association (AMA) Physician	All practitioner types	Must be verified within 120 calendar days.	Initial

	Master File. This verification must indicate the education has been verified. • The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the education has specifically been verified. • Confirmation directly from the accredited school. This verification must include the type of education, the date started, date completed, and if the practitioner graduated from the program. • Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after • Student Clearinghouse			
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<u>Residency Training</u> Practitioner must have satisfactorily completed a residency program from a training program accredited by The Accreditation Council for Graduate Medical Education (ACGME) in the specialty in which they are practicing. Verification of the residency is required as described in the Board Certification section below.	Residency Training is primary source verified by one of the following methods: • Primary source verification of Board Certification in the same specialty of the Residency Training program (as outlined in the Board Certification section). • The American Medical Association (AMA) Physician Master File. This verification must indicate the training has specifically been verified. • The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the training has specifically been verified. • Confirmation directly from the accredited training program. This verification must include the type of training program, specialty of training, the date started, date completed, and if the program was successfully completed. • For Closed Residency Programs, residency	MD's, DO's, DPM's, Oral Surgeons, DDS (if applicable)	Must be verified within 120 calendar days.	Initial
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	completion can be verified through the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS).			
<u>Fellowship Training</u> If the practitioner has not completed a Residency program in the specialty in which they are practicing, they must have completed a fellowship program in the specialty in which they are practicing.	Fellowship Training is primary source verified by one of the following methods: • Primary source verification of Board Certification in the same specialty of the Fellowship Training program (as outlined in the Board Certification section of this policy). • The American Medical Association (AMA) Physician Master File. This verification must indicate the training has specifically been verified. • The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must include the type of training program, specialty of training, the date started, date completed, and if the program was successfully completed.	MD's, DO's, DPM's	Must be verified within 120 calendar days.	Initial

<u>Board Certification</u> Board certification in the specialty in which the practitioner is practicing is preferred. Initial applicants who are not Board Certified may be considered for participation if they demonstrate they have equivalent training and competence in their specialty or is an Essential Community Provider (ECP) as defined by Network Health. NHP recognizes Board Certification only from the following Boards: • American Board of Medical Specialties (ABMS) • American Osteopathic Association (AOA) • American Board of Podiatric Medicine • American Board of Foot & Ankle Surgery • National Certification Commission for Physician Assistants • American Academy of Nurse Practitioners • American Nurse Credentialing Center • Applicable Dental Specialty Certifying Board	Board Certification is primary source verified through one of the following: • ABMS display agent, where a dated certificate of primary-source authenticity has been provided (as applicable) • AMA Physician Master File profile (as applicable) • AOA Official Osteopathic Physician Profile Report or AOA Physician Master File (as applicable). • Confirmation directly from the board. This verification must include the specialty of the certification(s), the original certification date, and the expiration date. • Online from the American Board of Podiatric Medicine • American Board of Foot & Ankle Surgery • National Certification Commission for Physician Assistants (NCCPA) • American Academy of Nurse Practitioners (AANP) • American Nurse Credentialing Center • Applicable Dental Specialty Board	MD's, DO's, DPM's, APNP's, PA's, DDS (if applicable)	Must be verified within 120 calendar days.	Initial & Recredentialing
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<u>Non-Board-Certified Practitioners with completed Training</u> Residency-trained practitioners who are completing a course of training in preparation for final certification exam must remain in good standing with the specialty board and complete and pass the board certification exam on time as scheduled.	Documentation included in Credentialing file	MD's, DO's, DPM's, DDS (if applicable)	Must be verified within 120 calendar days.	Initial & Recredentialing
<u>Malpractice History</u> Practitioner must supply absence of history for the past 5 years of professional liability claims, including, but not limited to, lawsuits, arbitrations, settlements, or judgments, or must show evidence that history of professional liability claims does not demonstrate probable future substandard professional performance. (The five-year period may include residency and fellowship years, however NHP/NHIC/NH TPA/NHAS is not required to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during residency or fellowship.) Must show absence of history of denial or cancellation of professional liability insurance or, must show evidence that history of denial or cancellation of professional liability insurance does not demonstrate probable future substandard professional performance. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. Documentation of malpractice and professional liability claims history is	Supplied by practitioner. Also found on NPDB query.	All practitioner types	Must be verified within 120 calendar days.	Initial & Recredentialing

requested from the practitioner on the credentialing application.				
<u>Work History</u> Practitioner must supply a minimum of the most recent 5 years of relevant work history as a health professional on the application or curriculum vitae. If the practitioner has practiced fewer than 5 years from the date of Credentialing, the work history starts at the time of initial licensure. Each gap exceeding six months will be reviewed and clarified in writing by practitioner, and NHP/NHIC/NH TPA/NHAS documents its review in the credentialing file.	Verified by application or CV, which includes the beginning and end month and year for each position of employment for 5 years or more with no gap.	All practitioner types	Must be verified within 120 calendar days.	Initial
<u>State Sanctions, Restrictions on licensure, or limitations on scope of practice.</u> Practitioners must disclose the most recent five-year history of all license actions, including denials, revocations, terminations, suspensions, restrictions, reductions, limitations, sanctions, probations, and non-renewals. Practitioners must also disclose any history of voluntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from	Verified directly with the appropriate state licensing or certification agency. The appropriate state agencies are queried directly for every practitioner, and if there are any sanctions, restrictions, or limitations, complete documentation regarding the action will be requested. The NPDB is also queried for every practitioner.	All practitioner types	Must be verified within 120 calendar days.	Initial and Recredentialing

the practitioner.				
<u>Medicare and Medicaid Sanctions</u> Practitioner must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.	The NPDB is queried for every practitioner.	All practitioner types	Must be verified within 120 calendar days.	Initial and Recredentialing
<u>Medicare and Medicaid exclusions</u> Practitioner must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.	The OIG is queried for every practitioner.	All practitioner types	Must be verified within 120 calendar days.	Initial and Recredentialing
<u>Medicare Opt Out</u> Practitioners participating in the Medicare Advantage product are prohibited from voluntarily opting out of Medicare participation.	The Medicare Opt Out website is queried for every practitioner.	All practitioner types	Must be verified within 120 calendar days.	Initial and Recredentialing
<u>Hospital Admitting privileges</u> Practitioners must have admitting privileges in good standing with an in-plan hospital or have a plan for hospital admission by using a Hospitalist or having an arrangement with a participating practitioner. Must show absence of history of loss or limitation of privileges or disciplinary activity by a hospital or other health care facility, or must show evidence that history or loss or limitation of privileges does not demonstrate probable future substandard professional performance	The practitioner's hospital privileges are verified by their attestation on the credentialing application, stating one of the following using NAMSS Pass or by verification from the indicated hospital: • They have hospital admitting privileges • They use a Hospitalist They have an arrangement with a participating practitioner to admit their patients for them.	MD's, DO's	Must be verified within 120 calendar days.	Initial and Recredentialing
<u>Background Checks</u>	Background Check sites	All practitioner	Must be	Initial and

Background checks, including in-state, out-of-state (if applicable), and other applicable agencies.	to include the WI Department of Justice, Moore Report, and/or other states as applicable.	types	verified within 120 calendar days	Recredentialing
<u>Wisconsin Circuit Courts</u> Queried for any criminal or professional cases in WI	https://wcca.wicourts.gov/	All practitioner types	Must be verified within 120 calendar days	Initial and Recredentialing

IV. Recredentialing Cycle Length

The length of the recredentialing cycle is at least every 36 months. Extensions can occur, and the reason will be documented, and the practitioner is recredentialed within 60 calendar days of the practitioner's return to practice. Applicable reasons for a leave are:

1. On active military assignment
2. Medical leave
3. Sabbatical

Termination and reinstatement: If NHP/NHIC/NH TPA/NHAS terminates a practitioner for administrative reasons (e.g., the practitioner failed to provide complete credentialing information) and not for quality reasons, it may reinstate the practitioner within 30 calendar days of termination and is not required to perform initial credentialing. Initial credentialing will be performed if reinstatement is more than 30 calendar days after termination.

If NHP/NHIC/NH TPA/NHAS does not have the necessary information for recredentialing, it informs the practitioner that this information is needed at least 30 calendar days before the recredentialing deadline and that without this information, the practitioner will be administratively terminated. This information is noted in the practitioner's credentialing file. If the practitioner is subsequently terminated for lack of information, the termination notice will be in the practitioner's file.

V. Ongoing Monitoring and Interventions

NHP/NHIC/NH TPA/NHAS performs ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.

- **Sources for Medicare/Medicaid Sanctions:** NHP/NHIC/NH TPA/NHAS implements ongoing monitoring by collecting and reviewing Medicare and Medicaid sanctions by conducting ongoing monitoring between recredentialing cycles.
 - a. **For Medicaid,** obtain sanction information from the State Medicaid agency, plus an additional source.
 - b. **For Medicaid and Medicare,** obtains verification of sanction information from at least one of the following sources, as appropriate:
 - i. AMA Physician Master File
 - ii. FSMB
 - iii. NPDB
 - iv. SAM.gov
- **Sources for Medicare/Medicaid exclusions:** NHP/NHIC/NH TPA/NHAS implements ongoing monitoring by collecting and reviewing Medicare and Medicaid exclusions by:
 - a. **For Medicaid,** the organization obtains exclusion information from each of the following sources:
 - i. The state Medicaid agency.
 - ii. List of Excluded Individuals and Entities maintained by OIG and available over the internet.
 - b. **For Medicare,** the organization obtains exclusion information from any of the sources listed below:

- i. List of Excluded Individuals and Entities maintained by OIG and available over the internet.
 - ii. Medicare Exclusion Database.
- **Sources for licensure sanction, limitations, and expiration Information:**
NHP/NHIC/NH TPA/NHAS implements ongoing monitoring by collecting and reviewing sanctions, limitations, and expiration on licensure by collecting and reviewing sanctions and limitations on licensure from at least one of the following sources, as appropriate:
 - **For all practitioner types:**
 - NPDB.
- Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General.
 - **Physicians:**
 - Appropriate state agencies.
 - FSMB.
 - **Chiropractors:**
 - State Board of Chiropractic Examiners.
 - Federation of Chiropractic Licensing Boards' Chiropractic Information
 - Network-Board Action Databank (CIN-BAD).
 - **Oral surgeons:**
 - State Board of Dental Examiners or State Medical Board, depending on the state.
 - **Podiatrists:**
 - State Board of Podiatric Examiners.
 - Federation of Podiatric Medical Boards.
 - **Nonphysician healthcare practitioners:**
 - Appropriate state agency.
 - State licensure or certification board.
 - The organization collects and reviews expiration of licensure from the state licensing or certification agency (or its website).
- **Time frame for reviewing sanction, exclusions, limitations, and expiration information:**
NHP/NHIC/NH TPA/NHAS reviews information from NCQA-approved sources listed above or at least monthly or within 30 calendar days of a new alert, if the organization subscribes to a monitoring service (e.g., NPDB).
- **Collecting and reviewing complaints:** NHP/NHIC/NH TPA/NHAS implements ongoing monitoring by collecting and reviewing complaints, investigating all practitioner-specific member complaints upon their receipt and evaluates the practitioner's history of complaints, if applicable, and Evaluates the history of all complaints for all practitioners at least every 6 months.
- **Adverse events:** NHP/NHIC/NH TPA/NHAS implements ongoing monitoring by collecting and reviewing information from identified adverse events by monitoring for adverse events at least monthly. Adverse events include injury or harm while a member is receiving care from a practitioner.

- **Appropriate Interventions:** NHP/NHIC/NH TPA/NHAS reports the findings to the Credentialing Committee, or other designated peer-review body, and implements interventions as needed at the next meeting after the identified occurrence. The credentialing committee or other designated peer-review body recommends appropriate interventions. After determining which interventions are appropriate, NHP/NHIC/NH TPA/NHAS acts to address quality and safety issues.
- **Notification to Authorities and Practitioner Appeal Rights:** If NHP/NHIC/NH TPA/NHAS has taken action against a practitioner for quality reasons, we report the action to the appropriate authorities and offers the practitioner a formal appeal process. (See applicable policy). NHP/NHIC/NH TPA/NHAS objective evidence and patient-care considerations when deciding on a course of action for dealing with a practitioner who does not meet its quality standards.

VI. Security Controls Section:

To ensure that Network Health has credentialing system controls in place for primary source verification, tracking and modification of credentialing information, authorized staff, security of the credentialing information, and auditing of Network Health's credentialing process and procedures.

Procedure:

Network Health receives primary source verification documents via USPS, secure email, NCQA-approved verification website, or fax. All primary source verification documents are electronically date-stamped upon receipt, electronically initialed by credentialing coordinator reviewing the document, electronically entered in the proprietary practitioner database, and stored in the credentialing/recredentialing practitioner's credentials electronic file. No paper files are maintained. Primary source verification documents are tracked via an electronic checklist that includes:

- the date the information was received; and
- the date the information was verified; and
- the name or initials of the credentialing coordinator who reviewed/verified the information.

The electronic checklist is stored in the credentialing/recredentialing practitioner's electronic credentialing file.

All modified primary source verification documents are electronically date-stamped upon receipt, initialed, or signed by the credentialing coordinator reviewing the document, and notification of said modification is sent to the Director or Provider Integration for review and tracking for adequacy. A note is also placed in the notes section of the applicable provider/facility notes section.

Network Health's credentialing department staff are the only authorized staff with the ability to review, modify, or delete any credentialing information.

The only time modification/deletion would be necessary is if the practitioner notifies Network Health of changes to the credentialing/recredentialing information, i.e., DEA, license, or malpractice coverage expires/renews, a data entry error, duplicate profiles, work history, or a change to the practice location.

Appropriate modifications/deletions would be necessary when corrected information was received from the practitioner to correct information with the practitioner's credentialing/recredentialing application, i.e., corrected SSN, corrected employment dates (work history), correction of school name or address, or when duplicate information exists with the practitioner's electronic credentialing file.

In the event information is modified or deleted, it will be tracked on the provider record that includes:

- The date the information was received to modify or delete Credentialing/recredentialing information
- The date the credentialing/recredentialing information was modified or deleted
- An explanation about why the information was modified or deleted
- The name or initials of staff who modified or deleted the information
- If verbal verification occurs, note the person who they spoke with.

Inappropriate modifications to credentialing information include, but are not limited to:

- Altering credentialing approval dates
- Altering dates on verifications
- Unauthorized deletion of provider files or documentation

The Network Health Credentialing department have "read/write" access to Network Health's proprietary practitioner database, protecting the credentialing/recredentialing information from unauthorized modification and unauthorized release of credentialing information. All other staff has "read only" access. No other entities will have access to Network Health's credentialing/recredentialing information.

Network Health has a secure proprietary practitioner database where practitioners' credentialing/recredentialing electronic information is stored. The secure proprietary practitioner database is a password-protected electronic cloud-based system, and only Network Health staff who need "read/write access" will be granted access by Network Health's IT staff via the approval of the Director of Provider Integration.

Staff approved to access information are required to:

- Use strong passwords
- Avoid writing down passwords
- Use different passwords for different accounts
- Change passwords periodically
- Changing or withdrawing passwords, including alerting appropriate staff who oversee computer security to change passwords when appropriate.

Network Health's Provider Integration Director audits quarterly the full universe of changes and any prior notified modifications shared from staff to ensure steps 1-4 are adhered to during the credentialing/recredentialing process. A log of any inappropriate deletions/modifications identified during the audit will be kept along with resolution details. In the event issues are identified, Network Health's Director of Provider Integration will address the issue with necessary staff for quick, timely resolution. Quarterly monitoring will occur to assess the effectiveness of the resolution until there are no issues identified for at least three consecutive quarters. Also, each provider file is audited by another Credentialing staff prior to review by the Medical Director, designee, or Credentials Committee.

Network Health's Director of Provider Integration will review job roles and current user access semiannually to ensure system access is still appropriate for each role.

Access to office after hours is limited to office staff and custodial staff. Custodial staff does not have keys to any electronic credentials to access computer systems.

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Regulatory Body: NCQA, CMS	Approving Committee: Credentialing Committee	
Policy Owner: Andrea Albright	Department of Ownership: Credentialing	Revision Number: 14
Revision Reason: 10/18/2016 – Updated to new policy owner. 10/06/2016 – Transferred to new policy template. 10/26/2017 – Annual review. 09/01/2019 – Annual review. 07/01/2020 - Added new NCQA requirements and added procedure instead of policy. 01/20/2021-Updated for 2022 NCQA requirements 1/19/2022 – Annual Review 1/18/2023 – Annual Review and added security changes 4/27/2023 Annual Review 1/8/2024 – Annual Review, Credentialing Committee Approval 2/1/2024 11/22/2024 – Annual review and adding TPA and NCQA verbiage 12/26/2024 – approved at credentialing committee 11/06/2025 - Modified to support 2026 NCQA changes 9/3/2026 – Annual Review		