n05768

Credentialing and Recredentialing Information Integrity, Confidentiality and Auditing of Credentialing Data

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

The purpose of this policy is to provide guidance to 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 in fulfilling its responsibilities for auditing of credentialing information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues. NHP/NHIC/NH TPA/NHAS demonstrates its commitment to protecting the integrity of credentialing information used in the credentialing process.

Credentialing information integrity refers to maintaining and safeguarding the information used in the initial credentialing and recredentialing process against inappropriate documentation and updates.

Policy Detail:

The Scope of the credentialing information

NHP/NHIC/NH TPA/NHAS's policies and procedures specify protection of each of the following types of credentialing information:

1. The practitioner application and attestation.
2. Credentialing documents received from the source or agent.
3. Documentation of credentialing activities:
4. Credentialing Committee minutes.
5. Documentation of clean file approval, if applicable.
6. Credentialing checklist which should include:
    a. Verification dates.
    b. Report dates (e.g., sanctions, complaints, identified adverse events).

c. Credentialing decisions.
d. Credentialing decision dates.
e. Signature or initials of the verifier or reviewer.

The staff responsible for performing credentialing activities

NHP/NHIC/NH TPA/NHAS credentialing staff are responsible for performing all credentialing activities. This would include the Provider Integration Director and Manager as well as all Credentialing Coordinators. Each staff member has responsibility for documenting credentialing activities and are authorized to modify (edit, update, delete) credentialing information.
The Provider Integration Director and Manager are responsible for oversight of credentialing information integrity functions, including auditing.

The process for documenting updates to credentialing information

The NHP/NHIC/NH TPA/NHAS credentialing staff process for documenting updates to credentialing information are for the following circumstances. Credentialing staff can update provider credentialing data at various points in the credentialing lifecycle, including:

1. **Initial Credentialing** – When a provider first applies for credentials.
2. **Re-Credentialing** – Every 3 years, credentialing data must be updated and re-verified to maintain compliance with accreditation bodies (e.g., NCQA, The Joint Commission, CMS).
3. **Provider Updates** – When a provider submits changes, such as new certifications, licenses, malpractice claims, or updated practice locations.
4. **Ongoing Monitoring** – Credentialing staff may update data based on continuous monitoring of licenses, sanctions, or exclusions (e.g., checking the OIG exclusion list or NPDB reports).
5. **Regulatory or Compliance Changes** – If new laws or accreditation requirements necessitate updates to credentialing records.

1. NHP/NHIC/NH TPA/NHAS's process for documenting is as follows:
    a. When (date and time) the information was updated.
    b. What information was updated.
    c. Why the information was updated.
    d. Staff who updated the information.

Inappropriate documentation and updates

NHP/NHIC/NH TPA/NHAS's identifies that the following documentation and updates to credentialing information are inappropriate:

1. Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates).
2. Creating documents without performing the required activities (e.g., photocopying a prior credential and updating information as a new credential).
3. Fraudulently altering existing documents (e.g., credentialing minutes, clean file reports, ongoing monitoring reports).
4. Attributing verification or review to an individual who did not perform the activity.
5. Updates to information by unauthorized individuals.

NHP/NHIC/NH TPA/NHAS audits CredentialingStaff and the process for documenting and reporting identified information integrity issues:
NHP/NHIC/NH TPA/NHAS audits the current credentialing staff documentation updates to manage appropriate and inappropriate documentation within credentialing files. This audit is performed on an annual basis.. Inappropriate documentation will be tracked with the existing credentialing software and outcomes of audits will be reported immediately to the Medical Director and Provider Integration Director for review and determination of action. If fraud and misconduct has been identified, NHP/NHIC/NH TPA/NHAS will report said misconduct to NCQA. Reference to the Reporting Hotline for Fraud and Misconduct; Notifying NCQA of Reportable Events process:

To report fraud or misconduct to the National Committee for Quality Assurance (NCQA), you can use their confidential and anonymous Reporting Hotline.

Reporting Hotline:

- **Toll-Free Number (USA and Canada):** 844-440-0077
- **Website:** Lighthouse Services - NCQA Reporting

Mailing Address:

National Committee for Quality Assurance (NCQA)
1100 13th St. NW, Third Floor
Washington, DC 20005

Additional Contact Information:

- **Telephone:** 202-955-3500
- **Fax:** 202-955-3599

The consequence for said actions depends on the severity of the violation, internal policies, and legal requirements. Common consequences include1. Internal Disciplinary Actions: Verbal or Written Warning – For minor, unintentional misuse or first-time offenses. Performance Improvement Plan (PIP) – Requires the employee to correct behavior within a specified timeframe. Suspension – Temporary removal from duties while an investigation takes place. Termination of Employment – For serious or repeated violations, especially if intentional fraud or abuse is found.

Information Integrity Training:
NHP/NHIC/NH TPA/NHAS training informs credentialing staff on:

1. Inappropriate documentation and updates:
    a. NHP/NHIC/NH TPA/NHAS trains credentialing staff on inappropriate documentation and updates to credentialing information, as defined in Element A, factor 4.
2. Auditing, documenting, and reporting information integrity issues
    a. NHP/NHIC/NH TPA/NHAS's training informs credentialing staff on organizational audits of staff documentation and updates in credentialing files.

3. The process for documenting and reporting inappropriate documentation and updates to:
    a. NHP/NHIC/NH TPA/NHAS's designated individual(s) when identified.
    b. NCQA, when NHP/NHIC/NH TPA/NHAS identifies fraud and misconduct.
    c. The consequences for inappropriate documentation and updates.

Audit and Analysis

NHP/NHIC/NH TPA/NHAS annually audits credentialing information used in the credentialing process for the following inappropriate documentation and updates:

1. Falsifying credentialing dates (e.g., licensure dates, credentialing decision dates, staff verifier dates, ongoing monitoring dates).
2. Creating documents without performing the required activities.
3. Fraudulently altering existing documents (e.g., credentialing minutes, clean- file reports, ongoing monitoring reports).
4. Attributing verification or review to an individual who did not perform the activity.
5. Updates to information by unauthorized individuals.

The audit universe includes practitioner files for all initial credentialing decisions and all recredentialing decisions made or due during the look-back period. NHP/NHIC/NH TPA/NHAS randomly audits a sample of practitioner files from the audit universe using 5% or 50 files, whichever is less. The random sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed within the look-back period, NHP/NHIC/NH TPA/NHAS audits all files. NHP/NHIC/NH TPA/NHAS may choose to audit more practitioner files than NCQA requires.

NHP/NHIC/NH TPA/NHAS provides an auditing and analysis report that includes:

1. The report dates.
2. The title of individuals who conducted the audit.
3. The 5% or 50 files auditing methodology.
4. Auditing period.
5. File audit universe size (described in the paragraph above).
6. Audit sample size.
7. The audit log (as a referenced attachment)
8. File identifier (individual practitioner).
9. Type of credentialing information audited (e.g., licensure).
10. Findings for each file.
11. A rationale for inappropriate documentation and updates.
12. The number or percentage and total inappropriate documentation and updates by type of credentialing information.

NHP/NHIC/NH TPA/NHAS must provide a completed audit report even if no inappropriate documentation and updates were found.

Qualitative Analysis

1. NHP/NHIC/NH TPA/NHAS conducts qualitative analysis of inappropriate documentation and updates. This includes audits of staff, documenting and reporting information integrity issues (Element A, Element C Audit and Analysis).
2. NHP/NHIC/NH TPA/NHAS annually conducts qualitative analysis of each instance of

inappropriate documentation and update identified in the audit (factor 1) to determine the cause.

3. NHP/NHIC/NH TPA/NHAS's auditing, and analysis report also includes:
   a. Titles of credentialing staff involved in the qualitative analysis.
   b. The cause of each finding.

Examples:

Practitioner ID	File Type (Initial/Recred)	Inappropriate Documentation/ Updates?	Credential Affected	Finding
Practitioner 1	Recredential	No		NA
Practitioner 2	Initial	No		NA

Practitioner ID	File Type (Initial/Recred)	Inappropriate Documentation/ Updates?	Credential Affected	Finding
Practitioner 3	Recredential	Yes	Attestation	Attestation date updated by staff (name) instead of practitioner because attestation was expiring. 3/4/ [previous year] @ 2:59 PM

Summary of findings:

Credentialing Information Reviewed	Noncompliant Initial Credentialing Files	Noncompliant Recredentialing Files	Percentage of Noncompliant Modifications
Application and Attestation	4	4	16%
License	2	2	8%
DEA/CDS	0	0	0%
Education and Training	0	NA	0%
Board Certification Status	0	0	0%
Work History	0	NA	0%
Malpractice History	0	0	0%
Sanction Information	2	2	8%
Credentialing Committee Minutes	0	0	0%
Clean-File Approvals	0	0	0%
Ongoing Monitoring Reports	0	0	0%

Qualitative analysis: The Provider Integration Manager/Director provided the credentialing staff with the audit log documenting how, when, and by whom files were updated.

Example:
The Provider Integration Manager/Director held a series of meetings (January 14-17, 2024) with credentialing staff (credentialing assistant director, credentialing team) to determine the causes of each

inappropriate update. The causes of the inappropriate updates are outlined in the table below.

Credentialing Information	Description of Noncompliant Update	Reason
Application and Attestation	Attestation date updated by staff instead of practitioner.	Staff spoke with the practitioner, who stated that all information remained accurate. Staff did not know that only the practitioner can update the information.
License	Verification was updated without going to the source.	Staff responsible for verification of licensure and sanction information was on emergency leave and did not complete the verification. Because temporary staff did not have time to complete verification of all practitioners, they copied existing credentials, changed dates and uploaded the information into the CR system before the Credentialing Committee meeting.

Improvement Actions

1. Implement Corrective Action: The organization documents corrective actions taken or planned, including dates of actions, to address all inappropriate documentation and updates (findings) identified in Element C. One action may address more than one finding, if appropriate.
2. Annual training (Element B) may not be the only corrective action. The organization identifies staff (by title) who are responsible for implementing corrective actions.

Examples:
[Organization Name]'s Provider Integration Manager/Director shared the audit analysis results and mitigation recommendations with the organization's leadership on January 31, [current year]. [Organization Name] leadership required immediate implementation of actions and completion of all corrective actions, outlined in the table below, on or before the dates specified.

Credentialing Information/ Noncompliant Update	Reason	Correction Actions Planned
Application and Attestation: Attestation date updated by staff instead of by practitioner.	Staff spoke with the practitioner, who stated that all information remained accurate. Staff did not know that only the practitioner can update the information.	Educate credentialing staff on the organization's policies and procedures by 4/15/[current year]. Owner: Credentialing Director. Train credentialing staff on NCQA's documentation requirements by 4/15/[current year]. Owner: Credentialing Director. Establish automated resending of attestation to practitioner 60 days before expiration by 4/15/[current year]. Owner: Credentialing Director.
License: Verification was not updated from the source.	Staff responsible for verification of licensure and sanction information was on emergency leave and did not complete verification.	Require credentialing staff to undergo ethics training, with emphasis on following the organization's processes even if under pressure to take shortcuts by 5/1/[current year]. Owner: Credentialing Director.
Sanction Information: Verification was not updated from the source.	Because temporary staff did not have time to complete verification of all practitioners, they copied existing credentials, changed dates and uploaded the information into the CR system before the Credentialing Committee meeting.	Incorporate system flags that do not allow updating information without going to the source and require confirmation that the information was received from the source by 6/1/[current year]. Owner: IT Director, Credentialing Director. Purchase software application to

Measure of effectiveness follow-up audit:

The organization audits the effectiveness of corrective actions (factor 1) on findings within 3–6 months of the annual audit completed for Element C. and draws conclusions about the actions' overall effectiveness. The audit universe includes practitioner files for all credentialing decisions made, or due to be made, 3–6 months after the annual audit. The organization conducts a qualitative analysis if it identifies noncompliance with integrity policies and procedures during the follow-up audit.

Summary of findings:

Credentialing Information Reviewed	Noncompliant Initial Credentialing Files	Noncompliant Recredentialing Files	Percentage of Noncompliant Modifications
Application and Attestation	0	0	0%
License	0	0	0%
Sanction Information	0	0	0%

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Qualitative analysis: Not required.

Actions' effectiveness:

Noncompliant Credentialing Updates	Corrective Actions Completed	Action Effectiveness Audit
Application and Attestation: Attestation date updated by staff instead of by practitioner.	All staff completed education on the organization's policies and procedures on 4/15/[current year]. All staff completed training on NCQA documentation requirements on 4/15/[current year]. Established automated resending of attestation to practitioner 60 days before expiration on 4/15/[current year].	These actions have eliminated updating of attestation by staff. There were no incidences identified in the audit.

Noncompliant Credentialing Updates	Corrective Actions Completed	Action Effectiveness Audit
License: Verification was not updated from the source. **Sanction Information:** Verification was not updated from the source.	All credentialing staff completed ethics training, with emphasis on following the organization's processes even if under pressure to take shortcuts on 5/1/[current year]. Incorporated system flags that do not allow updating information without going to the source and require confirmation that the information was received from the source6/1/[current year]. Purchased software application to automatically retrieve verification from accepted sources (web crawler) 6/1/[current year].	The were no incidences identified in the audit.

Overall effectiveness—Conclusion

The corrective actions implemented have been effective in preventing inappropriate documentation and

updates based on follow-up assessment and the fact that no incidences of inappropriate documentation and updates were made.

Regulatory Citations: None

Related Policies: None

Related Documents: None

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