

Policy: University of Utah Health Plans Credentialing Policy

Purpose: To ensure, through reasonable efforts, the caliber and high quality of the practitioners who are allowed to provide treatment and services to University of Utah Health Plans (U of U Health Plans) members.

Description: Applies to All Lines of Business. Includes NCQA Standards: (CR 1, CR 2, CR 3, CR 4, CR 5, CR 6, CR 7, CR 8)

TABLE OF CONTENTS

Practitioner Credentialing Guidelines

Types of practitioners credentialed and re-credentialed	5
Verification sources	11
Criteria for credentialing and re-credentialing	12
Making credentialing and re-credentialing decisions	16
Delegating credentialing or re-credentialing	17
Ensuring a non-discriminatory credentialing process	18
Notifying practitioners if information obtained varies from information provided	18
Ensuring practitioners are notified of credentialing and re-credentialing decision	19
Medical director or other designated physician's direct responsibility.....	19
Ensuring the confidentiality of information received during credentialing process	19
Ensuring listings in practitioner directories and member materials are consistent with credentialing information.....	20

Practitioner Rights

Review information submitted to support their credentialing application 20

Correct erroneous information 20

Receive status of credentialing or re-credentialing application 21

Access to records 21

Credentialing Committee

Participating practitioners..... 22

Ensures clean files are reviewed and approved by medical director or
designated physician 22

Ongoing Monitoring & Interventions

Medicare and Medicaid sanctions..... 23

Sanctions or limitations on licensure 24

Complaints & Adverse Events 25

NPDB Reports 25

Notification to Authorities and Practitioner Appeal Rights

Range of actions 26

Making the appeal process known 26

Review and Approval of Organizational Provider

Reviewed and approved by an accrediting body 26

Good standing with state and federal regulatory bodies 27

Onsite quality assessment for non-accredited providers 28

Medical Providers

Hospitals	28
Home Health Agencies	28
Skilled Nursing Facilities	28
Free-standing Surgical Centers	28
Behavioral Healthcare Providers	
Inpatient.....	28
Residential	28
Ambulatory	28
Assessing Medical Providers	
The organization assesses contracted medical health care providers	29
Assessing Behavioral Healthcare Providers	
The organization assesses contracted behavioral healthcare providers	29
Pre-delegation Evaluation	
Files evaluated for NCQA compliance before delegation begins	32
Delegation Agreement	
Mutually agreed upon.....	32
Delegated activities and responsibilities	32
Semiannual reporting	32
Evaluation of delegated entity’s performance	32
Organization’s rights	32
Remedies available to the organization	32
Provisions for PHI	
Allowed uses of PHI	32

Delegate safeguards 32

Sub-delegate safeguards 32

Access to PHI 32

Inappropriate usage 32

Ensures that PHI is returned, destroyed or protected if the delegation
agreement ends 32

Review of Delegate’s Credentialing Activities

Annual review 32

Annual audit 32

Annual evaluation of delegate performance 32

Semiannually evaluates regular reports 32

Practitioner Credentialing Guidelines

University of Utah Health Plans (U of U Health Plans) shall incorporate a credentialing program into the application procedures for network participation. U of U Health Plans has the right to make the final determination about which practitioners may participate in its provider networks.

Decisions about network participation are based upon the business needs of U of U Health Plans and the practitioner's credentials. U of U Health Plans does not discriminate based on race, gender, nationality, age, sexual orientation, or the type of procedure or patient in which the practitioner specializes.

The policy also includes procedures for verifying the Practitioners and Organizational Providers when they have met eligibility standards and requirements such as education, licensure, professional standing, services, accessibility, utilization, accreditation and quality. U of U Health Plans has an internal application system (Genie) that tracks credentialing information.

Credentialing requirements must be met for any of the following:

1. Practitioners who have an independent relationship with University of Utah Health Plans (U of U Health Plans). An independent relationship exists when U of U Health Plans selects and directs its members to see a specific practitioner or group of practitioners, including all practitioners who members can select as primary care practitioners.
2. Practitioners who see members outside the inpatient hospital setting or outside freestanding, ambulatory facilities.
3. Practitioners who are hospital based, but who also see U of U Health Plans members as a result of their independent relationship from the organization.
4. Non-physician practitioners who have an independent relationship with U of U Health Plans and who provide care under Health Plans' medical benefits.
5. When rental network practitioners are used as part of U of U Health Plans' primary network and U of U Health Plans has members who reside in the rental network area. If the rental network is specifically for out of area care and members may see only those practitioners or are given an incentive to see rental network practitioners, they too will be credentialed.
6. Per the above criteria, providers such as, but not limited to, those listed below require U of U Health Plans Credentialing:

Types of practitioners credentialed and re-credentialed

Practitioners and group of practitioners with whom U of U Health Plans contracts must be credentialed prior to seeing patients. These practitioners must have successfully completed a master's level degree in the practice specialty and be licensed, certified or registered by the state to practice independently. Providers who are licensed facilities will be credentialed as an organizational provider. The tables following identify the types of medical and behavioral health practitioners that will be credentialed and the credentials that shall be present in the file.

Provider Type by Degrees Known	States that License	States that do not License	License Verification Produced Y/N	Hospital Privileges/Admit Plan Required	DEA Required	Education /Training Deferred to Board	Board Certification Required	Work History	NPDB & Sanctions
Acupuncture ACU	MT, NV	WY, UT, CO, MT, ID	YES	NO	NO	YES	NO	YES	YES
Audiologist AuD	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Advanced Practice Nurse APRN/APN	UT, WY, ID, MT, NV, CO		YES	YES	YES	YES	YES	YES	YES
Behavioral Analysts BCBA	UT, MT	ID, WY, CO, NV	YES	NO	NO	YES	YES	YES	YES
Nurse Midwife CNM	UT, WY, ID, MT, NV, CO		YES	YES	YES	YES	YES	YES	YES
Clinical Practice Nurse Practitioners CPNP	UT, WY, ID, MT, NV, CO		YES	YES	YES	YES	YES	YES	YES
Clinical Nurse Specialists CNS	UT, WY, ID, MT, NV, CO		YES	YES	YES	YES	YES	YES	YES

Provider Type by Degrees Known	States that License	States that do not License	License Verification on Produced Y/N	Hospital Privileges/ Admit Plan Required	DEA Required	Education /Training Deferred to Board	Board Certification Required	Work History	NPDB & Sanctions
Chiropractor DC	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Family Nurse Practitioners FNP	UT, WY, ID, MT, NV, CO		YES	YES	YES	YES	YES	YES	YES
Occupational Therapists OT	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Optometrists OD	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Dentists & Dental Surgeons DDS/DMD	UT, WY, ID, MT, NV, CO		YES	DDS NO DMD YES	YES	YES	YES	YES	YES
Osteopathic Physicians DO	UT, WY, ID, MT, NV, CO		YES	YES	YES	YES	YES	YES	YES
Allopathic Physicians MD	UT, WY, ID, MT, NV, CO		YES	YES	YES	YES	YES	YES	YES
Podiatrists DPM	All states		YES	YES	YES	YES	YES	YES	YES
Licensed Clinical Social Workers LCSW	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES

Provider Type by Degrees Known	States that License	States that do not License	License Verification on Produced Y/N	Hospital Privileges/Admit Plan Required	DEA Required	Education /Training Deferred to Board	Board Certification Required	Work History	NPDB & Sanction
Physical Therapists PT, MPT DPT	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Physician Assistants PA, PA-C	UT, WY, ID, MT, NV, CO		YES	YES	YES	YES	YES	YES	YES
Certified Diabetes Educators CDE, RD/ CDE PharmD/ CDE, RN/CDE	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES- BS OR MS TRAINING ACCEPTED FOR RN AND RD'S	NO	YES	YES
Speech Language Pathologists SLP	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Nurse Practitioners NP	UT, WY, ID, MT, NV, CO		YES	YES	YES	YES	YES	YES	YES
Naturopathic Doctors ND	CO, MT, UT	ID, NV, WY	YES	YES	YES	YES	YES	YES	YES

Provider Type by Degrees Known	States that License	States that do not License	License Verification Produced Y/N	Hospital Privileges/Admit Plan Required	DEA Required	Education /Training Deferred to Board	Board Certification Required	Work History	NPDB & Sanctions
Professional Counselors LCPC PC	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Licensed Marriage Family Therapists LMFT	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Addiction or Substance Abuse Counselors LAC LADC ADC CASUDC LAT	MT/ID	WY, UT, NV, CO	YES	NO	NO	YES	NO	YES	YES
Clinical Psychologist PhD PSYD	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Mental Health Counselors CMHC LCMHC MHC CMH	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES

Practitioners Who Do NOT Need to be credentialed:

- Covering practitioners (e.g. PRN's or short term locum tenens) who do not have an independent relationship with U of U Health Plans
- Rental networks:
 - Specifically rented for out-of-area care; whereby members are not directed or incentivized to see the rental network practitioners, (e.g. Multiplan, American Well, Universal Health Network and First Health practitioners.)
- Practitioners who practice exclusively within the inpatient setting, who provide care for Health Plans members only as a result of members being directed to the hospital or another inpatient setting (commonly referred to as No Choice Providers), or who are not masters level degree trained but certified/licensed and require supervision by the state license agency. This list is a subset of these provider types:
 - All Acute Care In-Patient Providers
 - Hospital Based Anesthesiologists
 - Board Certified Assistant Behavioral Analyst (BCaBA)
 - Certified Registered Nurse Anesthetist (CRNA)
 - Clinical Social Worker (CSW)
 - Direct Entry Midwives
 - Emergency Room Physicians
 - First Surgical Assistants
 - Hospitalists
 - Licensed Master Social Worker (LMSW)
 - Licensed Practical Nurse (LPN)
 - Marriage Family Therapists (MFT)
 - Master of Social Work (MSW)
 - Medical Assistant (MA)
 - Pathologists
 - Physical Therapy Assistants (PTA)
 - Registered Nurses (RN)
 - Hospital Based Radiologists
 - Assistant Marriage, Family, Substance Abuse, Drug, Alcohol Counselors and/or Social Workers who require supervision and/or cannot hold an independent contract with the health plan
 - Dentists who provide primary dental care only under a dental plan or rider
 - Pharmacists with a pharmacy benefits management (PBM) organization to which Health Plans delegates utilization management (UM) functions
 - Dental (Rental) Networks
 - Practitioners who do not provide care for members in a treatment setting (e.g. board-certified consultants)
 - Contracted vendors for Utah Neuropsychiatric Institute (UNI) or Miner's plans who are credentialed elsewhere

Verification Sources

All applications are reviewed by the Credentialing Staff and/or Medical Director as appropriate for accuracy and completeness. Prior to sending applications to committee for consideration, U of U Health Plans staff shall document that the Credentialing Verification Organization (CVO) has completed verification by NCQA approved primary sources for the following elements within specified time limits:

1. Valid, current and unrestricted license to practice in State(s) where U of U Health Plans has contracted with the provider. Verification completed with each state's licensing agency. (e.g. in Utah - www.DOPL.utah.gov.) Must be effective at the time of credentialing decision. Verification time limit: 180 calendar days.
2. DEA or CDS Certificates if applicable – will be checked via www.NTIS.gov or www.deanumber.com. Certificate is an acceptable source and needs to be current at the time of the credentialing decision. Verification time limit: Prior to credentialing decision.
3. Hospital Privileges or Admission Plan if applicable – will be checked via application as U of U Health plans contractually obligates certain practitioners to have hospital privileges and admit members to a participating hospital or have an admission plan in place with a participating physician who can admit members to a participating hospital. Verification of privileges can be by application attestation or primary source; if a primary source letter is obtained the verification time limit will be 365 calendar days.
4. Education and Training (Initial only) – Highest level of education must be primary source verified. This includes Board Certification if applicable, Residency or Medical School. Acceptable Verification Sources for Education – State licensing agency, specialty board or registry, if it performs primary source verification, sealed transcripts, AMA, AOA, FCVS for closed residency programs. If a practitioner requests a change in specialty mid-cycle, the highest level of Education/Training and License will be primary source verified. Verification time limit: Prior to decision date.
5. Board Certification is preferred, but not required – A sample list of accepted Boards is provided in another section of the policy. Verification time limit: 180 Calendar days and effective on decision date if the practitioner includes it on their credentialing application.
6. Work History – (Initial Only) via CV or credentialing application which should include the past 5 years. Primary source verification is not required. If fewer than 5 years, the period should start at the time of initial licensure. Should include the beginning and ending month and year. Verification time limit: 365 calendar days.
7. Professional Liability Coverage – via credentialing application or certificate of coverage if supplied. Must state coverage amounts and date coverage expires. Verification time limit: 180 calendar days.
8. Malpractice History –via www.NPDB.hrsa.gov, www.OIG.hhs.gov and www.SAM.gov. NPDB will be queried to verify a history of professional liability claims resulting in settlements or judgments paid on behalf of the practitioner or state licensing sanctions and

the other sources will be queried for Medicaid or Medicare sanctions. Verification time limit: 180 calendar days.

Criteria for Credentialing and Re-credentialing

At its sole discretion, U of U Health Plans will determine whether the practitioner/organizational provider meets the minimum requirements prior to the credentialing or re-credentialing application being processed. A determination that an individual does not meet minimum requirements does not constitute a denial of network access. An individual who raises any Category IV issues (below) by definition does not meet minimum requirements for network eligibility. A re-credentialing application is processed every 36 months. An extension will be granted to any provider who is on active military assignment, medical leave (e.g. maternity leave) or on sabbatical. A documented return date to practice would be captured in Genie and the provider would be re-credentialed within 60 days of his/her return to practice. Otherwise, if a provider does not meet their re-credentialing date they will be notified and treated as an initial applicant. Solo practitioners who fail to re-credential within 30 days of their reappointment date will result in a full contract termination. Practitioners affiliated with a group contract, will be unaffiliated, but the group contract will remain in force. If 30 days or more transpire post termination, providers must reapply and will be treated as initial applicants.

All Practitioners who require Credentialing shall be required to successfully complete the Category I (Clean file) requirements prior to being deemed a participating practitioner, providing care to members, being listed in the provider directories and submitting claims for services provided to members. Practitioners/Organizational Providers who do not satisfy a specific requirement for participation may require that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed the criteria in question. U of U Health Plans may grant waivers after considering the specific qualifications of the individual in question, and the best interests of the community the provider serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals. No individual/organizational provider is entitled to a waiver or a hearing if U of U Health Plans determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a denial of network access.

U of U Health Plans uses the following categories to determine how to process each file:

Category I File (Clean)

Applicants for U of U Health Plans panel participation must be able to meet the following minimum requirements to be considered a **Category I**:

1. If applicable, the applicant has successfully graduated from an accredited school of medicine, osteopathy, podiatry or dentistry.
2. If applicable, the applicant has successfully completed an internship and residency program.
3. The applicant has a current license to practice medicine, osteopathy, podiatry, or dentistry in State(s) where contracted to practice, and where applicable, has a current, unrestricted DEA registration and state controlled substance license.

4. A completed Council for Affordable Quality Healthcare (CAQH), CVO, or U of U Health Plans Organizational Provider credentialing application with a signed attestation that has not been flagged category III or IV. The applicant attests to the correctness and completeness of all information furnished and acknowledges that any significant misstatement or omission from the application constitutes grounds for a discovery that the Practitioner/Organizational Provider did not meet criteria for participation in the provider network, agrees to abide by the policies and procedures. U of U Health Plans accepts faxed, scanned, digital, electronic and photocopied signatures. Signature stamps will not be accepted.
5. There are no discrepancies in information received from the applicant or references.
6. The applicant has no malpractice history.
7. The applicant has valid, professional liability insurance coverage satisfactory to U of U Health Plans, with limits of dollar amounts, name of company and expiration date. Insurance coverage must be current at the time of attestation.
8. If applicable, the applicant has been accredited or certified by a U of U Health Plans accepted accrediting body. Please see Accepted Accrediting Bodies Table, which is part of the Assessment of Organizational Providers standard.
9. Preferred board certification in the specialty(s) in which they practice medicine. U of U Health Plans will verify board certification as the highest level of Education if it is included in the credentialing application. **A practitioner may be considered for participation if they have completed a residency program in the specialty in which they are practicing. ***Practitioners who are not board certified and have not completed a residency program will ONLY be eligible for participation as a General Practitioner. The practitioner is responsible to notify the Credentialing Committee of any additions to or loss of his/her board certification. A sample of accepted Board certifying entities are listed below:

ABMS.org	ABPMED.org	NURSECREDENTIALING.org	AASM.org
AOA.org	AANPCERT.org	BOARDCERTIFIEDDOCS.org	ABIM.org
ABOMS.org	ABSURGERY.org	AMCBMIDWIFE.org	BACB.com
ABFAS.org	AANP.org	ABFM.org	NCCPA.net

Category II (Fast Track)

For an applicant's file to be considered **Category II**, the credentialing cycle must be in danger of expiring, or one of the primary source documents must be in danger of expiring. Category II files must also meet Category I criteria, under Category I (Clean Files), in order to be considered for "Fast Track". The Credentialing Committee Chair/Medical Director will have the authority to approve and fast track approve Category I and II files for network participation when the situation warrants.

Category III (Consent)

For a file to be considered **Category III**, the applicant's file will be flagged for Committee by U of U Health Plans CVO, but does not warrant a Category IV designation. These files will be flagged Category III for informational purposes for committee review and approval. Category III files also enable the Credentialing Committee to watch for patterns of aberrant behavior and or license disciplinary actions or sanctions.

Category IV (Discussion)

Evidence of one or more of the following may cause the practitioner/organizational provider application to be flagged for committee discussion as a **Category IV**:

1. The applicant has had a license to practice revoked (includes with a stay of revocation), suspended, or placed on probation by any state licensing agency within the past 5 years for an Initial applicant, or since the last re-credentialing cycle. Some license actions may result in disqualification from the U of U Health Plans Provider Network if the necessary rehabilitation has not been completed.
2. The applicant has had their medical staff appointment or privileges denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct. In addition, applicant has resigned medical staff privileges in the face of an investigation or to avoid an investigation.
3. The applicant has been convicted of any felony, or of any misdemeanor relating to the practice of medicine, including controlled substances, governmental or private health insurance fraud or abuse, or violence, and does not have a current Medicare or Medicaid sanction imposed restricting treatment of Medicare or Medicaid members. Applicants with felony convictions that are greater than five years old may be eligible for network participation at the sole discretion of U of U Health Plans. Applicants whose sanctions have been cleared may re-apply as initial applicants, so long as it can be proven that the provider is no longer excluded by Medicaid/Medicare, and the State Medicaid Agency acknowledges the health plan is permitted to proceed with the credentialing application.
4. The applicant's history of medical malpractice claims or professional liability claims must not reflect what, in the sole discretion of U of U Health Plans, constitutes a pattern of excessive claims history either due to the number of claims or the amount of the claims, as specified in the chart which follows on the next page.

Claim Threshold/Claim Frequency Chart

- Followed for Categories III-IV

Specialty	Claim Threshold	or	Claim Frequency
	Any Settlement in Past 5 Years involving a death or Greater Than:		Number of Settlements in the Last 5 Years Incident Date
Allergy & Immunology	\$100,000		3
Dermatology	\$100,000		
Internal Medicine	\$100,000		
Family Medicine	\$100,000		
Pediatrics	\$100,000		
Endocrinology, Diabetes & Metabolism	\$100,000		3
Gastroenterology	\$100,000		
Infectious Disease	\$100,000		
Psychiatry	\$100,000		
Cardiovascular Disease	\$200,000		3
Emergency Medicine	\$200,000		
Hematology	\$200,000		
Hematology & Oncology	\$200,000		
Nephrology	\$200,000		
Neurology	\$200,000		
Pulmonary Disease	\$200,000		
Surgery	\$250,000		
Physical Medicine and Rehabilitation	\$250,000		3
Urology	\$250,000		
Ophthalmology	\$500,000		3
Otolaryngology	\$500,000		
Thoracic Surgery (Cardiothoracic Vascular)	\$1,000,000		3
Gynecology	\$1,000,000		
Neurological Surgery	\$1,000,000		
Orthopedic Surgery	\$1,000,000		
Plastic Surgery	\$1,000,000		
Vascular Surgery	\$1,000,000		
Obstetrics & Gynecology	\$1,000,000		
Podiatry			3
Nurse Practitioner/Advanced Practice Registered Nurse			3
Physician Assistant			3
Certified Nurse Midwife			3
Board Certified Behavioral Analyst			3
Marriage Family Therapy			3
Physical Therapy			3
Occupational Therapy			3
Licensed Professional Counselor			3
Clinical Mental Health Counselor			3
Licensed Clinical Social Worker			3
Psychologist			3
Clinical Nurse Specialist			3

Process for Making Credentialing and Re-credentialing Decisions

Prior to a Practitioner/Organizational Provider seeing a U of U Health Plans member, it is U of U Health Plans' practice to ensure all applicants are credentialed. The following process is followed to ensure all applicants are reviewed and/or voted on by the Credentialing Committee.

- CVO will flag the file before sending it to U of U Health Plans for committee review, if there are issues
- Files determined to fall under Categories III and IV are taken to committee for review
- Those files that the Committee Chair/Medical Director determines need further review or do not have enough information will be put on the next credentialing meeting agenda for discussion
- A pre-meeting review with Credentials Committee Chair/Medical Director, as well as the Director of Provider Network Management to get input will be held prior to the committee meeting
- All primary source verified files get uploaded into Genie before committee, and a credentialing staff member(s) runs Clean Files Report from Genie application, as well as Malpractice Files Report from Genie
- Credentialing Committee reviews files presented according to category:
 - For Category I – Approval for clean files assigned a Category I can occur in one of two ways; 1. A U of U Health Plans medical director and/or current chair of the credentials committee can receive and sign off on a report of clean files. 2. The other option is to present a full report of the files to the committee and have them approved by unanimous vote. All approvals will be uploaded into the Provider Genie Application after the committee has adjourned.
 - For Category II – All fast track files will be ratified by unanimous vote and all approvals will be uploaded into the Provider Genie Application after the committee has adjourned.
 - For Category III – All consent agenda files will be reviewed and voted on during committee. All approved will be uploaded into the Provider Genie Application after the committee has adjourned.
 - For Category IV – After a committee discussion of each individual file, all decisions will be uploaded into the Provider Genie Application after the committee has adjourned
- All decisions will be entered into the CVO platform, and all applicants with a final decision will have their status deactivated at CAQH.
- For those applicants who did not meet minimum eligibility criteria, they will be marked as “Denied” in CVO platform, as well as removed from the CVO and CAQH rosters.
- Any applicants whose decision has been tabled for more information by the committee will be researched to get the applicable information before the next committee meeting.
- Within 60 days, approval letters will be generated and sent to each applicant notifying them if they were approved or did not meet criteria.

Process for Delegating Credentialing or Re-credentialing

U of U Health Plans delegates its credentialing to approximately 20 entities, in an effort to avoid duplicating the credentialing process undertaken by another organization and maximize efficiency. U of U Health Plans shall enter into a delegation agreement with an organization already performing credentialing of practitioners shared by both entities. The following requirements must be met prior to entering into an agreement:

1. Group must pass a pre-assessment review, if entering into a new delegation agreement.
2. Automatic Credit may apply if delegated entity is an NCQA Accredited Group, fully complies with U of U Health Plans credentialing requirements, and criteria for practitioner selection and follows NCQA Standards.

The following requirements are applicable for the Delegated Entity once the pre-assessment has been successfully completed and U of U Health Plans has signed the delegation agreement:

1. Delegated Entity provides U of U Health Plans with a roster of all participating practitioners including information specified in delegation agreement
2. Delegated Entity has written Policies and Procedures that correspond to NCQA Standards
3. Delegated Entity performs verification of credentialing elements specified in delegation agreement
4. Delegated Entity provides evidence that re-credentialing of practitioners is completed within the three year time frame and Category I requirements are met on an on-going basis
5. Delegated Entity provides U of U Health Plans with monthly updates
6. Delegated Entity agrees to assume responsibility for penalties for non-compliance with the delegation agreement
7. The delegated entity shall be required to submit to U of U Health Plans the minutes of their credentialing meetings. The minutes shall at minimum include the date of the meeting, who was present, a listing of all practitioners approved or re-approved, and those who were denied. For all practitioners with issues, the minutes shall include a brief summary of the discussion (enough to demonstrate that a meaningful discussion took place of the issues at hand) for each practitioner
8. The delegated entity shall be required to report all adverse events to U of U Health Plans within 30 days after notification of the adverse event
9. The minutes of the meeting will be reviewed and approved by the Credentialing Committee and signed and dated by the U of U Health Plans Medical Director
10. On a monthly basis, the delegated entity shall submit sufficient information to U of U Health Plans for U of U Health Plans to set up the approved practitioners in the claims system, add them to its directories and term practitioners no longer with the delegated entity

U of U Health Plans is responsible for the following:

At least once a calendar year, U of U Health Plans shall conduct an audit of the delegated entity's credentialing files and policies to ensure that at minimum they are meeting the current NCQA credentialing standards.

1. U of U Health Plans uses the 8/30 methodology of reviewing audit files.
2. A Corrective Action Plan (CAP) shall be required from the Delegated Entity if the audit score is less than 90%.

Monitoring of Delegation of Credentialing Entities

Delegated Credentialing Agreements are entered into on a case-by-case basis.

Each delegated entity is required to:

- Follow requirements outlined in 1-10 above;
- Maintain complete credentialing files on all practitioners covered by the agreement, accessible upon request by the U of U Health Plans Credentialing Team.

Process for Ensuring that Credentialing and Re-credentialing are Conducted in a Non-discriminatory Manner

University of Utah Health Plans (U of U Health Plans) does not make contracting or credentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type in which the applicant specializes. Additionally U of U Health Plans does not prohibit or restrict providers from acting within their lawful scope of practice or discriminate against health care professionals who serve high-risk populations or who specialize in the treatment of costly conditions. U of U Health Plans follows these steps in an effort to prevent discrimination:

1. Each January, credentialing staff members review committee minutes from the prior calendar year, and/or reports from the Genie provider application to identify patterns of acceptance / non-acceptance that would indicate possible discrimination.
2. A report of the findings is reviewed and signed by the Provider Network Director annually shall be placed with a print out of the log sheets in the Discrimination Monitoring binder.
3. If it was determined that discrimination based on one of the characteristics or situations listed above may have taken place, the following steps will be taken:
 - A more detailed review of the affected providers' applications will be conducted by the Medical Director and Provider Network Director to gather supporting facts.
 - If the facts support the alleged discrimination:
 - a corrective action plan will be developed and implemented, and
 - an additional audit of the current year's applicants will be reviewed 6 months later

Process for Notifying Practitioners if Information Obtained During the Credentialing Process Varies Substantially from the Information Provided

If information obtained during the credentialing verification, process varies substantially from information the practitioner submitted in the application, staff will request clarification from the provider via e-mail, phone or through our CVO. Practitioners are notified of this and how to submit corrections via U of U Health Plans' website: www.uhealthplan.utah.edu, as well as in the Provider Manual available on the U of U Health Plans website.

Process for Ensuring that Practitioners are Notified of Credentialing Decisions within 60 Calendar Days of the Credentialing Committee's Decision

Initial applicants shall be notified in writing via letter by a member of the Credentialing team regarding the Credentialing Committee decision. This notification shall be made within sixty (60) days of the committee's decision. In situations where the applicant did not meet criteria, the Committee Chair/Medical Director will notify the applicant via a certified letter, detailing reasons for the decision. If the Credentialing Committee tables an applicant, this is noted in the Genie and U of U Health Plans requests the missing information via email or certified letter. Re-credentialing applicants are considered approved unless they are notified otherwise.

Medical Director or Other Designated Physician's Direct Responsibility and Participation in the Credentialing Program

The Committee Chair/Medical Director is appointed by the University of Utah Health Plans Chief Medical Director. The Committee Chair/Medical Director has the authority to appoint committee members unless otherwise specifically provided. The Committee Chair/Medical Director approves the credentialing committee minutes, as well as chairs the committee meeting. In preparation for the monthly committee meetings, the Credentialing Manager and select members from the Contracting team review all sanctioned applicant files and make recommendations. Additionally, the Committee Chair/Medical Director has the authority to fast track approve Category II files (those files whose credentialing will expire before the next committee meeting) and approve Category I "clean" files for network participation when the situation warrants.

Process for Ensuring Confidentiality of all Information Obtained in the Credentialing Process, Except as Otherwise Provided by Law

U of U Health Plans maintains the confidentiality of all records, discussions, and deliberations obtained in the credentialing process, peer review and quality improvement activities, pursuant to Utah Code Annotated §26-25-1, for the purpose of evaluating health care rendered by hospitals or physicians and is NOT PART of the medical records. It is also classified as "protected" under the Government Records Access and Management Act, Utah Code Annotated §63G-2-101 et seq.

Disclosure of any information or documentation contained in practitioner credentials files will be permitted only as described in this policy. All minutes, reports (including those from outside consultants), recommendations, communications, and actions made or taken pursuant to this Policy shall be treated as confidential; provided that reports of actions taken pursuant to this Policy shall be made by the University Legal Counsel to such governmental agencies as may be required by law. Any breach of confidentiality may result in a professional review action, and/or appropriate legal action to ensure that confidentiality is preserved. The committees and members charged with making reports, findings, recommendations, or investigations pursuant to this Policy shall be considered to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq., and are intended to be covered by the provisions of Utah Code Ann. §26-25-1; §26-25-3; §26-25-4; §58-13-4; and §58-13-5, or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

Members of the Credentialing Committee are educated regarding state and federal peer review statutes by which they are bound, and annually sign and abide by the U of U Health Plans Confidentiality and Nondiscrimination Attestation.

Historically, electronic files were stored on secured network drive. Copies of a practitioner's credentialing application, verifications and any other document necessary to the credentialing process were stored in the practitioner's electronic file. Currently, credentialing files are stored securely within our CVO's electronic platform.

Process for Ensuring Listings in Practitioner Directories and Other Materials for Members are Consistent with Credentialing Data

To ensure that printed materials are consistent with data collected during the credentialing process, U of U Health Plans follows processes as outlined in the credentialing workflow. Provider Data Management Coordinators do roster reconciliations with rosters from contracted groups. U of U Health Plans makes sure that practitioners who should be listed in the printed directories have correct information by proofing each directory at least monthly, or as required.

- Typically, only practitioners that a patient would make an appointment to see are listed in the directories. "No Choice" practitioners are not usually listed.
- Provider directories and updated provider search engine are generated from the Genie as needed and available on our website www.uhealthplan.utah.edu.
- Members can also call Customer Service for assistance finding a practitioner.
- Members may request a printed provider directory by contacting Customer Service.

Utah Customer Service Phone Numbers

Toll Free #	Local	Name
833-981-0212	801 213-4104	Healthy U - Medicaid
833-981-0213	801 213-4008	UHP - Commercial
833-981-0214	801 213-4111	UHP - Individual

Practitioner Rights

- The applicant shall have the right to be informed of their application status (Ready for Committee, App In-process, App Incomplete or Missing Information) upon request. The request shall be made via email to: provider.credentialing@hsc.utah.edu, or by phone to 801-587-2838, opt 3. Information on Practitioner Rights can be found in the Provider Manual on our website: www.uhealthplan.utah.edu. Emails will be responded to within 24 hours, and voice mails returned within 48 hours.
- The Practitioner will have the opportunity to correct any erroneous information, as applicable, during the 2-3 month credentialing process. Applicants are notified of this right through our Provider Manual and website: www.uhealthplan.utah.edu
- Erroneous information must be lined through with black ink, corrections above or to the side and initialed. No white out will be accepted. Corrections will be communicated to our CVO within 2 business days. Corrections can be submitted to: provider.credentialing@hsc.utah.edu

- Upon request, applicants may review the information s/he has submitted in support of their credentialing or re-credentialing application, including but not limited to:
 - information from outside sources
 - malpractice insurance carrier face sheet
 - state licensing board
 - DEA agency verification
 - education verification letter from a school
 - board certification verification, if applicable

U of U Health Plans is not required to reveal sources of information that are not part of our verification requirements or if federal or state law prohibits us, such as NPDB reports. The applicant may view their file in the presence of the U of U Health Plans Medical Director and a member of the credentialing team. Applicants are notified of these rights in the Provider Manual and website: www.uhealthplan.utah.edu

Access to Records

All requests for access to credentialing records will be presented to an authorized representative of the U of U Health Plans credentialing team, who will keep a record of requests made and granted. Unless otherwise stated, an individual permitted access under this section will be afforded a reasonable opportunity to inspect the records, and to make notes regarding the requested records in the presence of an authorized representative.

The following individuals may access credentialing records to the extent described:

1. The U of U Health Plans credentialing team and Medical Director may have access to all records as needed to fulfill their responsibilities.
2. Consultants or attorneys engaged by the University of Utah or U of U Health Plans may be granted access to records that are necessary to enable them to perform their functions provided that he or she has signed and dated the appropriate "Confidentiality Agreement." The original agreement will be retained by U of U Health Plans.
3. All subpoenas pertaining to credentials records will be referred to the Credentialing Manager who will consult with legal counsel regarding the appropriate response. Representatives of regulatory or accreditation agencies may have access to records as required by law or accrediting rules.

Should a file review be requested, staff will set an appointment at the U of U Health Plans office for the practitioner to review the submitted materials in his or her credentialing file under the following circumstances:

- The request is approved by the U of U Health Plans Medical Director
- Review of the file is accomplished in the presence of the U of U Health Plans Medical Director and Provider Credentialing Consultant
- The practitioner understands that he or she may not remove or delete any items from the credentialing file
- The practitioner understands that he or she may add an explanatory note or other document to the file for the purpose of correcting erroneous information

The applicant attests to the correctness and completeness of all information furnished and

acknowledges that any significant misstatement or omission from the application is reason to find that the applicant no longer meets criteria.

Credentialing Committee

Committee Composition

The Credentialing Committee is composed of select members from U of U Health Plans' contracted provider network and other community providers who reflect multiple specialties, including Pediatrics, Surgery, OB/GYN and Family Medicine, who provide input during discussion of applicants to the U of U Health Plans provider panel. U of U Health Plans staff members serve as non-voting members of the committee as does the University General Counsel. A quorum shall consist of no less than three (3) voting members. Committee Chair votes if needed for quorum or tiebreaker.

Responsibilities

1. Reviews and approves the U of U Health Plans Credentialing Policies & Procedures
2. Evaluates completed applications of all applicants for initial and re-credentialing admittance to the U of U Health Plans provider network
3. Meets monthly to discuss Category I-IV files. When necessary, an e-mail may be sent for electronic file review and committee vote to meet a practitioner's deadline if prior to the meeting
4. Ensures the proceedings of each Credentialing Committee meeting are summarized in minutes and reported to the U of U Health Plans Provider Network Management Directors, Provider Network Team Members and Medical Directors
5. All members of the credentials committee shall keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee
 - Due to the increasing amount of materials that the credentials committee must review, committee members will be able to obtain certain minutes and information to review before each regularly scheduled meeting. Such materials are confidential and must be returned at the relevant meeting. A master copy of each information item will be maintained by the credentialing team.
6. The Credentialing Committee reviews the "Organizational Provider Report", "Clean File Report" and "Malpractice Report" at the next regularly scheduled meeting, and votes to approve, either table the application for participation or finds the applicant not to meet criteria.
 - If approved, Credentialing staff sends notification to the practitioner within 60 days of meeting.
 - If tabled, the application for further consideration must, except for good cause, be followed up within 30 days by approval or not meeting network criteria. Provider Credentialing Consultant will promptly send the applicant special notice of any action to table and include an explanation of the reason for postponement, as well as a request for the specific information, release or authorization or other material, if any, required from the applicant to make a final decision. A timeframe for response will be specified and will not exceed 30 days. If the applicant fails, without good cause, to respond or appear before the

Committee in a satisfactory manner within the specified time frame, it is deemed a voluntary withdrawal of the application.

- If the Committee determines the applicant does not meet criteria, the Committee Chair/Medical Director sends notification via certified letter to the applicant within 30 calendar days and if applicable, includes the process for appealing the decision.
7. The Credentialing Committee Chair/Medical Director ensures files that meet criteria are reviewed and approved. The Credentialing Committee Chair/Medical Director also has authority to fast track and approve network participation when the situation warrants, providing the applicant file meets criteria. If the Credentialing Committee Chair/Medical Director is unavailable to approve files, the approval decision may be deferred to an ad hoc chairperson.

Ongoing Monitoring and Interventions

Medicaid and Medicare Sanctions

Within 30 days of release from the reporting entity, U of U Health Plans will review the Medicaid and Medicare Sanctions report. All practitioners and organizational providers who have been sanctioned or otherwise debarred from participation with Medicare & Medicaid do not meet Health Plans criteria for participation in the Health Plans network. Practitioners or organizational providers discovered to have sanctions are given to the Medical Director for review. Based upon his/her recommendations, the sanctioned practitioner/organizational provider is then taken to the next Credentialing Committee for review, with subsequent action to be taken regarding the provider being determined by Committee. When necessary, the determined action will be carried out by the Senior Provider Credentialing Consultant and/or Credentialing Manager. The following websites will be searched for all active U of U Health Plans participating practitioners/organizational providers:

1. Office of Inspector General (OIG) website:
http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp
 - a) Download the current month's Exclusions (CSV) and save the files to the 'Provider Sanctions – Disciplinary Actions\OIG Reports' folder. (Found in the S:Drive – Health Plans Credentialing Files)
 - b) Open the Provider Sanctions Application (saved on desktop), and click on Tab that says 'Process OIG'. This will allow the selection of the recently saved OIG report. Select the correct report and click OPEN. Application will start running. Once complete, a message will pop up that says: "0 matches found, or 1 match found".
 - c) The Credentialing team is responsible for:
 - (i) reviewing the report, verifying whether or not the listed practitioner/organizational provider is participating in the U of U Health Plans network
 - (ii) initiating the termination process for each participating practitioner/organizational provider should there be a match
 - (iii) terming the practitioner/organizational provider from the Provider Genie Application, removing from CVO and CAQH rosters, and creating a JIRA

- to alert the Systems team of the termination so members can be re-assigned
(iv) documenting all findings and actions taken in the Sanctions OIG log

2. System for Award Management (SAM) Monitoring website:

<http://www.sam.gov/portal/public/SAM>

- a) Sign in at the top right of page with User Name and Current Password
- b) Accept Usage Agreement
- c) On left of page, under MY SAM, click Data Access, then Exclusions under the options that will appear
- d) Scroll to bottom of page and click on the most recent date under 'Complete File – Last 7 days'
- e) Open File
- f) When Excel Spreadsheet appears named SAM_Exclusions_Public_Extract_yy_dd, right click and copy the file
- g) Go to the following path: S-Drive – U of U Health Plans Credentialing Files – 0 Provider Sanctions – SAM Reports and paste the copy of the file into the SAM Reports folder without changing file name
- h) Open the Provider Sanctions Application, and click on Tab that says 'Process SAM'. This will allow the selection of the recently saved SAM report. Select the correct report and click OPEN. Application will start running. When complete a message will pop up that says: "0 matches found, or 1 match found". The Provider Sanction application looks for NPI matches against the Provider Genie application. Click on "Get Providers" tab if there is a match to see the practitioner's name.
- i) The Credentialing team is responsible for:
 - (i) reviewing the report, verifying whether or not the listed practitioners/organizational providers are participating in the U of U Health Plans network
 - (ii) initiating the termination process for each participating practitioner/organizational provider should there be a match
 - (iii) terming the practitioner/organizational provider in the Provider Genie Application, removing from CVO and CAQH rosters, and creating a JIRA to alert the Systems team of the termination so members can be re-assigned
 - (iv) sending a "did not meet criteria" letter as necessary
 - (v) documenting all findings and actions taken in the Sanctions OIG log

Licensure Sanctions

1. Providers are enrolled in the National Practitioner Data Bank's Continuous Query Service by the CVO upon initial credentialing and annually thereafter. This service informs the health plan of sanctions on licensure, limitations on scope of practice, malpractice judgements or settlements and ongoing monitoring of Medicare or Medicaid sanctions.
2. In addition, the State's Department of Professional Licensing's (DOPL) website is used to monitor disciplinary actions taken by the licensing board against all Utah licensed individuals. The DOPL Newsletter is checked within 30 days of its release. Go to: <http://www.dopl.utah.gov/investigations/disciplinary.html> and find the DOPL Disciplinary Actions and Citations Newsletter.

- a) On a monthly basis, the newsletter is downloaded from the site and saved in the 'S-Drive\U of U Health Plans Credentialing Files\Provider Sanctions-Disciplinary Actions\DOPL Report' folder
- b) The file is renamed as "MM-YYYY DOPL Newsletter and Citations.txt"
- c) The DOPL Log sheet is updated with the date of the download and the name of the staff member who downloaded it
- d) The practitioners/organizational providers on the Newsletter are compared to the Provider Genie Application. All Practitioner/Organizational Providers who are found on the newsletter and in the Provider Genie should be logged in the Sanctions Log Sheet, on the DOPL tab
- e) The Credentialing team is responsible for:
 - (i) taking the sanctioned Practitioner/Organizational Provider to Credentialing Committee for a review of the nature and severity of the actions that led to the disciplinary action taken by DOPL, the terms of the disciplinary action, and the provider's compliance with the disciplinary terms and make a decision as to whether or not the provider is to be termed from the Network
 - (ii) terming the Practitioner/Organizational Provider from the Provider Genie Application, removing from the CVO/CAQH rosters, creating a JIRA if necessary
 - (iii) sending a "did not meet criteria" letter as necessary

Complaints and Adverse Events

1. Members can go to the U of U Health Plans website: uhealthplans@utah.edu to log a complaint. Once submitted, complaints and adverse events are sent electronically to the Managed Care Coordinators, who are part of the Compliance Team. Once the Managed Care Coordinators have logged it, the complaint/adverse event is forwarded to the Credentialing Manager who logs it in the Provider Genie Application.
2. Review of complaints and adverse events occur on a monthly basis. A monthly report is run by the Credentialing Manager before the Credentialing Committee meeting, looking for any practitioner/provider with a history of 3 or more complaints/adverse events within the past year. Those that have 3 or more within the past year or who have a significant quality of care incident are taken to committee for discussion.
3. Possible Actions might include:
 - a) Removal from Network
 - b) Site Visit from Provider Relations team
 - c) Approval if actions are not deemed as egregious
 - d) A letter to the practitioner asking for additional information

NPDB Reports

1. Through our CVO, U of U Health Plans providers are enrolled in the NPDB Continuous Query process. Upon receipt of notification of an NPDB Report Disclosure, the Credentialing Coordinator enters the report into the Provider's record in the Provider Genie Application and the information is taken to the credentialing committee for review.
2. Possible Actions might include:
 - a) Removal from Network
 - b) Site Visit

- c) Approval if actions are not deemed as egregious
- d) A letter to the practitioner asking for additional information

Notification to Authorities and Practitioner Appeal Rights

Upon contracting with a Practitioner Group, U of U Health Plans Contracting Coordinator sends a Welcome Packet directing applicants to our Provider Manual on the U of U Health Plans website. More specific Credentialing information and policies are found in the U of U Health Plans Credentialing Policies, available to applicants by e-mailing provider.credentialing@hsc.utah.edu. In addition, the information outlining the process an applicant would follow to appeal a credentialing or re-credentialing decision in the event that an applicant disagrees with the Credentialing Committee's consensus regarding their participation status with the network, is included in the group's Welcome Packet and online at www.uhealthplan.utah.edu

In the event a decision is made to remove the provider from the network and requires a fair hearing or reporting to the National Practitioner Databank, U of U Health Plans will follow its Fair Hearing Policy which has been separated from this policy effective (insert date of new committee approved Fair Hearing Policy.)

In order to ensure the health and well-being of our members, U of U Health Plans monitors sanctions on a monthly basis to remain aware of the quality of practitioners/organizational providers we panel. The U of U Health Plans Customer Complaint Form for members to offer feedback is found on the U of U Health Plans website at the following link: <https://app.secure.uuhsc.utah.edu/uhealthPlans/forms/complaint>. Upon receipt of a complaint, the issue is investigated and appropriate action taken to protect our members.

Assessment of Organizational Providers

To provide quality of care for our members, before contracting with new organizational providers, U of U Health Plans ensures that each applicant meets established standards. U of U Health Plans will re-credential each organizational provider every 36 months provided the criteria for participation are being met on an on-going basis. Credentialing will be conducted according to licensure. Each location will be assessed, and if the parent company is accredited, but not the satellite locations, only the parent company accreditation will be used. Failure to provide proof of meeting established standards will make the application ineligible and will result in not being admitted to the network, or an administrative removal from the network. To be credentialed, organizational providers must meet the following criteria and the verifications produced by U of U Health Plans and/or its designated CVO as identified in a later section of this policy:

1. Completion of the organizational provider application (must be filled out in ink only...no white out will be accepted). Corrections must be made by drawing a line through the erroneous information, placing correct information above or beside and initialed.
2. If accredited, must submit an acceptance letter and/or report survey stating the organizational provider was reviewed and passed with the completed application. An attestation stating an organizational provider is accredited will not be accepted.
3. If not accredited, a CMS certification survey and/or a state license inspection would be acceptable if no more than 5 years old, and an acceptance letter and/or report survey stating

the organizational provider was reviewed and passed must be submitted with completed application. An attestation stating an organizational provider is certified will not be accepted. Survey findings with designations A-F are deemed acceptable. Survey findings with designations G and above will be sent to the Credentials Committee for review. If a plan of correction is available, it will be included.

4. If not accredited or does not have a completed CMS certification survey, or has not had a recent state license inspection, an onsite quality assessment will be performed by a Provider Relations Consultant and UM team member to determine if NCQA standards are being met. This requirement may be waived if the organizational provider is located in a rural area, as defined by the U.S. Census Bureau.
 - The employees performing the assessment will use U of U Health Plans' Physical Facility Questionnaire pertaining to the specific Organizational Provider Type being credentialed. Questionnaires are tailored for each facility type, based on the following evaluation categories:
 - Physical accessibility
 - Physical appearance
 - Adequacy of space
 - Privacy/HIPAA compliance
 - Registration process
 - Medical record keeping
 - Staff/patient interaction
 - Facility Personnel conduct
 - During the onsite quality assessment, it will also be determined that the organizational provider has a process in place to credential its practitioners. If not, U of U Health Plans will create a CAP, which outlines the credentialing process and the time frame in which to start credentialing. U of U Health Plans will contact the organizational provider 6 months after the CAP is instituted for follow-up.
 - A site visit may only be done at a parent location if all satellite sites follow the same policy and procedures as the parent company.
5. U of U Health Plans Credentialing Staff reviews application documentation, confirming the following criteria are current and free from sanctions:
 - Copy of current valid license, certification or registration as applicable to type of organizational provider type, which is used to confirm good standing with state requirements
 - Current professional malpractice liability insurance face sheet or included in the credentialing application. Must be current at the time of attestation.
 - Absence of any license or Medicare/Medicaid sanctions
 - Signed and dated attestation/release. U of U Health Plans will accept electronic, scanned, photocopied, digital and faxed signatures. A signature stamp will not be accepted.
 - Current CLIA in good standing (for hospitals & laboratories)

Accepted Accrediting Bodies:

(AAAHC)	Accreditation Association for Ambulatory Health Care
---------	--

(ACHC)	Accreditation Commission for Health Care
(AAAASF)	American Association for Accreditation of Ambulatory Surgery Facilities
(ABCOP)	American Board for Certification in Orthotics/Prosthetics
(ACR)	American College of Radiology
(ASHI)	American Society for Histocompatibility and Immunogenetics
(BOC)	Board of Certification / Accreditation, International (O&P or DMEPOS)
(CAP)	College of American Pathologists
(CARF)	Commission on Accreditation of Rehabilitation Facilities
(COLA)	Committee of Laboratory Accreditation
(CHAP)	Community Health Accreditation Program
(CT)	The Compliance Team
(COA)	Council on Accreditation
(DNV)	Det Norske Veritas
(HFAP)	Healthcare Facilities Accreditation Program – AOA
(HQAA)	Healthcare Quality Association on Accreditation
(IAC)	The Intersocietal Accreditation Commission
(NABP)	National Association of Boards of Pharmacy
(NBAOS)	National Board of Accreditation for Orthotics Suppliers
(NCQA)	National Committee for Quality Assurance
(TJC)	The Joint Commission
(URAC)	URAC, (aka, American Accreditation Healthcare Commission)
(CABC)	Commission for the Accreditation of Birth Centers
(PPFA)	Planned Parenthood Federation of America

Types of Organizational Medical Providers to be credentialed, but not limited to:

1. Hospitals
2. Home Health/Personal Care Agencies
3. Skilled Nursing Facilities
4. Free-standing Surgical Centers with more than one surgical suite

Types of Organizational Behavioral Healthcare Providers to be credentialed, but not limited to:

1. Residential Treatment Facilities – A live-in health care facility providing therapy for substance abuse, mental illness, or other behavioral problems.
2. Inpatient – Inpatient Services can be defined as 24-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both.
3. Ambulatory Behavioral Healthcare – Outpatient Services provided for mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner’s office.

Facility Credentialing/Site Visit Workflow

- Once the U of U Health Plans Credentialing Coordinator is given the contract, he/she is responsible for contacting the organizational provider to determine whom the credentialing

contact is, obtain an email/phone number and update the Genie with this information. When the completed application and supporting documents are received, credentialing staff will begin processing the file. If there is missing information and it is not obtained within a 2 week time frame, the credentialing staff will follow-up with the organizational provider.

- Verifications must be completed within 120-calendar days. The website for the accrediting/certifying body will be checked; licenses will be verified through the license copy or the licensing board for the state in which the organizational provider resides (Surgical Centers with only one surgical suite may be exempt from licensure by CMS, and some states do not issue a license for surgical centers. Sanctions will be verified through SAM/OIG; CLIA's will be verified through the appropriate state agency; if applicable, all rosters will be checked for Medicare/Medicaid sanctions. Electronic Files: The credentialing staff will create an electronic file for each organizational provider that will be stored on a secure network drive. Each credentialing document and verification will be saved with the staff person's name and date verified. Files will be kept confidential, and only those employees needing access to ensure network participation will be allowed to view and maintain the file.
- When verifications are complete and a file is deemed "Clean", the Senior Credentialing Consultant will be notified to take it to the next Credentialing Committee Meeting for review and approval.
- If an Organizational Provider is discovered on one of the sanction lists, the file will be reviewed by the Medical Director and Director of Provider Network Management pre-committee meeting for review and determination of next step.
- Any file deemed by the Consultant as "Does not meet criteria" will be sent directly to the Provider Relations Consultant (PRC) over the territory and they will be required to set-up a site visit with the organizational provider. The PRC must take a member of the UM team with them to the Site Visit. Based on the site visit findings, the PRC and UM team member will recommend the file is now ready, or "Category I" for credentialing committee approval, or recommend denial/removal from network participation.

If, after the site visit, the Organizational Provider still does not meet criteria, the Contracting Team will be notified. If they determine that they want to keep the Organizational Provider in the Network, or add them as an initial, they must create a CAP (Corrective Action Plan) so the Organizational Provider can work towards meeting U of U Health Plan's network participation criteria. Contracting will present the CAP to the Organizational Provider, and follow-up with them again after 3-months. When it is time for CAP follow-up, the Contracting team will notify the PRC and UM team member to do a follow-up site visit. They will alert the appropriate parties of their findings. At this point, they will recommend that the Credentialing Consultant starts the verification process again or denial/removal from the network by the Contracting team. If the Contracting team decides to remove from the network or deny network participation due to not meeting criteria, they will send a term/denial letter. They will also term the contract; create a JIRA if necessary to alert systems and log in the Genie. They will alert the credentialing coordinator to term in the Provider Genie Application.

- The applicant shall have the right to be informed of their application status upon request as noted in the Provider Manual and on the U of U Health Plans website. The request shall be made via email to: provider.credentialing@hsc.utah.edu. All correspondence will be responded to within 24 hours, and voice mails returned within 48 hours.
- The applicant shall also have the right to review the information s/he has submitted in support of their credentialing or re-credentialing application, and will have the opportunity to correct any erroneous information, as applicable, during the 2-3 month credentialing process. Applicants

are notified through the website, as well as the Provider Manual. Corrections can be submitted to: provider.credentialing@hsc.utah.edu

Verification Required	Circumstances Requiring Committee Discussion
State or Medicare survey present in file; a corrective action plan if/as necessary is also present; ratings on survey have quality findings = > G	<ul style="list-style-type: none"> • Survey results with identified deficiencies and no corrective action plan in the file will not meet criteria. • If the corrective action plan is present but there is no evidence it has been accepted by the state or federal authority it will be reviewed by the committee for a decision.
Organization has Star Rating from CMS > = 2	<ul style="list-style-type: none"> • Star ratings = 1 will not meet criteria. • Ratings = 2 are subject to discussion. • Providers who are too new to have a star rating are subject to discussion.
If accredited, evidence from accreditation agency	<ul style="list-style-type: none"> • If not accredited, state or Medicare survey and/or acceptance letter must be present in file. • If no state or Medicare survey present in the file, provider relations will conduct a site visit. If facility scores < = 45% on site visit the facility will not meet criteria. • Facility scores > 46% but < = 75% will be reviewed by the committee for a decision.
Organization is free of sanctions from any government agency and is not listed on OIG/SAM	<ul style="list-style-type: none"> • Presence of any ongoing sanction activity including any open or pending case, or recent activity < 36 months with no plan for corrective action will not meet criteria.
Organization attests they have never been convicted of a criminal offense related to healthcare	<ul style="list-style-type: none"> • An organization subject to an open or pending criminal offense related to healthcare or has been convicted in the past 5 years of a felony offense will not meet criteria; offenses > 5 years are subject to discussion.
License or certification to do business must be current and in good standing with evidence present in file	<ul style="list-style-type: none"> • A license status = pending, suspended, revoked or denied will be reviewed by the committee for a decision. • Any license subject to disciplinary action within the last 5 years will be reviewed by the committee.
Organization attests they have never been involved in any legal actions excluding medical malpractice	<ul style="list-style-type: none"> • Any pending or recent legal actions (within last 5 years) are subject to discussion. • The committee reserves the right to consider the egregiousness of legal actions and determine if the legal action will impact the organizations ability to deliver quality care to members.
Evidence of medical malpractice/professional liability insurance is present in the file	<ul style="list-style-type: none"> • Any facility unable to produce a certificate of insurance or attest to coverage will not meet criteria. • Any facility that is self-funded will be subject to discussion.

Delegation of Credentialing

U of U Health Plans delegates credentialing activities and has established a procedure for monitoring the credentialing process of approximately 20 entities with whom U of U Health Plans currently has Delegation of Credentialing Agreements. This is done to ensure all practitioners/organizational providers are credentialed/re-credentialed according to our Delegation Agreement with them, and that delegated credentialing services are meeting U of U Health Plans criteria.

Delegation agreement, provisions for PHI, pre-delegation evaluation, review of delegate's credentialing activities

In an effort to avoid duplicating the credentialing process undertaken by another organization and maximize efficiency, U of U Health Plans shall enter into a Delegation of Credentialing Agreement with an organization already performing credentialing of practitioners/organizational providers shared by both entities. The following guidelines are summarized from the Delegation of Credentialing Agreement:

1. Is mutually agreed upon
2. Describes delegated activities and responsibilities of both parties
3. Delegated Entity must pass a pre-assessment review prior to the Delegation of Credentialing Agreement going into effect which could include:
 - Site Visit
 - Telephone consultation
 - Documentation review (policies and procedures and file review)
 - Virtual Review
4. Delegated Entity has written policies and procedures that correspond to NCQA Standards regarding credentialing
5. Delegated Entity performs verification of credentialing elements specified in Delegation of Credentialing Agreement
6. Organization retains the right to approve, suspend and terminate individual practitioners, organizational providers and sites, even if the organization delegates decision making
7. Delegated Entity provides evidence that re-credentialing of practitioners is completed within the three year time frame and follows the guidelines specified in the Delegation of Credentialing Agreement
8. The allowed uses of PHI
9. Description of delegate safeguards to protect the information from inappropriate use or further disclosure
10. A stipulation that the delegate ensures that sub-delegates have similar safeguards
11. A stipulation that the delegate provides individuals with access to their PHI
12. A stipulation that delegate informs the organization of inappropriate uses of the information
13. A stipulation that the delegate ensures that PHI is returned, destroyed or protected if the delegation agreement ends
14. Delegated Entity provides U of U Health Plans with monthly updates including a roster of all participating practitioners/organizational providers (The information to be reported by the delegate about delegated activities and how and to whom information is reported.) On a monthly basis, the entity shall submit sufficient information to U of U Health Plans for the Provider Data Management Coordinator to set up the approved practitioners/organizational

providers in the claims system, add them to its directories and term if no longer with the delegated entity.

15. If it is found that the delegated entity is not meeting its obligations, the organization has the right to terminate the delegation agreement. The delegated entity agrees to assume responsibility for penalties for non-compliance with the Delegation Plan.
16. The delegated entity shall be required to submit to U of U Health Plans the minutes of their credentialing meetings. The minutes shall at minimum include the date of the meeting, who was present, a listing of all applicants approved or re-approved, and those who did not meet criteria. For all practitioners/organizational providers with issues, the minutes shall include a brief summary of the discussion (enough to demonstrate that a meaningful discussion took place of the issues at hand) for each applicant. The minutes of the meeting will be reviewed, approved and dated by the delegated entity's Medical Director.
17. The delegated entity shall be required to report all adverse events to U of U Health Plans.
18. At least once a calendar year, U of U Health Plans shall conduct an audit of the entity's credentialing files and policies to ensure that at minimum they are meeting the current credentialing standards:
 - Annually reviews its delegate's credentialing policies and procedures
 - Annually audits credentialing and re-credentialing files against NCQA Standards for each year that delegation has been in effect
 - The greater of a minimum of eight initial and eight re-credentialing files, or 5% of total files shall be reviewed
 - A Corrective Action Plan (CAP) shall be required from the delegated entity if the audit score is less than 80%
 - Annually evaluated delegate performance against current NCQA Standards for delegated activities
 - Semi-Annually evaluates regular reports as specified in NCQA Standard 8, Element A, Factor 3

Owner:

Todd Sprouse, Director of Provider Network Management

Signature: _____ Date: _____

Liaison:

Charlene Frail-McGeever, MBA CPCS Credentialing Manager

Approval Body:

U of U Health Plans Credentialing Committee and U of U Health Plans Medical Director/Committee Chair

Signature: _____ Date: _____

Organizational Area:

Provider Relations & Contracting

Current Approval Date:

Current Revision Date:

Last Update:

2/10/2016, 8/24/16, 7/21/17, 10/17/17, 2/4/19

Origin Date:

05/06/2008