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COMMUNITY HEALTH PLAN

CREDENTIALING PLAN

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GOALS/OBJECTIVES

The goals and objectives of the Credentialing Program are to:

- Ensure each Community Health Plan provider is qualified by education, training, licensure and experience to deliver quality medical services.
- Maintain only competent and qualified providers through appropriate parameters of credentialing and application of performance standards without discrimination based on race, creed, color, religion, national origin or sex.
- Provide a means to address issues of peer review appropriate to the practitioner's professional conduct, physical and psychological health status and current clinical competence.

INITIAL CREDENTIALING

The scope of provider credentialing applies to all licensed, independent practitioners who wish to provide care to Community Health Plan members and are requesting initial credentialing status with Community Health Plan. Applicants are required to:

- Deliver a fully completed, signed application to the Plan.
- Maintain staff appointment in good standing at a Community Health Plan network hospital, if applicable.
- Provide documentation of successful training completion from an accredited school. All foreign/international documentation must be accompanied by written, English translation.
- Provide documentation of successful completion of postgraduate residency training or specialty board certification, as applicable.
- Possess a valid license and controlled substance registration in the state in which the provider practices.
- Provide information documenting individual professional liability coverage.
- Document that he/she has not been convicted of any criminal offense punishable as a felony, or has engaged in any improper act substantially related to the qualifications, functions or duties of a provider.
- Maintain absence of Medicare/Medicaid sanctions, fines or suspension from either program.
- Attest that all information included on the application is correct and complete.

Applicants must include the following information with their application:

- A complete listing and copies of all professional education degrees.

- A complete listing and copies of all board certifications.
- A complete listing and copies of all current professional licenses and controlled substance registrations.
- A complete chronological listing of the applicant's professional and educational appointments, employment or positions.
- A complete listing of all hospital and other health care entities in with the applicant currently holds privileges.
- A complete listing of all health insurance companies the provider is a participating provider with.
- Information as to whether the applicant, within the last five years, has ever been a participating provider of another insurance company with which the applicant is not affiliated with at the time of application.
- Information as to whether the applicant has ever been suspended or terminated, for any period of time, from participation in Medicare or Medicaid.
- A copy of the individuals current professional liability insurance face page showing the carrier's name, address, policy period, policy number and policy limits.
- The history of malpractice verdicts and the settlement of malpractice claims as well as pending claims.
- Information on the applicant's current physical and mental health status, including chemical dependency or substance abuse.
- Information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime.
- Information on the applicant's citizenship and/or visa status.

REVIEW COMPONENTS

Primary Source Verification

From the provider application, the following items are verified through primary source:

- Licensure in noted profession
- Professional liability insurance
- Hospital affiliation(s), if applicable
- Education at the highest level
- Board Certification, if applicable
- DEA and CDS certificate, if applicable
- Sanction activity

National Practitioner Data Bank (NPDB) and Healthcare Integrity Practitioner Data Bank (HIPDB)

The National Practitioner Data Bank and Healthcare Integrity Practitioner Data Bank are queried to confirm malpractice history and determine sanctions, fines or suspension from Licensure agencies.

Office of Inspector General (OIG)

The OIG database is queried at the time of initial credentialing and monthly to determine any sanctions, fines or suspensions from the Medicare or Medicaid programs.

On-site Office Reviews

An on-site review is conducted to review the quality of the facility where care is provided and to confirm basic operations, facility and record-keeping for all primary care and OB/GYN providers. Results from the structured review of the site and of medical record-keeping practices ensure conformance with Community Health Plan's standards.

Site reviews include the following criteria:

- Physical accessibility;
- Physical appearance;
- Adequacy of waiting room and examining room space;
- Adequacy of medical records filing;
- Content and format of medical record; and
- Availability of appointments.

Results from the structured on-site review and of medical recordkeeping practices are considered in the credentialing recommendation.

RECREREDENTIALING

A provider must continue to meet the eligibility and participation criteria for initial appointment in order to be approved for continued participation. Community Health Plan recredentials practitioners every two years.

REVIEW COMPONENTS

During the recredentialing process the following items are verified through primary source:

- State license
- Board certification, if the practitioner states the he/she is board certified
- Hospital appointments
- History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner, and
- A current, signed attestation by the applicant regarding:

1. Reasons of any inability to perform the essential functions of the position
2. Lack of present illegal drug use
3. History of loss or limitation of privileges or disciplinary activity
4. Current malpractice insurance coverage
5. The correctness and completeness of the application

Member concerns, onsite review scores, medical record review scores, quality of care issues, quality improvement activities and over/under utilization data are considered during the recredentialing recommendation.

National Practitioner Data Bank (NPDB) and Healthcare Integrity Practitioner Data Bank (HIPDB)

The National Practitioner Data Bank and Healthcare Integrity Practitioner Data Bank are queried to confirm malpractice history and determine sanctions, fines or suspension from Licensure agencies.

Office of Inspector General (OIG)

The OIG data base is queried at the time of initial credentialing and monthly to determine any sanctions, fines or suspensions from the Medicare or Medicaid programs.

APPLICANT REVIEW OF INFORMATION

Applicants have the right to review information submitted in support of their credentialing/recredentialing application. Applicants are made aware of this upon signature of a provider application.

ERRONEOUS INFORMATION

Applicants are notified in writing within ten (10) working days of credentialing/recredentialing information obtained through primary source verification, which varies from that provided by the practitioner. Notification is sent certified, return receipt mail. Applicants have ten (10) working days after receipt of notification to correct erroneous information submitted by another party to correct his/her own information submitted incorrectly.

APPROVAL PROCESS

Provider Relations/Quality Review Committee

The Provider Relations/Quality Review Committee determines the ability of providers to provide quality medical care to members. Participants on the Committee take part in the initial and continued quality assessment process applied to applicants.

The purpose of the Provider Relations/Quality Review Committee is:

To provide an effective mechanism for the selection and appointment of physicians, allied health professionals and ancillary providers; to provide network contract strategy direction and address provider relationship issues; to provide overall direction for a comprehensive, planned, and systematic Quality Improvement Program. Various areas of oversight include review of the

medical management programs, utilization management (including pharmaceuticals) and Quality Improvement standards, quality of care, provider network maintenance and contract review process, routine measurement and monitoring of provider performance, provider profiling and the provider satisfaction process as they relate to the provider network.

The Provider Relations/Quality Review Committee is responsible for overseeing certain aspects of the operation of the Quality Improvement Program. This committee has been granted the authority for providing such oversight by the Community Health Plan Board of Directors.

- Coordination, integration, clinical approval and monitoring of Quality Improvement Program clinical activities and provider network activities.
- Initiates requests for monitoring, recommend action, and assures follow-up on identified issues and problems for Community Health Plan.
- Develop and recommend standards to monitor quality of care, accessibility, and availability as it relates to clinical issues and the provider network.
- Assures that a continuous quality improvement process is used to develop, implement, monitor and improve the Quality Improvement Program.
- Review and evaluate the results of Quality Improvement activities, corrective action plans, and ensure follow-up as appropriate.
- Measure, report, make recommendations, and evaluate implementations regarding: Pharmacy Utilization, Inpatient/Outpatient Utilization, Provider Clinical Performance Improvement, Case Management, Referral Management, Mental Health/Chemical Dependency Management, Peer Review, Credentialing/Recredentialing, Provider Network and Contract Review Process.
- Recommend policy and report activities for the Quality Improvement Program to the Community Health Plan Board of Directors.
- Steer the development, implementation, monitoring and evaluation of Clinical Practice Guidelines, Clinical Preventive Health, Chronic, and Behavioral Health Initiatives.
- Assists in the development, implementation, monitoring and review of the Quality Improvement Program, Quality Improvement Evaluation, Quality Improvement Work Plan and Quality Improvement Policy and Procedures.
- Analyzes and evaluates aggregate data and reports of quality improvement activities.
- Participates in the identification and prioritization of the aspects of care designated for routine monitoring and evaluation.
- Monitors activities of contracted entities to whom quality improvement activities are delegated.
- To evaluate utilization statistics objectively and recommend action, if warranted.

- To implement and evaluate utilization review/management projects and offer strategies for quality medical services.

A participating Physician of Community Health Plan chairs the Provider Relations/Quality Review Committee. Committee members include physicians in the specialty of Family Practice, Neurology, Neurosurgery, Nurse Practitioner, OB/GYN, and Behavioral Health Counseling, physician practice staff, hospital administration and Community Health Plan staff. Meetings of the Committee are held the second Thursday of each month.

The Medical Director and Credentialing Manager administratively review all applications for completeness. Recommendations are presented to the Provider Relations/Quality Review Committee. The Provider Relations/Quality Review Committee makes recommendations, modifications or gives further instructions and reports to the Board of Directors summarizing activity and recommendations. The Board acts on recommendations of the Provider Relations/Quality Review Committee. Appointments become effective after final determination by the Board of Directors.

The Credentialing/Recredentialing process is complete in 180 days or less.

CONFIDENTIALITY

To preserve the integrity of the credentialing process all information regarding the credentialing of providers is treated as confidential.

All personnel involved in credentialing activities are informed of their responsibility in maintaining the confidentiality of information reviewed pursuant to the credentialing process and their obligation to prevent unauthorized disclosure of information.

The minutes of the Provider Relations/Quality Review Committee meetings are treated as confidential and are not disclosed to unauthorized personnel, except as required by law.

All provider documents, reports and communication are maintained in a locked file.

The credentialing database is maintained in a secure manner with security codes accessed by authorized personnel.

ORGANIZATIONAL PROVIDERS

The purpose of credentialing organizational providers is to ensure all organizations contracted with Community Health Plan meet State and regulatory requirements as well as Community Health Plan standards.

Community Health Plan credentials the following organizational providers:

- Hospitals
- Home Health, Hospice and Infusion Providers
- Free Standing Dialysis Centers
- Free Standing Rehabilitation Centers

- Laboratories
- Free Standing Ambulatory Surgical Centers
- Free Standing Diagnostic Radiology Centers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting.

REVIEW COMPONENTS

- Community Health Plan confirms that the provider is in good standing with state and federal regulatory bodies and has been reviewed and approved an accrediting body.
- Verification that the provider has current liability insurance.
- If an accrediting body has not approved the provider, an on-site review is conducted to assure conformance with Community Health Plan's standards.

Organizational providers are recredentialed every three years.

FAIR HEARING

An applicant is entitled to a Fair Hearing, if the provider is not approved as a participating provider by the Board of Director or if the Board of Directors takes a final action that is adverse to a provider that will affect the provider's status for greater than thirty (30) days and is based on the competence or professional conduct of the provider.