PARKVIEW HEALTH

# The Center for Enterprise Credentialing and Methods

# Credentialing Policy

## Effective January 9, 2025

## TABLE OF CONTENTS

## SECTION I. SCOPE

A. Credentials Verification Services and Payer Enrollment

The Center for Enterprise Credentialing and Methods (ECM) of Parkview Health provides systemized credentials verification services for Parkview Health entities, and delegated credentialing/payer enrollment for practitioners of Parkview Physicians Group (PPG). Health plans and similar programs may delegate credentialing and quality monitoring activities to ECM.

B. Practitioners and Organizational Providers

1. Individual Practitioners

ECM, on behalf of its delegated arrangements, credentials practitioners listed below, locum tenens and other practitioners eligible to be credentialed as members of the delegating health plan and who meet threshold eligibility criteria of the health plan.

Physician (MD, DO)
Podiatrist (DPM)
Dentist (DDS)
Chiropractor (DC)
Advanced Practice Nurse (NP, CNS, CNM)
Certified Registered Nurse Anesthetist (CRNA)
Physician Assistant (PA-C)
Psychologist (PhD, PsyD, EdD in Clinical Psychology)
Board Certified Behavior Analyst (BCBA)
Licensed Mental Health Counselor (LMHC)
Licensed Marriage and Family Therapist (LMFT)
Licensed Clinical Social Worker (LCSW – Indiana only)
Licensed Independent Social Worker (LISW – Ohio only)
Licensed Social Worker (LSW – both Indiana and Ohio eligible based on state specific licensure requirements)
Licensed Clinical Addiction Counselor (LCAC)
Registered Behavior Technician (RBT)
Registered Dietician (RD)
Speech Pathologist (CCC-SLP)
Audiologist (CCC-A)
Optometrist (OD)
Anesthesia Assistant (AA)
Athletic Trainer (AT)
Occupational Therapist (OT)
Physical Therapist (PT)
Genetic Counselor (PCGC)

2. Organizational Providers

ECM, on behalf of its delegated arrangements, may also credential various organizational providers including, but not limited to, the organizational provider types listed below.

Hospitals
Home health agencies
Skilled nursing facilities

Free-standing surgical centers
Clinical laboratories
Outpatient rehab facilities
Physical therapy centers
Speech language pathology centers
End stage renal disease
Outpatient diabetes
Portable Xray
Rural Health Clinics

Behavioral healthcare facilities providing mental health or substance abuse services in the following settings:

1. Inpatient
2. Residential
3. Ambulatory

For Ohio Organizational Providers (Health Delivery Organizations) scope may include the additional following as applicable. State mandated Form B must be utilized for these provider types.

Community Mental health Center
Crisis Stabilization Program
Free Standing Surgical Centers
Free Standing Voluntary Interruption of Pregnancy Centers
Home Care Agencies
Intensive Outpatient Programs and Clinics
Nursing Homes
Residential Treatment Facilities
Skilled Nursing

3. ECM is not required to credential hospital-based physicians or individual Practitioners who work exclusively in a hospital setting.

## SECTION II. CREDENTIALING COMMITTEE

A. Authority

The Parkview Health Board of Directors delegates full authority to conduct credentialing and recredentialing activities, including verification, review, approval/denial, and modification to scope of the credentialing program to the ECM Credentialing Committee (“Committee”) in accordance with ECM credentialing policies, applicable regulatory standards, the National Committee for Quality Assurance “NCQA”, or Utilization Review Accreditation Commission “URAC”, and other applicable accreditation standards. The Committee will review, evaluate, and approve or deny the applications of all practitioners and organizational providers within those health plans as delegated to ECM.

In this capacity, ECM will utilize an ongoing process to evaluate and verify the qualifications of all initial credentialing and recredentialing applicants, by collecting information and verifying directly from the original source that issued the credentials of the practitioner, or from other accepted sources according to applicable accreditation standards and as outlined in ECM credentialing policies. The Committee will review, evaluate, and approve or deny the credentials of individual practitioners and organizational providers requesting participation in health plans who have delegated to ECM.

B. Composition

The Credentialing Committee is a peer review body comprised of licensed practitioners of various specialties, sufficient to adequately review practitioner and organizational provider applications and make credentialing decisions. The Committee shall engage participating practitioners to provide advice and expertise for credentialing decisions.

1. Committee membership shall include no fewer than five (5) members, including a Medical Director and Chair who is not the Medical Director, including at least one in the specialty type that most frequently provide services to beneficiaries participating in delegated arrangements, and who falls within the scope of the ECM credentialing activities.
2. At least two-thirds of the physician members are in active practice.
3 All physician members, including the Chair and Medical Director, are voting members.
4. The Board of Directors shall approve the Credentialing Committee Chair. The Credentialing Chair shall approve all Committee members.
5. All members of the Committee shall be indemnified by ECM for their good faith participation credentialing activities pursuant to policies and as permitted by law.
6 The Committee will access various specialists for consultation, as needed, in its review of practitioners' and organizational providers' credentials.

C. Conduct of Business/Manner of Action

1. The Committee shall meet at least once every quarter to review applicant files or other business requiring approval, such as Committee policies or credentialing action concerning a practitioner.
2. The presence of a majority of Committee members constitutes a quorum to conduct business of the Committee. Determinations to deny, suspend or terminate an applicant's participation in any delegated arrangement requires a majority vote of the voting members of the Committee.
3. The Committee shall review, approve, deny, or defer applications. Applicant files that have been deemed Clean, according to established criteria, do not require Committee review and may be approved by the Chair or Medical Director.
4. Complete and accurate minutes of all Committee meetings shall be prepared and maintained by ECM staff. Minutes will reflect discussion and major decisions, recommendations and the status of activities in progress. Applicable reports and supporting data will be appended as necessary.
5. The Committee will maintain and restrict access of information to Committee members, to ECM staff, and to those specific individuals designated by the Chair and/or the Medical Director.
6. Meetings and decisions may take place by face-to-face or virtual meetings via audio conference. Decisions may not be made via email.
7. The Committee may use various resources to fulfill its duties and responsibilities, including various ECM staff and other individuals.
8. Other persons may attend on an ad hoc basis for specific discussion and input, but shall not have voting rights.
9. Initial and recredentialing applications determined to not meet requirements as outlined in this policy will be deemed incomplete and will not be processed or acted upon by the Committee.

D. Responsibilities

1. Medical Director
   a. Assist Credentialing Committee in accordance with Job Description and policies.
   b. Review applicant files, and approve those deemed "clean," according to credentialing criteria.

c. Review complaints, evaluates for any further action, and notifies practitioner to request response, as applicable.
d. May serve as Credentialing Committee Chair, as needed.
e. Delegate any or all responsibilities, as needed

Complete scope of Medical Director duties is outlined in Exhibit C.

2. Credentialing Committee Chair
   a. May review applicant files and approve those deemed as "clean," according to credentialing criteria.
   b. Consult with ECM staff regarding credentialing applications or issues when required.
   c. Oversee proceedings of Committee.
   d. Delegate any or all responsibilities, as needed.

3. Credentialing Committee
   a. Review with thoughtful consideration all relevant credentialing information and approve, deny, suspend or terminate applicants based on an assessment of the practitioner or organizational provider's qualifications and ability to deliver quality health care.
   b. Deny applicant who does not meet applicable qualification or requirements.
   c. Provide reconsideration and/or an appeal process for applicants who have been denied access or continued participation.
   d. Provide, approve and maintain written credentialing requirement policies.
   e. Annually review all policies and approve revisions.

E. Confidentiality

It is the intention of ECM that the credentialing process shall be protected under applicable Indiana peer review laws. The Credentialing Committee shall act as a peer review committee. All proceedings of the Committee shall remain confidential, and all communications with the Committee shall be privileged. Individuals engaged in credentialing activities, including various ECM staff and any non-voting members that may attend Committee meetings, shall maintain the confidentiality of information. Information supplied with and on the application shall remain confidential.

F. Conflict of Interest

Credentialing Committee members shall disclose and abstain from voting on a practitioner or organizational provider if the member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner or organizational provider; or (ii) feels his or her judgment might otherwise be compromised. A Committee member will also disclose if he or she has been professionally involved with the practitioner or organizational providers. Determinations to deny an applicant’s participation, or suspend or terminate a practitioner from participation in networks, plans or programs for which ECM assumes delegated credentialing activities requires a majority vote of the voting members of the Committee in attendance. No Committee member may participate in the review and evaluation of any applicant with whom they have been professionally involved or when their judgment may be compromised.

G. Non-Discrimination

The Credentialing Committee conducts all credentialing or recredentialing in a nondiscriminatory manner.

1. The Committee will continuously monitor credentialing and recredentialing activities to remain cognizant of any indication or suggestion of discriminatory comment or manner in

order to proactively identify discrimination, and will annually review processes to ensure there are no gaps or potential opportunity for discrimination.

2. Each Committee member will be required to sign a statement affirming that they do not discriminate: “As a member of the Credentialing Committee, I will conduct my review of applicants in a non-discriminatory manner. In the decision-making process, I will not discriminate against practitioner applicants based on race, ethnic/national identity, gender, age, sexual orientation, patient type (for example, practitioners who serve high-risk populations, Medicaid beneficiaries or who specialize in conditions that require costly treatment in which the practitioner specializes).”

3. The minutes of business will contain the non-discriminatory statement as a reminder to members and will serve as an ongoing monitoring measure.

H. Membership Statement and Acknowledgement

Credentialing Committee Membership Statement will be provided to each Committee member to have an understanding of responsibilities, confidentiality, conflict of interest, fiduciary duty, liability coverage for corporate acts and indemnification for acts within Committee responsibilities. Each member will acknowledge by signature.

## SECTION III. CREDENTIALING AND RECREDENTIALING

A. Application

Each practitioner and organizational provider requesting participation in health plans delegated to ECM must complete a standard application form utilized by ECM. Practitioners must complete the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH), which will include the following data elements:

- Personal Information name, addresses, phone numbers, contact, identification numbers, demographics
- Professional ID’s
- Professional license, DEA, CDS, Medicare, Medicaid, ECFMG, USMLE, as applicable
- Education and Training, including beginning and ending months and years, as applicable Professional School, Internship, Residency, Fellowship, Other
- Specialties Primary, Secondary, Additional Specialties
- Certifications, Clinical Practice
- Practice Locations, Hospital Affiliations, Credentialing Contacts
- Professional Liability Insurance
- Employment Information, Professional References
- Disclosure
  - License, DEA, CDS, Hospital Privileges and Other Affiliations, Education, Training, Board Certification
  - Medicare, Medicaid, other Governmental Program Participation
  - Professional Liability Insurance and Claims History
  - Criminal/Civil History
  - Ability to perform job or any reasons for inability to perform essential functions of the job, with or without accommodation
  - Disclosure of Ownership and Control Interest Statements, if relevant and required

B. Eligibility Criteria

All practitioners or organizational providers, as applicable, requesting participation in networks, plans or programs for which ECM assumes delegated credentialing responsibilities must meet the

following minimum criteria to be considered for participation, unless otherwise established by a particular delegated arrangement:

1. Must hold a current and valid professional license to practice in the state in which the practitioner is applying for participation

2. Must hold current and valid Drug Enforcement Administration (DEA) and Controlled Substance Registration (CSR), as applicable to practice

3. Must have successfully completed residency training or other program applicable to profession

4. Must be board certified or have alternative to board certification, as applicable

5. Must provide evidence of current malpractice coverage with limits as determined by the Credentialing Committee or as required by law

6. Must have current and unrestricted admitting privileges in good standing at a network hospital, or admitting arrangement, as applicable. Some specialties and provider types may function exclusively in the outpatient setting or otherwise not serve in an admitting capacity, and in the Credentialing Committee's discretion may be deemed hospital clinical privileges not relevant to these specialties or applicant.

7. Must have acceptable reports from the National Practitioner Data Bank.

8. Any of the following must be explained by the applicant and found acceptable by the committee.

    a. Any gaps in work history greater than 180 days
    b. State sanctions, restrictions on licensure or disciplinary actions within the past five (5) years
    c. Current or prior Medicare/Medicaid sanctions or excluded provider status
    d. Current or prior criminal history
    e. Current or prior loss or limitation of privileges or disciplinary actions
    f. Current or prior restrictions or disciplinary actions on Federal DEA or state CSR
    g. History of involuntary termination from an HMO, PPO, or other health plan
    h. Current illegal use of any legal or illegal substance
    i. Current or prior hospital membership restrictions
    j. Current participation in a supervised rehabilitation program and/or professional assistance program
    k. Patient complaints in prior year related to conduct or quality

C. Applicant Requirements

1. Applicant is responsible for providing timely and complete information for a proper evaluation of competence, character, ethics and other qualifications, and for resolving any questions about such qualifications.

2. Any applicant that does not meet all requirements as outlined will not be accepted for credentialing and the application will be deemed incomplete by the Medical Director, Credentialing Committee Chair, ECM staff their designees and will not be processed or acted upon by the Committee.

3. Applicants shall maintain compliance with all requirements for qualifications between recredentialing cycles. Recredentialing will occur at least every 36 months, according to

established cycles. The applicant must update information obtained provided during initial credentialing and attest to the correctness and completeness of the new information.

D. Incomplete Application

1. Indiana providers will be notified of a deficiency on a completed unclean credentialing application form submitted by the provider not later that five (5) business days after ECM receives the completed unclean credentialing application form. A notice describing the deficiency must:
   a. Provide a description of the deficiency
   b. State the reason why the application was determined to be unclean

   Applicants must respond to the notification not later than five (5) business days after receipt of the notice.

2. ECM will notify a provider concerning the status of the provider's completed clean credentialing application when the provider is provisionally credentialed. If a credentialing determination is unable to be made within fifteen (15) days after receiving a completed clean credentialing application, the provider will be provisionally credentialed if required by relevant Federal or State laws or regulations and in accordance with NCQA standards.

3. ECM staff will notify Ohio applicants of an incomplete application within 21 calendar days (90 days for organizational providers) of receipt. Notification of deficiency shall occur electronically or by certified mail, return receipt requested.

4. ECM staff will notify applicant of discrepancies obtained during the credentialing process as compared to information provided on the application.

5.. Applicants have both the right and the obligation to correct errors or discrepancies within 14 days of receipt of request by submitting written clarification to ECM staff via reply to original emailed request or by mail to: 11109 Parkview Plaza Drive, Mailbox 117, Fort Wayne, IN 46845. Responses are subject to review and approval by the medical director and/or Credentialing Committee.

6. If required information is not received, the applicant will be informed that the credentialing application fails to meet requirements and the application shall be deemed voluntarily withdrawn.

7. If corrected application contains a material misstatement or omission, or if, upon review after correction, the Credentialing Committee concludes that a misstatement or omission was material and, the Committee may consider the application failing requirements and the application shall be deemed voluntarily withdrawn.

E. Credentialing and Recredentialing Process

1. ECM conducts primary source verification of credentials at initial application and at recredentialing, in accordance with Primary Source Verification Elements, Sources and Timelines as outlined in Exhibit A.

2. ECM will review credentialing and verification data requirements as outlined in Exhibit A, and assess applicant to determine minimum qualifications are met including criteria listed below, to be considered for participation in health plans delegating to ECM.

   a. Completed application and required supplemental information/attachments without material omissions or misrepresentations
   b. Current attestation

c. Primary source verification within acceptable timeline established by the Credentialing Committee.

3. For organizational providers, in coordination with the verifications outlined in Exhibit A, ECM will complete the following reviews:

    a. Confirm the provider is in good standing with state and federal regulatory bodies
    b. Confirm the provider has been reviewed and approved by an accrediting body
    c. Conduct an onsite quality assessment if the provider is not accredited

    If a facility is not accredited, a CMS or state review may be substituted in lieu of a site visit under the following circumstances:

    a. The CMS or state review is no more than 3 years old
    b. A survey report or letter from CMS or the state, from either the provider or the agency, stating that the facility was reviewed and passed inspection

4. Review of credentialing and verification data will include any other qualifications or criteria as required and set for under any individual delegation agreement.

5. Verification information will be documented in the credentialing files using any of the following methods, or a combination:

    a. Credentialing documents signed (or initialed) and dated by the verifier either manually or through system automation.
    b. A checklist that includes for each verification:
        - Source used
        - Date of verification
        - Signature or initials of staff who verified the information (typed initials are only acceptable if there is a unique electronic signature or identifier on the checklist.
        - The report date, if applicable
    c. A checklist with a single signature and a date for all verifications that has a statement confirming the signatory verified all of the credentials on that date and that includes for each verification:
        - Source used
        - The report date, if applicable

6. Unless determined to be a "clean" file, review of applications will be conducted by the Credentialing Committee. The information provided to the Committee shall include the applicant’s profile and documentation related to the issue(s) in question. If the file contains sufficient information that meets established eligibility criteria in the Committee's discretion, the Committee may issue a vote to accept the applicant and document such approval in the meeting minutes. If the Committee denies an applicant for failure to provide sufficient information, such discussions and vote are to be documented in the meeting minutes.

7. The Credentialing Committee may request further information from any persons or organizations, including the applicant, in order to assist with the evaluation process. If the applicant does not provide the requested information by the specified due date, the application or credentialing request will be closed. An application closed due to failure to provide requested information when due will not be considered a denial that triggers appeal rights.

8. ECM will verify and approve or deny an application within a reasonable period of time, but no greater than 180 days from the date of receipt of the completed application. If ECM

requires additional information from the Applicant, ECM shall send a written request to the Applicant. If the Applicant does not respond within the timeframe specified, the application will be deemed incomplete and closed with no further action. Such action does not trigger appeal rights.

9. ECM will notify provider of credentialing status within 60 calendar days of receiving a completed application, and then every 30 calendar days until a decision is made.

10. Applicants are notified of the rejection of their credentialing or recredentialing request within sixty (60) days.

11. The recredentialing process involves reverification and identification of changes in elements as were set forth in initial credentialing and in accordance with the criteria and process described above.

12. Recredentialing will occur at least every 36 months. The practitioner's recredentialing cycle may be extended under the following circumstances:

    - On active military assignment.
    - On medical leave (e.g., maternity leave).
    - On sabbatical.

    Extensions will be documented in the practitioner's file and practitioner must be recredentialing within 60 days of return to practice.

13. If the practitioner is terminated for administrative reasons (e.g., the practitioner failed to provide complete credentialing information) and not for quality reasons, reinstatement may occur within 30 calendar days of termination and does not require initial credentialing. If the termination is for greater than 30 days, initial credentialing must be performed.

14. Applicants have the right to request information about the status of their application and to review certain information submitted in connection with their credentialing or recredentialing application, including information received from any primary source verification of credentials. Professional or personal references, recommendations, or peer protected information will remain confidential in the applicant's file. Credentialing status requests will be addressed via email, phone or in writing by ECM staff within a timeframe not to exceed 30 business days.

15. Applicants have the right to be notified of the credentialing decision within ten (10) calendar days of the Credentialing Committee's decision, and recredentialing denials within ten (10) days of decision date. The provider is considered to be recredentialed unless otherwise notified. Notwithstanding this provision, credentialing timeframes and notification will not exceed timelines required by applicable accreditation standards.

16. Enrollment or participation in any network plan or program for which ECM has assumed delegated credentialing is conditioned upon the applicant's signature on the applicable participation agreement. Indication by the Credentialing Committee that the applicant meets the credentialing criteria does not create a contract between the applicant and ECM.

F. Clean File

1. An initial or recredentialing application may be deemed "clean" if application is complete and verification of background and credentials meets all requirements sufficient to make recommendation for approval without Credentialing Committee review, including the

following criteria. If any criteria have not been fully met, the file must be reviewed by the Committee.

a. Current and valid license to practice
b. No current state sanctions, restrictions on licensure or limitations on scope of practice, and none within the past five years
c. No current investigations or adverse actions and none within the past ten years
c. Current and valid Drug Enforcement Administration (DEA) and Controlled Substance Registration (CSR), as applicable to practice
d. Graduation from medical or applicable professional school
e. Successful completion of residency training or other program applicable to profession
f. Work history in past 5 years, as applicable, with explanation of gaps greater than 180 days
g. No current Medicare/Medicaid sanctions
h. Evidence of current malpractice coverage with limits as required by law
i. For initial applications:
    1) No more than two malpractice cases settled with payment in the past ten (10) years;
    2) No single malpractice case settled with payment greater than $200,000;
j. At recredentialing, since initial or last recredentialing:
    1) No more than two malpractice cases settled with payment;
    2) No single malpractice case settled with payment greater than $200,000;
k. Current admitting privileges in good standing at a network hospital, as applicable
l. Acceptable NPDB report, as applicable according to specific delegated credentialing agreement
m. Reasons for inability to perform the essential functions of the position
n. None of the following:
    1) Present illegal drug use
    2) History of loss of license, restrictions, or disciplinary actions within the past ten years or since last credentialing cycle
    3) History of felony convictions within the past ten years or since last credentialing cycle
    4) History of loss or limitation of privileges or disciplinary actions within the past ten years or since last credentialing cycle
    5) Miscellaneous credentialing red flags, to include but not limited to, employment terminations, training discrepancies or other concerns identified through the verification process.

2. Upon completion of the verification of an application and if ECM staff determine an application is eligible to be deemed a "clean" file, the Credentialing Committee Chair or Medical Director will review and document approval of "clean" files with his or her signature and date. No further review is required. If there are any questions or concerns about an applicant, the applicant will be forwarded for Committee review at the next scheduled meeting.

3. At the discretion of ECM staff, Credentialing Committee Chair or Medical Director, an application that meets all "clean" file criteria may be forwarded for Committee review if there are other questions or concerns.

G. Confidentiality and Security

1. Applicant file will contain a signed consent and release.
2. ECM will ensure confidentiality of all documents and information obtained from the applicant, from verification sources, or Credentialing Committee documentation. All information is maintained in the electronic database.

3. Individual database confidentiality statements are signed by all ECM staff and other end users annually and are on file in ECM for each individual ECM staff member.
4. Electronic database securities are applied by database system administrators at time of new hire or initial access request and maintained until such time access is no longer needed or appropriate. All requests for access are reviewed for appropriate business purpose and to protect from unauthorized disclosure, modification, or destruction.
5. Mid-year security audits will be conducted to confirm continued access needs for all active database users.
6. Credentialing database is password-protected and falls under Parkview Health's single sign-on security process, including assignment of unique ID for each user, required password updates every two hundred eighty (280) days and removal of access at employment resignation or termination.
7. Use of strong passwords that meet Parkview Enterprise password policy parameters is required.
8. Staff are discouraged from sharing, writing down or leaving passwords in a location easily accessible by others. This includes both paper and digital formats.
7. The credentialing process is electronic, and the ECM team is fully remote with no physical office space. Physical access to the operating environment that houses credentialing information is secured and monitored under Parkview Health Information Services security and access policies.
8. Unique user IDs will be utilized in the credentialing verification process and system automated on checklists and verification documents where applicable.

## SECTION IV. CREDENTIALING INFORMATION INTEGRITY

A. Protecting the Integrity of Credentialing Information

ECM is committed to protecting the integrity of credentialing information used in the credentialing process.

1. Protection of the integrity of credentialing information includes, but is not limited to the following elements:
   a. Practitioner application and attestation.
   b. Credentialing documents received from the source or agent.
   c. Documentation of credentialing activities:
      1) Verification dates.
      2) Report dates.
      3) Credentialing decisions.
      4) Credentialing decision dates.
      5) Signature or initials of the verifier or reviewer.
      6) Credentialing Committee minutes.
      7) Documentation of clean file approval, if applicable.
      8) Credentialing checklist, if used.
2. ECM roles are responsible for performing credentialing activities as follows:
   a. Responsible for documenting and modifying credentialing information:
      1) Credentialing Specialist
      2) Project Coordinator
      3) Delegation Coordinator
      4) Department Secretary
      5) Supervisor
      6) Manager
      7) Director
   b. Responsible for oversight of credentialing information integrity functions including the audit:

1) Director
2) Manager
3) Supervisor

3. Process for documenting updates to credentialing information:
   a. Appropriate updates include but are not limited to the following:
      1) Updates due to renewal of expiring documents
      2) Updates during initial and recredentialing processing
      3) Correction of errors
      4) Deletions of duplication errors to records or data within a record
   b. Modifications to credentialing information are documented by Credentialing staff and include date and time modified, what information is being modified and why, and identification of staff making the change.
4. Inappropriate documentation and updates:
   a. The following documentation or updates to credentialing information are considered inappropriate:
      1) Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates).
      2) Creating documents without performing required activities (e.g., photocopying a prior credential and updating information as new credential).
      3) Fraudulently altering existing documents such as credentialing minutes, clean file reports or ongoing monitoring reports.
      4) Attributing verification or review to an individual who did not perform the activity.
      5) Updates to information by unauthorized individuals.
5. Auditing, documenting and reporting information integrity issues:
   a. At least annually, an audit is performed to ensure compliance with credentialing integrity standards.
   b. If inappropriate documentation or updates are identified during an audit, the following actions will occur:
      1) ECM Credentialing Supervisor, Manager or Director will be notified for root cause analysis and appropriate corrective action planning, which may include but not be limited to the following:
         i. Retraining or education of staff.
         ii. Revisions to workflow processes contributing to error.
         iii. Implementation of automation, if applicable.
   c. NCQA will be notified if instances of fraud or misconduct are identified.
   d. Fraud and misconduct occurrences will be addressed as outlined in Parkview Health policy.

B. Information Integrity Training

1. Credentialing staff will be trained annually on the importance of compliance with protecting the integrity of credentialing information. Training will inform credentialing staff of the following:
   a. Inappropriate documentation and updates.
   b. Audits will be completed to ensure compliance of staff documentation and updates in credentialing files.
   c. Process for documenting and reporting identified inappropriate documentation and updates to:
      i. ECM Leadership.
      ii. NCQA, when fraud or misconduct is identified.
   d. Corrective actions for inappropriate documentation and updates.

2. Annual training will be conducted at ECM staff team meetings and documented in meeting minutes.

C. Audit and Analysis
   1. Annually, ECM will perform audits for and conduct qualitative analysis of inappropriate documentation and updates to credentialing information.
      a. Credentialing verifications, decisions and ongoing monitoring will be audited for inappropriate documentations and updates as outlined in this policy.
      b. A random sample audit of 5% or 50 files, whichever is less will be completed. The audit universe includes practitioner files for all initial and all recredentialing decisions made or due during the look-back period.
      c. The random sample includes at least 10 initial and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed within the look-back period, all files will be audited.
      d. An auditing and analysis report will be completed to include at least the following elements:
         1) Date of the report.
         2) Title of staff who conducted the audit.
         3) The audit methodology:
            i. Auditing period.
            ii. File audit universe size.
            iii. Audit file sample size.
            iv. File identifier (individual practitioner).
            v. Type of credentialing information audited (e.g., licensure).
            vi. Findings for each file – rationale for inappropriate documentation and updates.
            vii. The number or percentage and total inappropriate documentation and updates by type of credentialing information.
      e. Auditing report will be completed even if no inappropriate documentations and updates were found.
   2. At the time of audit, qualitative analysis will be conducted for each identified instance of inappropriate documentation and update. Findings will be documented to include the following:
      a. Cause of each finding.
      b. Titles of credentialing staff involved in the analysis.

D. Improvement Actions
   1. Corrective actions for inappropriate documentation and updates will be implemented by Credentialing Supervisor, ECM Manager or ECM Director and may include but not be limited to:
      a. Education and retraining of staff.
      b. Revision of processes creating barriers or challenges in workflows.
      c. Addition of automation to support appropriate documentation and updates.
      d. Leader/staff member review of policies.
   2. Within 3-6 months of the annual audit, subsequent audit will be conducted to ensure the effectiveness of the corrective actions implemented.
      a. The audit universe includes practitioner files for all credentialing decisions made or due to be made 3-6 months after the audit where issue was identified.
   3. If non-compliance with integrity policies and procedures is identified in the follow up audit, a qualitative analysis will be conducted.

## SECTION V. SUSPENSIONS, TERMINATIONS, INVESTIGATIONS AND APPEALS

ECM has established policies and procedures related to ECM's monitoring, investigation and formal appeals process, if applicable, when ECM makes determinations regarding practitioner and organizational provider eligibility and continued participation in networks, plans or programs for which ECM assumes delegated credentialing activities. See ECM policy entitled *Suspensions, Terminations, Investigations and Appeals*.

## SECTION VI. NOTIFICATION TO AUTHORITIES/REPORTING REQUIREMENTS

When ECM takes a professional review action with respect to a practitioner's participation or continued participation in networks, plans or programs for which ECM assumes delegated credentialing activities, ECM may have or assume an obligation to report such to the National Practitioner Data Bank (NPDB). Once ECM receives a verification of the NPDB report, the Verification Report document will be sent to the applicable state licensing board. ECM will comply with all state and federal regulations with regard to the reporting of adverse actions, notification of ownership or control disclosure changes, or recommendations relating to professional conduct and competence. These reports will be made to the appropriate, designated agencies or authorities as required by contract, licensure agreement and/or relevant laws or regulations.

## SECTION VII. ONGOING MONITORING

A. Identifying Complaints, Adverse Events and Quality Issues

1. ECM has established an ongoing monitoring program for the purpose of monitoring complaints, adverse events and quality of care issues. ECM staff perform ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. Unless otherwise indicated, ECM staff will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

    a. State licensing boards
    b. Monthly List of Excluded Individuals and Entities
        1) Completed by Parkview Compliance Department, in accordance with Parkview Federal Program Eligibility Screening and Exclusion Check Policy, to run lists against all OIG, SAM, FDA debarment and state Medicaid exclusion or sanction lists
        2) Compliance Department reports to ECM sanctions or exclusions of practitioners
        3) ECM forwards sanctions to Credentialing Committee for review
        4) Identified sanctions are acted upon within thirty (30) days of notification
    c. Medicare/Medicaid Sanctions and Reinstatement Report
    d. Continuous monitoring of NPDB, as applicable according to specific delegated credentialing agreement
    e. American Medical Association (AMA) Physician Profile
    f. Adverse events, no less than every six (6) months
    g. Quality, performance, and complaint information received on participating providers from beneficiaries, quality departments and health plan/payers upon receipt and at recredentialing.

B. Review and Action

1. The Medical Director or designee shall review any evidence of poor quality that could affect the health and safety of patients, including sanctions or limitations on licensure, member complaints, and information from adverse events.

2. The Medical Director or designee shall refer all instances or potential instances of patient safety or issues of poor quality to the Credentialing Committee for appropriate investigation and action, which may include:
   a. No action
   b. Communication with practitioner
   c. Collegial intervention with practitioner
   d. Other intervention, as appropriate
   e. Recommend further review or investigation

3. Finding reports shall include at least the following:
   a. Practitioner Name
   b. Incident Date
   c. Quality issue
   d. Date reported to Committee or other designated peer review body
   e. Actions

4 Actions will be communicated to health plans as contractually required.

## SECTION VIII. DELEGATED CREDENTIALING

A. Delegation Agreement

ECM may enter into a delegation agreement with a health plan to initially credential and recredential practitioners and organizational providers who are eligible, and as otherwise set forth in the agreement. To ensure sufficient oversight of any delegated arrangement, the written delegation agreement must:

1. Be mutually agreed upon by ECM and the health plan describes the delegated activities and responsibilities of the health plan and ECM
2. Describe the process whereby the Health Plan evaluates the performance of ECM
3. Establish timeframes for ECM reporting to the health plan
4. Specify that the health plan retains the right to approve, suspend, and terminate individual practitioners, providers and sites, even if the Health Plan delegates decision making
5. Describe remedies available to the Health Plan if ECM does not fulfill its obligations, including revocation of the delegation agreement
6. Include provisions for addressing the permitted and appropriate use and sharing of protected health information

B. Authority and Responsibilities

Authority and responsibilities are outlined in detail, and as set forth, in individual delegation agreements.

## SECTION IX. REVIEW AND APPROVAL OF CREDENTIALING POLICIES

All policies must be reviewed and approved by the Credentialing Committee. Annually thereafter, each policy will be reviewed by the Credentialing Committee. With the exception of technical corrections made by ECM staff related to reorganization, renumbering, punctuation, spelling or grammar related changes, all policy amendments require Credentialing Committee review and approval.

**APPROVAL:**

**01/09/2025**

**Credentialing Committee Chair**

**Board of Directors Chair**

**EXHIBIT A – Primary Source Verification Elements and Timeline**

**A. Physicians and other health practitioners**

| Element | Acceptable Source(s) | Initial | Recred |
|---|---|---|---|
| Application Attestation | Attestation date must be within 180 days of credentialing decision | X | X |
| State License | State Licensing Agency – online<br>AMA or AOA Physician Profiles<br>Current and valid state license to practice in all states where practitioner provides care.<br>*Verification time limit*: Current at time of credentialing decision/valid for 120 calendar days. | X | X |
| State CDS/CSR (Controlled Substance) Certificate | State Licensing Agency – online<br>Applies to practitioners who are qualified to write prescriptions and only for those states that require CDS registration<br>*Verification time limit:* Prior to the Credentialing decision | X | X |
| Federal Drug Enforcement Administration (DEA) Certificate | Copy of DEA Certificate<br>DEA online database<br>Applies to practitioners who are qualified to write prescriptions<br>*Verification time limit:* Prior to the Credentialing decision | X | X |
| Education and Training | Highest of the following three levels of education and training obtained by the provider:<br>1. Board Certification – obtained through Certifacts online subscription, AMA or AOA physician profiles<br>2. Residency – obtained through AMA or AOA Physician Profiles or primary source with the training institution<br>3. Graduation from Medical or Professional School – obtained through AMA or AOA Physician Profiles, primary source with the institution, or National Student Clearing House<br>*Verification time limit:* Prior to the Credentialing decision and valid indefinitely | X | N/A |
| Board Certification Status | Certifacts subscription for ABMS, AMA, AOA, or other accepted national certification body for Advanced Practice Professionals.<br>Board certification verified for all providers who indicate they are currently board certified.<br>*Verification time limit:* 120 calendar days | X | X |
| Work History | Employment dates and assessment for gaps obtained through CV or application.<br>Most recent 5 years of work history. If provider has fewer than 5 years of work history, the time frame starts at the initial licensure date.<br><u>Gaps in employment</u>:<br>1. If greater than six months, practitioner may clarify verbally or in writing<br>2. If greater than one year, practitioner must clarify in writing<br>*Verification time limit*: 120 calendar days | X | N/A |
| Current Hospital Affiliation or admitting arrangement | CAQH application<br>Hospital verification letter<br><br>*Verification time limit*: 180 calendar days | X | X |
| Malpractice Coverage | Provider must maintain current malpractice coverage with Certificate of Insurance showing effective date, expiration date, amount of coverage and, where applicable, participation in the Indiana Patient Compensation Fund or copy of a federal tort letter or attestation of federal tort coverage from the practitioner.<br>*Verification time limit*: 180 calendar days | X | X |
| Claims history | Claims history: the most recent five years of malpractice cases opened, closed or settled with be obtained through provider disclosure, Indiana Department of Insurance (IDOI), If practicing in Indiana, and through continuous query services through the National Practitioner Databank (NPDB), as applicable. Any identified discrepancies between provider disclosures and NPDB will require clarification from the provider.<br>*Verification time limit*: 120 calendar days | X | X – any new since last recred |
| Sanction Queries | Possible restrictions on practitioner's license, limitations on practice scope, Medicaid and Medicare Exclusions will be reviewed via one of the following approved sources:<br>1. NPDB through Continuous Query service subscription, as applicable.<br>2. Office of the Inspector General (OIG)<br>3. System for Award Management (SAM)<br>4. Physicians: State Licensing Boards<br>5. Chiropractors: State Board of Chiropractic Examiners<br>6. Oral Surgeons or Dentists: State Board of Dental Examiners or State Medical Board<br>7. Podiatrists: State Board of Podiatric Examiners<br>8. Other non-physician health care professionals: State licensure or certification board<br>Medicare/Medicaid sanctions will be reviewed via one of the following:<br>a. Office of the Inspector General (OIG) List of Excluded Individuals and Entities<br>b. System for Award Management (SAM)<br>c. Medicare Exclusion Database<br>9. IN and OH Medicaid Exclusion Lists<br>10. Medicare Opt-Out | X | X |

| | | | |
|---|---|---|---|
| | *Ongoing sanction monitoring performed monthly by Parkview Compliance Department<br>*Verification time limit*: 120 calendar days | | |

**B. Organizational Providers**

| Element | Acceptable Source(s) | Initial | Recred |
|---|---|---|---|
| State License | State Licensing Agency – online, as applicable to facility type<br>Copy of state licensure from provider<br>Agent of the applicable state or federal agency | X | X |
| State CDS/CSR (Controlled Substance) Certificate | State Licensing Agency – online, as applicable to facility type<br>Copy of state licensure from provider<br>Agent of the applicable state or federal agency | X | X |
| Federal Drug Enforcement Administration (DEA) Certificate | DEA online database<br>Copy of DEA Certificate from provider | X | X |
| CLIA Certificate | Copy of certificate from provide<br>List of CLIA certificates and search on CMS Laboratory Registry | X | X |
| Accreditation | Applicable accrediting body (e.g. JC, AAAHC, CAP) for each provider type<br>Agent of the applicable accrediting body.<br>Copy of credentials (e.g. accreditation report or letter) from the provider | X | X |
| Malpractice Coverage | Provider must maintain current malpractice coverage with Certificate of Insurance showing effective date, expiration date, amount of coverage and, where applicable, participation in the Indiana Patient Compensation Fund or copy of a federal tort letter or attestation of federal tort coverage from the practitioner. | X | X |
| Claims History | Attestation | X | X – any new since last recred |
| Other items | Other items may be collected and confirmed as deemed appropriate based on Organizational Provider type. | X | X |

## EXHIBIT B – CREDENTIALING POLICIES REFERENCING NCQA STANDARDS

**NCQA Standard CR1: Credentialing Policies**

Section I: Scope
- Health Plan Delegation
- Practitioners and Organizational Providers

Section II: Credentialing Committee
- Responsibilities
- Non-Discrimination

Section III: Credentialing and Recredentialing
- Credentialing System Controls and Oversight

Section VII: Delegated Credentialing

Exhibit A: Primary Source Verification and Timeline

**NCQA Standard CR2: Credentialing Committee**

Section II: Credentialing Committee
- Composition
- Conduct of Business/Manner of Action

**NCQA Standard CR3: Credentialing Verification**

Section III: Credentialing and Recredentialing
- Application
- Eligibility Criteria
- Clean File

Exhibit A: Primary Source Verification and Timeline

**NCQA Standard CR4: Recredentialing Cycle Length**

Section III: Credentialing and Recredentialing
- Applicant Requirements
- Credentialing and Recredentialing Process

**NCQA Standard CR5: Ongoing Monitoring**

Section VI: Ongoing Monitoring

**NCQA Standard CR6: Notification to Authorities and Practitioner Appeal Rights**

Policy: Suspensions, Terminations, Investigations and Appeals

Section V: Notification to Authorities/Reporting Requirements

**NCQA Standard CR7: Assessment of Organizational Providers**

Section I: Scope

Exhibit A: Primary Source Verification and Timeline

**NCQA Standard CR8: Delegation of CR**

Section VII: Delegated Agreement

## ECM Credentialing Policy – Exhibit C

## Complete Scope of Medical Director
## The Center for Enterprise Credentialing and Methods

### Responsibility and Accountability:

With respect to delegated credentialing functions of the Center for Enterprise Credentialing and Methods (ECM), the Medical Director is responsible and accountable for:

- provision of medical direction of ECM Committee;
- assessment of then current quality and utilization management;
- development and implementation of credentialing policies;
- working collaboratively with ECM leadership;
- serving as a liaison between and working collaboratively with Parkview and ECM leadership and participating providers and delegating entities;
- exemplifying the core values of Parkview Health;
- being reasonably available to ECM management as requested.

### Qualifications:

- Licensed Physician in the State of Indiana
- Board Certified
- Minimum two years of administrative experience preferred
- Knowledge of standard medical business practice and operations
- Effective written and verbal communication skills.
- Able to mentor and educate ECM participating practitioners

### Authority:

In fulfilling the purpose of his/her job, the Medical Director will employ a wide range of managerial processes and techniques, and in general has the latitude to choose methods that work best in that setting. The Medical Director should have the full authority of a department head to manage and direct the activities assigned to the position and as set forth in applicable ECM governing documents and credentialing policies, provided it is done in agreement with the objectives, policies, and standards of ECM and within recognized ethical, moral, and legal guidelines.

The Medical Director's authority to act in all areas of his/her responsibility is derived from ECM credentialing policies, Parkview administration, and Parkview Board of Directors.

For purposes of Services provided under the terms of this Agreement, Medical Director shall report to, and comply with, the directives of the Chief Executive Officer (CEO) of Parkview, who will provide principal oversight for the performance of the Medical Director's Services.

### Duties:

The Essential Functions of the role of ECM Medical Director are outlined below.

### A. ECM Administration

- Participates in the oversight and leadership, planning, organization, coordination and evaluation of delegated credentialing functions.
- Promotes and participates in a collaborative, interdisciplinary ECM leadership team.
- With ECM management, participates in the development of the credentialing plan, and annual review and revision, as applicable.
- Collaborates with ECM management to ensure ECM policies, accreditation standards, State and Federal regulations, and other applicable accreditation standards and are adhered to.
- Supports then current ECM reporting systems (quality, safety, satisfaction) and reviews provider-level clinical reports specific to ECM delegated credentialing activities. This includes reviewing quality performance of practitioners and reports to the ECM Credentialing Committee, and evaluating compliance with procedures for which ECM or delegated entity participation is requested.
- Advises on issues to ensure compliance of activities with standards established through delegated credentialing agreements and accreditation reviews and quality audits.
- Is available for counseling, advice, information, and general support to the ECM management.

## B. Committee

- Serves on the ECM Credentialing Committee. Ensures appropriate representation on the Committee as provided for ECM policies.

## C. Quality and Utilization Management

- Oversees and collaborates on related Quality and Patient Safety activities.
- Assists, establishes, implements and maintains quality and utilization management programs.
- Supports ECM in compliance with and in preparing for site visits and surveys by appropriate accrediting agencies or delegated entities.
- Demonstrates a high level of skill, expertise and experience in credentialing activities.
- Has and uses a broad and deep knowledge base that is contemporary with the latest credentialing standards.
- Works with Parkview legal services and risk management, in partnership with ECM leadership.
- Assists with evaluating provider eligibility and competence.
- Provides timely audit and follow up correction of credentialing files.
- Advocates due process for complaint resolution and other issues relating to ECM participating providers.

All other duties and responsibilities as mutually agreed upon.