CREDENTIALING PLAN

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Introduction

Deaconess Health Partners (DHP) was formed in 1985. Deaconess Health Partners merged into Deaconess Health Plans, LLC on January 26, 2000. The DHP Board of Managers has ultimate authority on matters of policy. DHP management is charged with the development of procedures that are consistent with the DHP Board of Managers policy, that are sensitive to consumer needs and that maintain strict practitioner confidentiality. The DHP Board of Managers authorizes, endorses and supports the proactive, ongoing credentialing process of selecting and evaluating practitioners and providers who provide care and services to covered members.

Deaconess Hospital and the physician members are committed to continuously improving the quality of patient care and serving the community in an efficient and cost-effective manner. Through Deaconess Health Plans (DHP), the hospital and physician members will deliver care as an integrated health care delivery system. DHP will exercise reasonable care to select and retain practitioners who have demonstrated clinical competence, efficiency, acceptable service levels and are interested in participating in managed care.

Purposes

The purposes of the Credentialing Plan are to ensure that only practitioners who have appropriate education, training and competency are participating health care professionals in Deaconess Health Plan (DHP) and to ensure that the DHP Credentialing Plan and primary source verifications meet or exceed the accreditation requirements of the Centers for Medicare and Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA) and Deaconess Health Plans. The Credentialing Plan will be reviewed annually by DHP's Credentialing Committee (DHP-CC). All revisions to the plan will be with the approval by DHP's Board of Managers. In order to assure high quality providers are in the managed care plan, expert credentialing and recredentialing processes are necessary and will include recredentialing at least every 36 months.

Scope

The scope of this Plan will apply to physicians (MD, DO), podiatrists (DPM), dentists (DDS), chiropractors (DC), doctor of psychology (PsyD), doctor of philosophy (PhD), optometrists (OD), licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), licensed mental health counselor (LMHC), licensed clinical professional counselor (LCPC), mental health professionals, certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM), nurse practitioner (NP), certified nurse specialist (CNS), certified surgical first assistant (CSFA), audiologist, speech language pathologist, occupational therapists (OT), physical therapist (PT), respiratory therapist (RRT), physician assistant (PA), genetic counseling (LSGC), board certified behavior analyst (BCBA), board certified assistant behavior analyst (BCaBA), board certified behavior analyst doctoral certification (BCBA-D) and organizational providers.

Governance

DHP's Board of Managers ("Board") retains ultimate authority, accountability and responsibility for the credentialing and recredentialing of participating practitioners and organizational providers ("Credentialing Program"). The Board has delegated administration of the Credentialing Program to the DHP Credentialing Committee (DHP-CC). DHP-CC accepts the responsibility of administering the Credentialing Program and having oversight of operation activities, which includes making recommendations (i.e. approve, table, deny) on all practitioners, providers and organizational providers regarding participation in the network. Monthly, a report will be presented, for review and approval, to the Board of all recommendations the Credentialing Committee has made. A quorum consists of the majority of voting members of the Board present.

DHP Credentials Chair or Medical Director

The Credentials Chair or Medical Director will consult with and provide oversight to DHP's credentialing staff regarding credentialing applications or issues when required and will oversee the proceedings of DHP-CC meetings and provide a tie-breaking vote when necessary. DHP's Credentials Chair or Medical Director notifies practitioners and organizational providers of denial or termination from DHP. The letter includes the right to appeal the action.

DHP Credentialing Committee (DHP-CC)

The DHP-CC is a peer review committee that accepts responsibility of administering the Credentialing Program and having oversight of operation activities. The DHP-CC is responsible for (i) review and approval of the Credentialing Plan; (ii) making decisions regarding approval or denial of participating practitioners and organizational providers; (iii) providing a reconsideration and/or appeal opportunity for practitioners denied access or continuation in DHP; (iv) recommending actions or discipline for continuation in DHP for practitioners and organizational providers who breach the DHP Credentialing Plan or breach the provisions set forth in the Provider Participation Agreement; and (v) annually reviewing the Credentialing Plan and recommending changes, as needed, to the Board of Managers.

Credentialing and recredentialing decisions are made without regard to the practitioner's race, religion, color, gender, sexual orientation, age, national origin, disability, other protected characteristic or patient type in which the practitioner specializes. Provider profiles given to DHP-CC for credentialing/recredentialing will not include the following provider information: race, creed, color, marital status, or national origin. The Committee gives thoughtful consideration to credentialing information and documents discussed which includes a signed affirmative statement with monthly committee minutes.

Credentialing decisions are monitored to prevent discriminatory practices. Monitoring involves tracking and potentially identifying discrimination in the credentialing and recredentialing process. This includes the review of decisions made regarding approvals and denials. The report of the findings will be reported to the DHP-CC at least twice a year. A monthly report will be presented for review and approval to the Board of all recommendations by the Credentialing Committee. A quorum will consist of the majority of voting members of the Committee present.

DHP-CC Membership

The DHP-CC will include community based practitioners specializing in Primary Care and a range of other specialties. The Board of Managers will approve all Committee members, including the Credentials Chair. Voting members may consist of not more than two (2) physician members from the Board of Managers, not more than five (5) non-Board members and the Medical Director of DHP. Other non-voting members may attend the DHP-CC meetings including the Manager and/or CEO of DHP and the credentialing staff. Committee and staff members shall be indemnified by DHP for their credentialing activities pursuant to the Plan. DHP-CC Meetings are held monthly or as required by the number of applications to be reviewed and approved for new membership or renewal.

Confidentiality

It is the intention of the Plan that the credentialing process be protected under Indiana and federal peer review laws. The DHP-CC shall act as a peer review committee. All proceedings of the DHP-CC shall remain confidential and all communications with the DHP-CC shall be privileged. DHP and all individuals involved in credentialing activities will maintain the confidentiality of all information obtained about participating practitioners in the credentialing and recredentialing process as required by law. DHP maintains the confidentiality of all practitioners and organizational provider files and data and will maintain in a secure locked area. DHP will not disclose confidential participating practitioner information to any person or entity except with the written permission of the participating practitioners or as otherwise permitted by law. The participating practitioner may review information provided to support their application and may not review information not legally available for review.

No DHP-CC 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.

All DHP-CC members and credentialing staff are required to execute a Confidentiality/Conflict of Interest Agreement.

Delegated Activities

DHP does not delegate or sub-delegate any credentialing or recredentialing activities to any other entities.

Periodic Plan Review

The Plan will be reviewed annually and revised as needed by the Board of Managers in order to maintain compliance with state or federal regulatory requirements. The Board of Managers must approve all revisions.

Pre-Application Policy

The purpose of the pre-application policy is to reduce unnecessary application processing by DHP staff and to prevent unnecessary completion of the application by the applicant.

This policy allows DHP staff to screen applicants to determine if the applicant meets the minimum application requirements of DHP prior to initial credentialing. If, the applicant is needed for the panel in order to provide and maintain a sufficient number of qualified participating physicians by specialty to meet the network needs of any of the Tri-State area (southwest Indiana, southeast Illinois and western Kentucky) and to uphold the principle of nondiscrimination. DHP may discontinue processing practitioner applications for membership based on the following criteria:

- Insufficient number of covered lives in a geographic area to justify expanding the physician and/facility network;
- Oversupply of physician and/or facility providers in a geographic area, resulting in the absence of adequate levels of steerage to existing practitioner network.

All practitioners inquiring about application to DHP must submit a Request for Practitioner Application. All applicants must, at a minimum, meet the minimum application criteria to receive an application for practitioner participation. Additional exceptions are limited, must be discussed with the DHP credentialing staff and/or DHP CEO and must be approved by the DHP-CC.

All Requests for Practitioner Application forms shall be reviewed for completeness and approved by the DHP credentialing staff and the provider relations staff before applications will be provided or denied. If the applicant meets the criteria outlined in this Plan, a practitioner application may be provided to the applicant. Denials of applicant inquiries who meet these criteria must have DHP-CC approval. Any requests for application that are denied by the DHP credentialing staff or provider relations staff will be sent a non-acceptance letter with the reason(s) for denial noted in the letter. An applicant who is denied the opportunity to apply through the pre-application screening process will have their application held on file for one (1) year in case the needs of DHP change or the applicant's circumstances change.

Pre-application and application information is considered private and confidential. Information about pre-application status should not be released to anyone other than DHP staff members. Applicants have the right to be informed of the status of their application upon request. Participating practitioner information may be released as appropriate.

Minimum Criteria for Credentialing

The DHP-CC has the authority to waive any qualification for participation based upon determination that a waiver is consistent with good medical practice and the provision of patient care. Waiving of any qualification shall be done on an individual basis and reported to the Board of Managers.

DHP shall credential all physicians and allied health practitioners who request to contract with DHP, meet its credentialing criteria and meet pre-application screening. All on-call physicians not in the DHP network that are used by a DHP contracted physician must be credentialed.

Each applicant has the responsibility of submitting accurate information in a timely manner to allow for proper evaluation of the applicant's competence, character, ethics and other qualifications. The applicant has the responsibility of resolving any discrepancies or doubt about his/her qualifications. Each applicant is required to maintain compliance with all general credentialing criteria as a condition of continued participation. Any initial applicant who does not meet the general credentialing criteria need not apply, as the application will be considered incomplete by the credentialing staff and will not be processed. Any recredentialing applicant who fails to continue to meet the general credentialing criteria will be subject to disciplinary actions up to and including suspension or termination from the network. Recredentialing must occur at least every 36 months.

Initial Credentialing Process

1. Completion of the correct state required Council for Affordable Quality Healthcare (CAQH) application attested within 180 days. A paper application will only be offered when CAQH does not have an available specialty specific application for the provider.
2. Current, active, unrestricted state license and controlled substance registration(s), as applicable, with no history or suspension, restriction or limitation in all states of practice. For the state of Indiana, practitioners must hold a CSR in order to prescribe, administer, and dispense controlled substances per practice location. A separate registration is required for each location where a practitioner physically possesses controlled substances to administer or dispense.
   See **ATTACHMENT E** – Indiana CSR Exempt Form
3. Professional liability insurance coverage for applicants practicing in Indiana must have either current professional liability coverage verified at $500,000/$1,500,000, be qualified as a healthcare provider under the Indiana Medical Malpractice Act and participate in the Patient Compensation Fund by paying the required surcharge, or have current professional liability coverage of $1,000,000/$3,000,000 verified. Applicants practicing in Illinois and Kentucky must have current professional liability coverage of $1,000,000/$3,000,000 verified. For practitioners with Federal Tort Coverage, the application need not contain the current amount of the malpractice insurance coverage. Professional liability coverage is required for each entity location. The must be no history of denial, non-renewal, or cancellation of liability insurance, regardless of the state in which the provider is practicing.
4. Current, active Federal Drug Enforcement Agency certificate (DEA) which includes the appropriate drug schedules for all states in which the practitioner practices, as applicable.
5. The completed application must include the participating practitioner's NPI number.
6. Graduation from medical school (or applicable professional school) and completion of a residency, as applicable.
   a. Physician (MD) and (DO): graduation from medical school and completion of an accredited residency training program
   b. Podiatrist (DPM): graduation from podiatry school and completion of an accredited residency training program
   c. Dentist (DDS) and (DMD): graduation from dental school and completion of a residency, as applicable
   d. Chiropractor (DC): graduation from chiropractic college
   e. Doctor of psychology (PhD) and doctor of philosophy (PsyD): graduation from accredited school. Applicants who are behavioral health professionals must have a PhD degree in behavioral science or a recognized mental health specialty which includes a supervised preceptorship.
   f. Optometrist (OD): graduation from accredited optometry school
   g. Certified nurse midwife (CNM), certified registered nurse anesthetist (CRNA), nurse practitioner (NP), certified nurse specialist (CNS): graduation from an accredited nursing program and must be a registered nurse (RN)
   h. Licensed clinical social worker (LCSW), licensed marriage and family therapist (LFMT), licensed mental health counselor (LMHC), licensed clinical professional counselor (LCPC): graduation from master's level studies in social work, counseling, psychology or related field
   i. Physician Assistant (PA): graduation from a physician assistant program accredited by Accreditation Review Commission on Education for the Physician Assistant (ARC-PA)

j. Audiologist: preparation as an audiologist in either a master's degree program or satisfactory completion of postgraduate program
k. Speech language pathologist: preparation as a speech language pathologist in either a master's degree program or satisfactory completion of postgraduate program
l. Occupational therapist (OT): bachelor's degree or certificate in occupational therapy
m. Physical therapist (PT): bachelor's degree or certificate in physical therapy
n. Genetic counselor: master's degree in genetic counseling from an accredited educational institution. Completion of a postgraduate training program in genetic counseling accredited by the American College of Genetic Counseling (ACGC)
o. Respiratory therapist (RRT): graduation from an accredited respiratory therapy program
p. Certified surgical first assistant (CSFA): graduation from an accredited surgical assistant program
q. Board Certified Behavior Analyst (BCBA): graduation from an accredited behavioral analyst program
r. Board Certified Assistant Behavior Analyst (BCaBA): graduation from an accredited assistant behavioral analyst program
s. Board Certified Behavior Analyst Doctoral Certification (BCBA-D): graduation from an accredited behavioral analyst program

7. Education Commission for Foreign Medical Graduates (ECFMG), as applicable.
8. All physicians that apply for participation in the DHP network after January 1, 2013 must successfully complete an accredited residency program appropriate for the applicant's specialty of practice. Exceptions can be made for family medicine practitioners who completed medical school prior to 1978, who also completed a one (1) year internship.
9. Board Certification (must maintain board certification, unless exception applies)
    a. MDs, DOs, DDSs, and DMDs: Applicants should be currently certified by the board of their specialty, which is a recognized member of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada, the American Board of General Dentistry, or the American Dental Board of Anesthesiology
    b. DPMs: podiatric board certifications will be verified through the American Board of Foot and Ankle Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine
    c. CRNA: must have current certification by the American Association of Nurse Anesthetists (AANA) or the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA)
    d. NP: must have current certification through the American Academy of Nurse Practitioners (AANP), American Nurses' Credentialing Center (ANCC), American Association of Colleges of Nursing (AACN), Pediatric Nursing Certification Board (PNCB), or National Certification Corporation (NCC)
    e. CNM: must have current certification by the American College of Nurse Midwives
    f. PA: must have current certification by the National Commission on Certification of Physician Assistants (NCCPA)
    g. CSFA: must have current certification by the National Board of Surgical Technology and Surgical Assisting (NBSTSA)
    h. BCBA: must have current certification by the Behavior Analyst Certification Board (BACB)

i. BCaBA: must have current certification by the Behavior Analyst Certification Board (BACB)
j. BCBA-D: must have current certification by the Behavior Analyst Certification Board (BACB)
k. Board Certification is not applicable for the following providers: DC, PhD, PsyD, OD, LCSW, LFMT, LMHC, LCPC, mental health professional, audiologist, speech language pathologist, OT, PT, RRT, genetic counselor and organizational providers.

Exceptions may be granted if not board certified; applicants must be able to provide documentation of meeting at least one of the following exceptions:

- ✓ MD/DO has recently completed degree requirements and is in the process of seeking board certification within five (5) years of residency.
- ✓ MD/DO/DDS/DMD has been in the medical practice for 10 years without a malpractice payment or settlement of $30,000 or more and completes 50 hours of CME approved by the Accreditation Council for Continuing Medical Education, the American Medical Association, or the American Osteopathic Association per each credentialing cycle. A minimum of 10 CME hours must be in the physician's specialty of practice.
- ✓ MD/DO has satisfactorily completed a residency program in the appropriate specialty of practice and has acquired a minimum of 25 Category 1 CME in the previous 12 months or 50 Category 1 CME in the previous 24 months or 75 Category 1 CME in the previous 36 months in his/her primary specialty.
  See **ATTACHMENT F –** CME Attestation Form
- ✓ Practice is located in a rural area where lack of a participating MD/DO would create a public health hardship
  NOTE: for non-board certified urgent care MD/DO, the CMEs shall be in the urgent care or emergency medicine

10. Work history for a least the most recent ten (10) years provided on the application with month and year. Work history with no unexplained lapses from the time of completion of training to present. Must satisfactorily explain any gaps or more than six (6) months.
11. Malpractice claims history with no pattern of suits over a five (5) year period of time, no more than two payments or settlements of $30,000 or more per suit in one (1) calendar year, no activity within the last ten (10) years resulting in permanent disability or death in which payment of over $30,000 was made, and no pending cases or frequency of cases which, in the view of DHP-CC, could result in failure to meet these malpractice history criteria.
12. Verified current/active admitting or courtesy privileges in the specialty of practice at a DHP participating facility. Applicants who do not have active/admitting or courtesy privileges must have a referring statement in place with another DHP practitioner who has active/admitting or courtesy privileges at a DHP participating facility or a referring statement with an in-network hospitalist program. All Advance Practice Providers (APPs) and Allied Staff will require admitting arrangements unless hospital based privileges are required. Admitting arrangements are not acceptable for Hospitalist, Emergency Medicine, Pathology, Diagnostic Radiology, Surgery, Neuro-hospitalist, Neonatology, Anesthesiology, CRNA, and any hospital based provider.
    See **ATTACHMENT D** – Admitting Arrangements Form
13. Satisfactory National Practitioner Data Bank (NPDB) reports.

14. No current Medicare/Medicaid sanctions or exclusions. DHP will not contract with any practitioner for any Medicare Advantage Plan who has not signed a Medicare Amendment and/or who has chosen to opt out of Medicare.
15. A statement regarding no current illegal drug use, as attested on CAQH.
16. A statement regarding history of loss or limitation of professional license and/or felony convictions. No criminal conviction either felony or misdemeanor (excluding minor traffic violations), including a plea or verdict of guilty or a conviction following a plea of nolo-contendere, as attested on CAQH.
17. A statement regarding history of loss or limitation of privileges or disciplinary activity, suspension, restriction or termination by any managed care plan or hospital where the practitioner has held privileges, as attested on CAQH.
18. A statement regarding inability to perform the essential functions of a practitioner in his or her area of practice even with reasonable accommodation, as attested on CAQH.
19. A signed Standard Authorization, Attestation and Release (SAAR) of the correctness and completeness of the application with in twelve (12) months.
20. A Deaconess Health System signed consent and release form dated within 180 days.
21. Providers must provide 24-hour coverage for all members with another DHP participating physician/advanced practice providers (within same scope of practice). Providers not meeting call coverage requirements may submit in writing their circumstance/reason for submission to the Credentials Committee for review and consideration. Call coverage is not required for Hospitalist, Emergency Medicine, Pathology, Diagnostic Radiology, Tele-Radiology, Tele-Medicine, Neuro-hospitalist, Neonatology, Anesthesiology, and any hospital based provider. Call coverage is not required for the following Allied Health providers: CRNA, OT, PT, CCC-SLP, CCC-Aud, CSFA, LSGC, and OD.
22. Disclosure and information concerning any past denial, non-renewal or cancellation or malpractice insurance, as attested on CAQH.
23. Practitioners will have the right to review the information submitted in support of their credentialing applications (except for references, recommendations or other information that is peer review protected), correct erroneous information and receive the status of their application upon request. Notification of this right will be documented in the cover letter that accompanies the application packet. If an applicant has erred in his/her application, they will be required to resubmit information in writing within 30 calendar days to DHP's credentialing staff; failure to do so will result in the voluntary withdrawal of their application. Upon receiving the corrected documentation, DHP's credentialing staff will date and initial the corrected documents. The credentialing staff will respond to their request verbally or in writing.
24. All information will be handled in a confidential manner and in compliance with Indiana code 34-30-15. All credentialing information shall be maintained in the CACTUS credentialing database under the custody of Deaconess Health Plans' Provider/Network Systems Specialist. Access to the CACTUS database is strictly controlled and permission for access may only be granted by the System Administrator. Associates who are granted access are entered into a security group. The security group delineates access by entity and field level security and authorizes read, write or read and write privileges. Each user will have a log on ID and password to access the file server where CACTUS resides. Passwords will be changed every 90 days. Each user will have a log on ID and password to access the CACTUS database. File cabinets where paper credentialing files may be maintained shall be kept locked except during regular business hours when credentialing staff are present.

25. DHP may, from time to time, decide to discontinue processing practitioner applications for membership based upon the following:
    a. Insufficient number of covered lives in a geographic area to justify expanding the provider and/or facility network, or
    b. Oversupply of providers and/or facility providers in a geographic area resulting in the absence of adequate levels of steerage to existing practitioner network.

    The applicant may request reconsideration or appeal if received within 30 days of notification. If no request for consideration or appeal is received within 30 days of notification, the file is closed.
26. DHP will notify the practitioner within 60 calendar days of the final credentialing decision. The letter will be placed in the credentials file.
27. Applicants who have been denied credentialing by DHP or have had their application deemed voluntarily withdrawn because of a material omission or misstatement must wait three (3) years before submitting a new applications.
28. Verifications and provider signed documents are valid for 180 days (exception SAAR). Once the provider signs the release, DHP must present provider's completed file to DHP-CC within 180 days.

Uniform Credentialing Legislation

Indiana Uniform Credentialing Legislation (Effective 07/05)

Insurers and health maintenance organizations that perform practitioner credentialing activities in Indiana will utilize the application issued by the Council for Affordable Quality Healthcare (CAQH) in electronic format for credentialing and recredentialing.

Providers may obtain a Provider ID (PID) by contacting a DHP credentialing staff.

The CAQH application may be accessed at https://proview.caqh.org

Indiana practitioners will be required to provide any other information required by DHP that is not present on the CAQH application.

The Indiana practitioner will be responsible for keeping the CAQH application updated with current information and documents.

The Indiana credentialing/recredentialing form pertains to practitioners who have their primary practice site in Indiana.

Indiana State Requirement 27-8-11-7 "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" per health plan.

Illinois Uniform Credentialing Legislation (Effective 01/02)

All credentialing and recredentialing of Illinois MDs, DOs and DCs will be required to download or print off of the Illinois Department of Public Health website the credentialing form required by the State of Illinois. The form can be accessed at http://www.idph.state.il.us/about/credentialing.htm. By downloading the form in Microsoft Word, the practitioner may complete the form and store it electronically.

Providers are required by new legislation to update DHP, with which they are credentialed, on any changes in the information on the form. There is an update form provided on the website, http://www.idph.state.il.us/about/credentialing.htm.

If the provider does not have internet access, they may contact DHP for a copy to be mailed to them.

The Illinois providers will be required to provide any other information required by DHP that is not present on the Illinois Credentialing/Recredentialing form.

Illinois providers may be recredentialed between 24 – 36 months.

Credentialing will be completed within 60 days from receipt and verification of information.

The Illinois credentialing/recredentialing form pertains to providers who have their primary practice site in Illinois.

Kentucky Uniform Credentialing Legislation (Effective 12/05)

All health insurers offering managed care plans in Kentucky are required to use the Council for Affordable Quality Healthcare's (CAQH) practitioner application Form KAPER-1, Part A for the credentialing and recredentialing of participating health care practitioners.

The Form KAPER-1 may be accessed on the Office's Web site: http://insurance.ky.gov/Documents/kaper1a_1to35_0409.pdf or obtained directly from Kentucky's Office of Insurance, Division of Health Insurance Policy and Managed Care.

The Kentucky practitioner may submit a handwritten or electronically generated application with required attachments/documents.

The Kentucky practitioners will be required to provide any other information required by DHP that is not present on the KAPER-1.

The Kentucky practitioner will be responsible to keep the Form KAPER-1 updated with current information and documents.

The Kentucky credentialing/recredentialing form pertains to practitioners who have their primary practice site in Kentucky.

Kentucky State Requirement 806 KAR 17:480 “Notify provider of an incomplete KAPER application within 30 calendar days” and “ 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” per health plan.

Kentucky State Requirement 307.17A-576 “Process/approval time of complete-90 days –HMO and PPO” per health plan.

Primary Source Verification

Verification of primary source credentialing information can be either written or oral, unless otherwise noted. Oral verification requires a dated, signed note in the credentials file stating who verified the item and how it was verified. Written verification may take the form of documented review of cumulative reports released by primary source of credentials data. Internet sites may be used as a primary source if the site is in the control of an approved NCQA source.

All credentialing information will be dated upon receipt. Verification of primary source credentialing information will be completed within 180 days prior to the credentialing decision with the exception of work history and attestation. Primary source verification dates and staff initials are documented. Handwritten documentation shall be done in ink, as pencil is not an acceptable writing instrument. Electronic signature is an acceptable method for providers to sign and date documents.

Documentation for verification of credentialing information will be included in the participating practitioner's credentials file and will include, at a minimum, the following:

1. **State Professional License:** Verification will be obtained directly from the applicable state licensing board/agency via internet, phone or in writing. If the practitioner holds licensure in more than one state, verification will be made for the current medical licensure. DHP credentialing staff will obtain information regarding five (5) year history of any adverse actions, previous and/or current state sanctions, restrictions or limitations on licensure or any disciplinary actions taken against the practitioner's licensure and/or limitation on scope of practice for all states in which the practitioner has worked during the time period.
2. **DEA and Controlled Substance Registration (CSR), as applicable:** Verification will be obtained through a copy of the practitioner's DEA certificate for each state where the practitioner is currently practicing. Verification may also be obtained directly from the DEA number or the National Technical Information Service (NTIS). For practitioners who do not prescribe medications that require a DEA certification an explanation as to why they do not prescribe must be obtained. The explanation must include arrangements for the practitioner's patients who need prescriptions for medications that require a DEA. DEA is not applicable for chiropractors and various other practitioners (i.e. diagnostic radiologists, pathologists, and allied health practitioners). All DEAs shall have current address for prescribing purposes.
3. **Graduation from Medical or other Applicable Professional School and/or Completion of a Residency:** Verification will be completed via internet, phone or in writing. Residency programs for MD and DO must be accredited by one of the following: Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA). Verbal or written explanation is required for any gaps in education and training greater than six (6) months. Gaps greater than (1) year must be explained in writing.
    a. **Physician:** Verification of graduation from medical school and completion of residency will be obtained for each specialty and sub-specialty in which a physician or practitioner requests to be listed. Verification is obtained in one of the following ways:
        1. If the physician is board certified, medical school graduation and completion of a residency will be verified from one (1) of the following:

a. ABMS, its member boards or through an official ABMS display agent where verification has been approved;
b. Entry in the AOA Official Osteopathic Physician Profile Report or AOA Physician Masterfile;
c. Confirmation from the appropriate specialty board;
d. Entry in the American Medical Association (AMA) Physician Masterfile;
e. Royal College of the Physicians and Surgeons of Canada;
f. Confirmation from the state licensing agency/board, if the agency/board conducts verification of board status.

2. If the physician is not board certified, completion of a residency will be verified from one (1) of the following:
   a. Confirmation from the residency training program;
   b. Entry in the AMA Physician Masterfile, AOA Official Osteopathic Physician Profile Report or AOA Physician Masterfile
   c. Federation Credentials Verifications Service (FCVS) for closed residency programs;
   d. Confirmation from the state licensing agency/board, if the agency/board conducts primary source verification of residency training.

   NOTE: Verification of fellowship does not meet this education verification requirement.
3. If the physician has not completed a residency program, graduation from medical school will be verified from one (1) of the following:
   a. Confirmation from the medical school;
   b. Entry in the AMA Physician Masterfile, AOA Official Osteopathic Physician Profile Report or AOA Physician Masterfile;
   c. Confirmation from the state licensing agency/board, if the agency/board conducts primary source verification of graduation from medical school;
   d. Confirmation from the Education Commission for Foreign Medical Graduates (ECFMG) for international medical graduates after 1986.
4. Annual confirmation is requested in writing from any non-ABMS or non-AOA board that they conduct primary source verification of education and training.

b. **Podiatrist:** Graduation from podiatry school and completion of a residency program, if applicable, will be verified from one (1) of the following:
1. If the podiatrist is board certified, podiatry school and residency will be verified from one (1) of the following:
   a. Confirmation by the American Board of Foot and Ankle Surgery (ABFAS), formerly the American Board of Podiatric Surgery;
   b. Entry in a Podiatry specialty board Masterfile, if the certifying board conducts primary source verification of podiatry school graduation;
   c. Confirmation from the state licensing agency/board, if the agency/board conducts primary source verification of board status.
2. If the podiatrist is not board certified, completion of residency training will be verified from one (1) of the following:
   a. Confirmation by the residency training program;

b. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of residency training.

3. If the podiatrist has not completed a residency, graduation from podiatry school will be verified from one (1) of the following:
   a. Confirmation by the podiatry medical school;
   b. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of podiatry school.

c. **Medical Geneticist/Genetic Counselor:** Possess a doctoral degree in medical genetics or a Master's degree in genetic counseling from an accredited educational institution. Certification in Medical Genetics by the ABMGG or certification in Genetic Counseling by the ACGC within two (2) years of completion of Doctorate or Master's degree.
   1. Completion of at least two (2) years in a post graduate medical genetics training program accredited by the American Board of Medical Genetics and Genomics (ABMGG) or completion of a post graduate training program in genetic counseling accredited by the American College of Genetic Counseling (ACGC).
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of school recognized for licensure.
   3. Must be supervised by or have a transfer agreement with a DHP participating physician with admitting privileges at a DHP participating facility.

d. **Dentist:** Graduation from dental school and completion of residency, if applicable. The highest level of education will be verified from one (1) of the following:
   1. Completion of residency training will be verified by confirmation by the residency training program;
   2. Confirmation from the dental school;
   3. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of dental school.

e. **Optometrist:** Graduation from an accredited optometry school will be verified from one (1) of the following:
   1. Confirmed by the optometry school;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of optometry school.

f. **Chiropractor:** Graduation from an accredited chiropractic school will be verified from one (1) of the following:
   1. Confirmed by the chiropractic school;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of chiropractic school.

g. **Behavioral Healthcare Practitioner:** Graduation from an accredited school will be verified from one (1) of the following:
   1. Confirmed by the school related to the discipline;
   2. Confirmation by the state licensing agency/board, if the agency conducts primary source verification of school recognized for licensure;
   3. Master's degree in counseling, social work, psychology, or related field;
   4. Doctoral degree for PhD or PsyD in clinical or counseling psychology.

h. **Nurse Midwife Practitioner:** Graduation from a school of nurse midwifery accredited by the American College of Nurse Midwives will be verified from one (1) of the following:
   1. Confirmed by the school related to the discipline;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

i. **Advanced Nurse Practitioner:** Graduation from an accredited school of nursing. Graduation from an accredited Nurse Practitioner program. Must have a Master's degree or post Master's degree in nursing. Education will be verified from one (1) of the following:
   1. Confirmed by the school related to the discipline;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

j. **Clinical Nurse Specialist:** Graduation from an accredited school of nursing. Graduation from an accredited Clinical Nurse Specialist program. Must have a Master's degree or post Master's degree in nursing. Education will be verified from one (1) of the following:
   1. Confirmed by the school related to the discipline;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

k. **Certified Nurse Anesthetist:** Graduation from a school of anesthesia accredited by the American Association of Nurse Anesthetists. Education will be verified from one (1) of the following:
   1. Confirmed by the school related to the discipline;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

l. **Physician Assistant:** Graduation from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). Education will be verified from one (1) of the following:
   1. Confirmed by the physician assistant school;
   2. Entry in the AMA Masterfile;
   3. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

m. **Audiologist:** Must have a Master's degree or satisfactory completion of postgraduate program for audiologist. Education will be verified from one (1) of the following:
   1. Confirmed by the school related to the discipline;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

n. **Speech Language Pathologists:** Must have a Master's degree or satisfactory completion of postgraduate program for speech language pathologist. Education will be verified from one (1) of the following:
   1. Confirmed by the school related to the discipline;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

o. **Occupational Therapist:** Bachelor's or Associate's degree or certificate in occupational therapy. Education will be verified from one (1) of the following:
   1. Confirmed by the school related to the discipline;

2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

p. **Physical Therapist:** Bachelor's degree or certificate in physical therapy. Education will be verified from one (1) of the following:
   1. Confirmed by the school related to the discipline;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

q. **Respiratory Therapist:** Graduation from an accredited respiratory therapy program. Education will be verified from one (1) of the following:
   1. Confirmed by the school related to the discipline;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

r. **Certified Surgical First Assistant:** Graduation from an accredited surgical assistant program. Education will be verified from (1) of the following:
   1. Confirmed by the school related to the discipline;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

s. **Board Certified Behavior Analyst:** Graduation from an accredited behavioral analyst program. Education will be verified from (1) of the following:
   1. Confirmed by the school related to the discipline;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

t. **Board Certified Assistant Behavior Analyst**: Graduation from an accredited assistant behavioral analyst program. Education will be verified from (1) of the following:
   1. Confirmed by the school related to the discipline;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

u. **Board Certified Behavior Analyst Doctoral Certification**: Graduation from an accredited behavioral analyst program. Education will be verified from (1) of the following:
   1. Confirmed by the school related to the discipline;
   2. Confirmation by the state licensing agency/board, if the agency/board conducts primary source verification of this credential.

4. **Board Certification:** If the participating practitioner states on the application that he or she is board certified, then verification of board certification will be obtained through one (1) of the following sources:
   1. ABMS, its member boards or through an official ABMS display agent where a dated certificate of primary source authenticity has been provided;
   2. Entry in the American Osteopathic Association (AOA), Official Osteopathic Physician Profile Report or AOA Physician Masterfile;
   3. Confirmation from the appropriate specialty board;
   4. Entry in the American Medical Association (AMA) Masterfile;
   5. American Board of Foot and Ankle Surgery;
   6. American Board of General Dentistry;
   7. American Dental Board of Anesthesiology;

8. American Association of Nurse Anesthetists (AANA):
9. American Nurses' Credentialing Center (ANCC);
10. American Association of Nurse Practitioners (AANP);
11. American College of Nurse Midwives;
12. National Commission on Certification of Physician Assistants (NCCPA);
13. American College of Genetic Counseling (ACGC);
14. National Board of Surgical Technology and Surgical Assisting (NBSTSA);
15. Other recognized specialty boards (Board must verify education);
16. Confirmation from the state licensing agency/board, if the agency/board conducts verification of board status. If the expiration date for a practitioner's board certification is not provided, DHP credentialing staff must verify the board certification is current.
17. Board certification does not apply to chiropractors.

5. **Work History:** A minimum of the most recent ten (10) years of work history must be included on the application. The dates of employment must include the months and years unless the most recent employment is over ten (10) years. Gaps greater than six (6) months will be reviewed and clarified either verbally or in writing. Verbal communication will be documented in the credentials file. Gaps greater than one (1) year must be clarified in writing.
6. **Professional Liability Claims History:** Verification of malpractice claims history will be obtained through written confirmation of the last ten (10) years, at a minimum, of history of settlements or judgements from the National Practitioner Data Bank (NPDB).
7. **Hospital Privileges:** Verification of current active/admitting or courtesy privileges in the specialty of the practice at a DHP participating facility listed in the most recently published DHP practitioner directory and subsequent directory updates. Medical staff appointments at a DHP participating facility are verified in all states for no history of denial, revocation or termination of privileges. Verification conducted directly with the primary source.
8. **National Practitioner Data Bank (NPDB):** Prior to making a credentialing decision, DHP credentialing staff will request a report regarding malpractice claims history, disciplinary actions or sanctions or limitation on licensure and will include this information in the practitioner's credentials file. DHP will query the NPDB to obtain information regarding any disciplinary actions taken by hospitals and/or managed care organizations that limited, suspended, or revoked the privileges and any malpractice settlements or judgements filed against the practitioner.
9. **Medicare and Medicaid Sanctions:** DHP will verify the practitioner's Medicare and Medicaid status and review for previous sanction activity by Medicare and Medicaid through query of OIG or National Practitioner Data Bank.
10. **Medicare Opt Out List:** The Medicare Opt Out list will be queried to ensure practitioner is participating with the Medicare program. The Medicare Opt Out website is for all states:
    https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z
11. **Kentucky Medicaid Program Terminated and Excluded Provider List:** The Kentucky Medicaid Program Terminated and Excluded Provider list will be queried to ensure practitioner has not been terminated and excluded from Kentucky Medicaid.
12. **System for Award Management (SAM):** The SAM will be queried to ensure practitioner is not listed in the Sam which includes the Excluded Parties List System (EPLS).
13. **Office Site Visit and Medical Record Keeping Practices:** DHP credentialing staff conducts a site visit for all practitioners upon receipt of a member complaint.

See **ATTACHMENT C -** DHP Practice Site Evaluation Guidelines

14. **CME Requirement:** When CME is required, the provider must sign and date a CME Attestation form confirming the required amount of CME is completed.
See **ATTACHMENT F -** CME Attestation Form

Recredentialing Process

For purposes of this Credentialing Plan, recredentialing will mean the formal process through which DHP updates, re-verifies and reviews all participating practitioners' credentialing information and qualifications and assesses performance over the previous three (3) years through multiple sources in order to determine whether to approve the participating practitioner's continued participation in DHP. DHP will identify and evaluate any changes in the participating practitioner's performance, licensure, clinical privileges, training, experience, current competence, quality improvement, utilization management, member satisfaction, complaints, grievances, other sanctions or health status that may affect the participating practitioner's ability to perform the services he or she is providing to DHP.

Every practitioner that participates in DHP must be recredentialed at least every 36 months. Failure to complete the recredentialing process by the end of the 36th month will result in termination from the network. The only exceptions are practitioners on military assignment, maternity leave or sabbatical. If the practitioner wants to continue their participation in DHP after the 36th month, the practitioner must reapply as an initial applicant.

Recredentialing Primary Source Verification

Upon receipt of a completed recredentialing application, DHP will collect and re-verify the participating practitioner's credentials and qualifications through primary sources of verification within 180 days in the same manner as was required for the initial credentialing process (other than previously verified education and training) and will document the information in the practitioner's credentials file.

Credentialing Status Definitions

1. **Routine Status:** Practitioner meets all membership criteria established by the DHP Board of Managers.
2. **Review Status:** Practitioner does not meet all of the membership criteria established by the DHP Board of Managers, but a waiver of the unmet criteria has been granted. Review Status does not affect participation in the network but necessitates review of credentials every 12 months or at intervals to be determined by the DHP-CC, but not to exceed two (2) years. Failure of provider to return requested release to DHP will result in voluntary termination.
3. **Deferred Status:** Applicant/practitioner does not meet all membership criteria due to incomplete information. The applicant/practitioner is considered when the required information is obtained. If the required information is not received within 30 days, the applicant/practitioner file will be moved to the inactive file. Inactive files are maintained a minimum of one (1) year.
4. **Denied or Terminated Status:** Applicant/practitioner fails to meet all membership criteria established by the DHP Board of Managers and a waiver of the unmet criteria was not granted. Denied or terminated status notification includes information on the appeal process.
5. **Automatic Suspension:** Applicant/practitioner's status has been automatically suspended. This suspension shall be deemed an interim precautionary step while professional review activities related to the ultimate professional review action are taking place. Automatic Suspension is not a final action in and of itself. A practitioner who has been placed on automatic suspension shall assign the responsibility of care for his/her patients to another network practitioner with appropriate clinical privileges. The DHP-CC shall review any automatic suspension at its next scheduled meeting. If at the meeting, the DHP-CC does not terminate the automatic suspension, the automatic suspension will continue. The suspended practitioner is entitled to the procedural rights of the Appeals/Due Process and Fair Hearing Process as set forth in this Plan.

The applicant/practitioner granted a Routine or Review status will receive notification of the DHP-CC status decisions within 60 days. The applicant/practitioner granted a Deferred, Denied or Terminated or Automatic Suspension status will receive notification of the DHP-CC status decision within 30 days. The notification will include specific reason(s) for the status decision.

Denials of Initial and Recredentialing Applications

Initial and recredentialing applicants denied for failure to meet the minimum criteria for credentialing based upon one (1) or more of the following reasons are not eligible for Fair Hearing Procedures:

1. Refusal to complete the credentialing or recredentialing application;
2. Failure to maintain compliance with the general credentialing criteria for practitioners;
3. Falsification of information;
4. Failure to maintain admitting privileges at a participating facility as listed in the most recently published DHP practitioner directory and subsequent directory updates;
5. Failure to maintain malpractice insurance as specified;
6. A medical malpractice history that, after explanatory documentation, is not acceptable to the DHP-CC;
7. Suspension or exclusion from Medicare or Medicaid;
8. Revocation or suspension of practitioner license in any state;
9. Revocation or suspension of DEA certificate or any other controlled substance certifications;
10. Criminal conviction or indictment, including a plea or verdict of guilty or a conviction following a plea of nolo contendere;
11. Occurrence of investigation, discipline or censure for violation of state laws or standards of ethical conduct;
12. Refusal to execute a DHP Practitioner Participation Agreement;
13. Breach of any material term of the DHP Practitioner Participation Agreement.

Initial and recredentialing applicants denied for one (1) or more of the following reasons are eligible for Fair Hearing Procedures:

1. Inappropriate utilization of medical resources, either excessive or inadequate;
2. Substantiated quality problems;
3. Repeated or substantiated complaints from patients, institutions, peers or other health care practitioners;
4. Any other activities or practices that present concerns about the clinical competency of a Practitioner or the patient care provided by a practitioner.

Fair Hearing Procedures

If a practitioner or facility has been denied acceptance into or continued participation in the DHP network, reconsideration and an appeal process are available. An applicant/practitioner may request a reconsideration of or appeal denial decisions within 30 calendar days of notification of denial decision. Failure to request an appeal within 30 days constitutes waiver of the right to an appeal. The DHP-CC may reverse or uphold the denial decision based on additional information provided by the applicant/practitioner. The DHP-CC provides written notice of reconsideration decision to the DHP Board of Managers. If an applicant appeals to the DHP Board of Managers, a fair hearing is conducted as follows:

The hearing shall be held pursuant to one of the following options, as determined by the DHP Board of Managers:

1. Before an arbitrator mutually acceptable to the practitioner and the DHP Board of Managers;
2. Before a hearing officer who is appointed by the DHP Board of Managers and who is not in direct economic competition with the practitioner involved or;
3. Before a panel of individuals, who are appointed by the DHP Board of Managers and are not in direct economic competition with the practitioner involved.

The arbitrator, hearing officer and the majority of panel members shall be peers (same professional license) of the affected practitioner.

The right to a hearing may be forfeited if the practitioner or facility fails, without good cause, to appear.

1. Practitioner or facility may be represented by an attorney or other person of the practitioner's or facility's choice.
2. Hearing procedure:
    a. Board of Managers notifies practitioner or facility of the time, place and date of the hearing 30 calendar days prior to the hearing. The practitioner or facility will also be provided with a list of witnesses expected to testify, if applicable.
    b. Arbitrator, hearing officer or panel conducts hearing and makes final recommendations. Provides recommendations to the DHP Board of Managers.
    c. DHP Board of Managers notifies practitioner or facility of final status within 90 calendar days of hearing.
3. Practitioner or facility is entitled to the following rights:
    a. To have a record made of the proceedings;
    b. To call, examine and cross-examine witnesses;
    c. To present evidence determined to be relevant by the arbitrator, hearing officer, or panel, regardless of its admissibility in a court of law;
    d. To submit a written statement at the close of the hearing;
    e. To receive the written recommendation of the arbitrator, officer or panel, including a statement of the basis for the recommendations;
    f. To receive a written decision of the DHP Board of Managers, including a statement of the specific reason(s) for the decision.

Continued Participation/Disciplinary Actions

It is the responsibility of the participating practitioner or facility to meet and maintain the general credentialing criteria. Practitioners/facilities must notify DHP of any change in status or other pertinent information as outlined below. Failure of the practitioner/facility to inform DHP of changes within 30 days may be grounds for termination from the network. Practitioners/facilities must notify DHP within 30 days of:

1. Changes in on-call coverage practitioners;
2. Receipt of notice of filing of malpractice claims or litigation;
3. Change in Medicare and/or Medicaid status;
4. Suspension or loss of any hospital privileges;
5. Probation, suspension or loss of state license(s), state controlled substance certification (if applicable) or DEA certification;
6. Physical or emotional impairment affecting practitioner performance;
7. Change or cancellation of professional liability insurance;
8. Non-compliance with an impaired practitioner program;
9. Indictment based on any criminal charges or allegations that could lead to a felony or misdemeanor conviction.

Failure to maintain compliance may result in a voluntary or involuntary withdrawal of the practitioner's application, suspension or revocation of credentialing status. Practitioner is notified via certified mail that an action has been taken on the practitioner's participation status based on DHP's Credential Committee review and recommendation. Practitioner is provided a contact person if they wish to submit a written appeal within 30 days receipt of the certified letter. If the practitioner wishes to submit an appeal, the process outlined in the Fair Hearing Process will be followed.

Disciplinary Actions: Practitioners may lose their participation status with DHP for reasons including but not limited to the following:

1. Engaging in conduct that violates the standards of ethical conduct governing the practice of medicine in which the practitioner is subject to discipline, otherwise subjects the practitioner to being censured and/or subjects the practitioner to investigation with respect to any of the above stated conduct;
2. Inappropriate utilization of health care resources, either excessive or inadequate;
3. Providing medically unnecessary care, according to recognized medical standards of care;
4. Substantiated quality problems;
5. Substantiated complaints from patients, institutions, peers or Allied Health Care Professionals;
6. Failed compliance with an impaired practitioner's program;
7. Failure to maintain compliance with any other minimum credentialing criteria or this Plan;
8. Lack of accountability for pre-certification review;
9. Breach of contract provisions;
10. Demonstration of poor judgment, unacceptable quality of care or other inappropriate actions.

Disciplinary Actions Continued:

In general, warning letters are sent to practitioners by the DHP staff for the first two (2) occurrences of any of the above noted infractions. A third occurrence is referred to the DHP Medical Director / Credentials Chair for review and follow-up. Any further occurrence is presented by the DHP Medical / Credentials Chair to the DHP-CC for review and continued participation status decision. Any behavior presenting a risk to patients or others should be presented directly to the DHP-CC for review and continued participation status decision.

Practitioner Resignation

A participating practitioner may resign from the DHP network in accordance with the process described in the DHP Practitioner Participation Agreement.

Reporting Obligations

The DHP staff shall report any suspension, denial, termination, non-renewal or restriction of network participation to the appropriate federal and state authorities as required by law. DHP will follow the requirements outlined in the NPDB on reportable events.

Ongoing Monitoring

DHP will conduct ongoing monitoring of all practitioners for sanctions, complaints and quality issues monthly and takes appropriate action against practitioners when it identifies occurrences of poor quality. Any sanctions or limitations on licensure are discussed with the DHP-CC to determine necessary actions. Problems, concerns and complaints will also be reviewed between credentialing cycles. DHP reviews information within 30 calendar days of the release by the reporting entity. DHP staff will complete the ongoing monitoring using any of the following sources:

1. NPDB Continuous Query;
2. Office of Inspector General (OIG);
3. License Expiration Monitoring Model (LEMM);
4. State Medical Licensing Board.
5. Medicare Opt Out Site
   All states: https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z
   EPLS (Excluded Parties List System) / SAM (System for Award Management) - https://www.sam.gov/SAM/

The Medical Director/Committee Chair will be notified immediately if any participating practitioner is found listed on any report(s). The Medical Director/Committee Chair will assume responsibility for any actions to be taken.

DHP staff will investigate practitioner-specific member/patient complaints upon their receipt and evaluates the practitioner's history of complaints, if applicable. DHP will evaluate the history of complaints for all practitioners at least every six (6) months. DHP Board of Managers will take appropriate action if there is evidence of poor quality that could affect the health and safety of the members.

Credentialing of Organizational Providers

DHP will credential the following organizational providers as a DHP participating facility:

1. Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting;
2. Dialysis Centers;
3. Clinical Laboratories;
4. Freestanding Radiology facilities;
5. Orthotic/Prosthetic Labs;
6. Rehabilitation Centers;
7. Pharmacies;
8. Durable Medical Equipment;
9. Hospitals;
10. Home Health Agencies;
11. Skilled Nursing Facilities;
12. Hospices;
13. Comprehensive Outpatient Rehabilitation Facilities
14. Outpatient Physical Therapy Providers;
15. Speech Pathology Providers;
16. Providers of End-stage Rehal Disease Services;
17. Providers of Outpatient Diabetes Self-Management Training;
18. Rural Health Clinics;
19. Federally Qualified Health Centers;
20. Freestanding Surgical Centers.

Organizational providers' credentials are reviewed and reverified every three (3) years.

DHP participating organizational providers should be licensed by all applicable states, federal or other regulatory agencies and accredited by a recognized accrediting body, such as TJC, HFAP, AAAHC, CARF, Veritas, etc.

If the organizational provider is not accredited, prior to approval as a participating facility, DHP will perform an assessment within 180 days which includes, as applicable:

1. A site visit;
2. Verification of licensure status;
3. Review of exclusion by Medicare or Medicaid, if any;
4. Review of professional liability coverage and any claims activity;
5. A process for ensuring that the provider credentials its practitioners.

DHP may substitute a CMS or state quality review in lieu of a site visit under the following circumstances:

- The CMS or state review is no more than three years old;
- DHP obtains 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;

Exceptions, if:

- CMS or the state has not conducted a site review of the provider, and
- The provider is in a rural area, as defined by the US Census Bureau.

All organization providers will be monitored for complaints and sanctions against license, and limitations imposed by the federal Medicare/Medicaid program. Issues will be identified and investigated by DHP in a timely manner and will be reported to DHP-CC. Monthly reports must include date, time, source and person obtaining information.

Assessment of organizational providers tracking log (sample):

				Minimum Status of Participation (NA if accredited)	Confirmation of Good Standing with Fed. Reg. Bodies (OIG Verification)			Hospitals > 50 beds		
Org. Name	Org. Type	Current Verification Date/License Status	Current Accred. Validation Date/ Body/ Status	Current Site Visit Date/Status	Current Review Date-Sanction Report	Medicare Certification # (as appl.)	Current validation Date/ Malpractice Liability	CCN #/ Verified Date (Hospitals)	Current Review/ Approval Date	Prior Review/ Approval Date
SAMPLE XYXY	Home Health	4/5/2015; Active	4/5/2015; Joint Commission, Active	N/A	4/5/2015	N/A	3/1/2015	N/A	5/15/2015	5/6/2012
SAMPLE YSYSY	Hospital	4/1/2015; Active	12/1/2015; Joint Commission; Active	2/1/2014; Compliant	4/5/2015		3/31/2015	#/ 4/5/2015	5/15/2015	5/5/2012

ATTACHMENT A

Confidentiality/Conflict of Interest Agreement

CONFIDENTIALITY/CONFLICT OF INTEREST AGREEMENT

The undersigned understands and acknowledges that all information related to Deaconess Health Plans and its operations is strictly confidential and that under no circumstances can there be any unauthorized disclosure of such information. Included as confidential, without limitation, are data including financial, quality and utilization or other information concerning patients, hospitals, physicians, other providers, insurance companies and third-party administrators. As one who will have access from time to time to confidential information, the undersigned agrees and declares, and hereby solemnly binds himself or herself to, Deaconess Health Plans as follows:

A. The undersigned will hold in strictest confidence all information of every nature learned or obtained as a result of his or her affiliation with; or services for, Deaconess Health Plans unless expressly authorized in writing.
B. If the undersigned is engaged, or is about to be engaged, in any and proceeding or other matter of Deaconess Health Plans, in which he or she has, or may have, a conflict of interest (such as the person under consideration has a business arrangement with, or is related to, or otherwise is affiliated with the undersigned), the undersigned will disclose such immediately and will abstain from any discussion or voting on the matter being discussed or acted upon.

It is understood that Deaconess Health Plans will place its reliance upon the declarations and agreements wherein made by the undersigned.

This_____ day of _____, 20_____ at Evansville, Indiana.

_____

Signature of Declarant

WITNESS:

_____

Signature of Witness

ATTACHMENT B

DHP Appointment Availability Policy

DHP Appointment Availability Policy

Access Descriptions	Definition	Accessibility Standards
Preventive Care	Well-child exam, annual physical, wellness visits or gynecological exams	Within 4 weeks of request
New Pregnancy	Onset new pregnancy	Within 30 days of request
Routine Primary Care	Primary care for non-urgent symptomatic conditions (differentiates it from wellness visits), such as chronic health problem or ongoing illness in which the member is experiencing no significant change in ADL's; i.e., HTN, seasonal allergies, medication checks	Within 7 days of request
Routine Specialist Care	Specialist care for non-urgent stable health problems, such as cardiovascular disease, MS, medication checks	Within 90 days of request
Follow-up Visit	Recheck of sprain, ear infection, new medication	Within 14 days of request
Symptomatic/Non-Urgent Acute Complaint	Sore throat, no fever	Within 3 days of request
Urgent Care	Sudden, severe onset of illness or health problem requiring medical attention; i.e., sore throat with fever, localizing abdominal pain	Within 24 hours
Emergency Care	Sudden, severe injury or symptoms requiring immediate attention; i.e., chest pain with cardiac HX/unrelieved by NTG, uncontrolled bleeding	Provide and/or refer for emergency care immediately
After-Hours Care	Practitioners are available to members 24 hours a day either directly or by call coverage* Calls are answered within 45 seconds at least 95 percent of the time	Answering system that arranges access of : ER & Urgent calls = 30 min response time Life-threatening = refer to appropriate health care facility

Behavioral Health

Non-Life-Threatening Emergency		Within 6 hours
Urgent Care		Within 48 hours
Routine Care		Within 10 working days

*If you use an answering machine, please make sure the recording specifically includes the following information. NCQA requires messages include instructions for the terms urgent, emergency and life threatening. "If this is an urgent situation, please contact (appropriate contact). If this is an emergency or life-threatening situation, please call 911 or go to the nearest emergency room."

ATTACHMENT C

Practitioner Office Site Quality

Member Complaints Related to Quality of Practitioner's Office Site(s)

DHP will monitor and investigate member complaints related to the quality of the practitioner's office site. Complaint site visits will be conducted utilizing the facility criteria survey form for all practitioner types. The site visit will be performed within 60 calendar days of the complaint regarding the office. The complaint site visit will review physical accessibility, physical appearance and adequacy of waiting and exam room space. If the practitioner was required to correct a deficiency, follow-up site visits will be conducted within 60 calendar days of the complaint site visit. Some methods for detecting deficiencies include:

- Complaint monitoring
- Practice specific member surveys
- Reports from Provider Relations staff visits
- Staff audits.

Facility:

1. Office: Location should be adequately marked.
2. Exits: At least two, clearly marked.
3. Parking: Any type is appropriate, so long as street or lot parking facilities are within three (3) blocks of office.
4. Waiting room: The arrangement of the waiting room should seat people comfortably.
5. Exam rooms: Each patient should have complete privacy. At least two exam rooms should be available.
6. Sterilization: Any clinically valid method is appropriate, so long as at least one such method is used.
7. Drugs and Medications: It is permissible to have sample drugs available. Appropriate storage must be available. Drugs/medications must not have expired.
8. Storage: As appropriate. Drugs should be kept in a locked cabinet or cupboard.

Office Systems:

1. Hours: Ability to meet the majority of enrollee needs must be shown. Should have hours at least five days a week for primary care.
2. Phone system: There may be one person answering phones, but there should be at least two lines for patient calls to come in on. Staff should be trained in phone techniques and some type of arrangements should be made for incoming lunchtime calls.
3. On-call coverage arrangements: Twenty-four (24) hour coverage must exist. This may range from answering service to provider rotation within a group to whatever method will allow 24 hour accessibility in accordance with the physician's contractual obligation to the plan. Response time to call can have variance based on severity of condition. However, response time for urgent/acute problems should be within 45 minutes.
4. Scheduling: At least one person should be assuming responsibility for the scheduling and should be able to explain the prioritizing format. Current patient condition will dictate how long it is before they obtain an appointment. It is expected that urgent problems will be addressed in at least 24 hours.

Some conditions will require immediate action. Availability: See **ATTACHMENT B** for the DHP Appointment Availability Policy.

5. Staffing:
    a. Staffing should be appropriate for the size of the office.
    b. All outpatient centers/facilities that provide urgent care and/or physician offices/outpatient facilities that perform stress tests and/or invasive procedures requiring conscious sedation must have a Board Certified Cardiologist **or** a Board Certified Cardiovascular Surgeon **or** a MD/DO **or** RN certified in Advanced Cardiac Life Support (ACLS) <u>on duty</u> during hours of operation.
    c. A crash cart is preferred, but an external defibrillator (traditional or automatic) is mandatory.
6. Medical record keeping: Medical records are maintained in a manner that is current, detailed, organized and permits effective patient care and quality review.
7. Delivery Capabilities:
    a. New patients: All practitioners requesting an application must be accepting new patients. Recredentialing practitioners must be willing to continue to provide care to their existing patients if they become enrollees in a DHP plan.
8. Hospital Affiliations:
    a. At least one affiliation with a hospital under contract with the plan.

The evaluator should document an appropriate comment on the office's ability to meet the needs of the plan enrollees. Completed site visit will be presented to DHP-CC for evaluation. The benchmark score of 85% overall is considered "satisfactory". Deficiencies will be brought to the attention of the practitioner in question. DHP will evaluate the effectiveness of the actions taken at least every six (6) months until the deficient offices meet the site standards and thresholds. DHP will document follow-up visits for offices that had subsequent deficiencies.

Medical Record Review Guidelines

Secure, confidential, consistent and complete documentation in the medical record is an essential component of quality patient care. Medical record reviews may be conducted at any time deemed necessary by the DHP credentialing staff, including but not limited to:

- During recredentialing
- As a result of a member complaint.

Standards and Thresholds

1. Page in the record contains the patient's name or ID number.
2. Personal biographical data includes the address, employer, home and work telephone numbers and marital status.
3. All entries in the medical record contain author identification.
4. All entries are dated.
5. The record is legible by someone other than the writer.

6. Significant illnesses and medical conditions are indicated on the problem list.
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately documented in the record.
8. Past medical history (for patients seen three (3) or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history related to prenatal care, birth, operations and childhood illnesses.
9. For patients 14 years and older, there are appropriate notations concerning the use of cigarettes, alcohol and substances (for patients seen three (3) or more times query substance abuse history).
10. The history and physical records appropriate subjective and objective information pertinent to the patient's presenting complaints.
11. Laboratory and other studies are ordered, as appropriate.
12. Working diagnoses are consistent with findings.
13. Treatment plans are consistent with findings.
14. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed.
15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. Review for underutilization or over utilization of consultants.
17. If a consultation is requested, is there a note from the consultant in the record?
18. Consultation, lab and imaging reports filed in the chart are initialed by the primary care physician to signify review. If the reports are presented electronically or by some other method, there is also representation of physician review. Consultation, abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
19. There is no evidence that the patient is placed in inappropriate risk by a diagnostic or therapeutic problem.
20. An immunization record has been initiated for children, or an appropriate history has been made in the medical record for adults.
21. There is evidence that preventative screening and services are offered in accordance with the practice guidelines.

ATTACHMENT D

Admitting Arrangements Form

Deaconess Health Plans

7100 Eagle Crest Blvd, Evansville, IN 47715
P: 812-450-7265 F: 812-450-7215

Admitting Arrangements

In accordance with DHP's credentialing guidelines, we are requesting that you submit to us in writing your admitting arrangements should one of your patients require hospitalization. Your admitting arrangements should be with a DHP provider who has privileges at a DHP facility. Please note your arrangements on this letter, sign and return when completed.

Respectfully,

Credentialing Specialist
Deaconess Health Plans

Dr. (s)_____will admit patients who require hospitalization to _____ (DHP Facility).

X_____ _____
Signature Date

X_____
Print Name

OR

In the event that one of my patients needs to be admitted to the hospital, they will be referred to Deaconess Care Group or to another DHP participating physician/provider.

X_____ _____
Signature Date

X_____
Print Name

Deaconess Health Plans also credentials for Deaconess Health System (Combined Medical Staff), Evansville Surgery Center (ESC), Gibson General Hospital (GGH), and OneCare, LLC. (OC).

ATTACHMENT E

Indiana CSR Exempt Form

Deaconess Health Plans

Indiana Controlled Substance Registration Exemption Statement

Active Indiana Practitioner License:
Applicants must have an active Indiana practitioner license before they can obtain a CSR. Practitioners must hold one CSR in order to prescribe, administer, and dispense controlled substances in the State of Indiana. A separate registration is required for each location where a practitioner physically possesses controlled substances to administer or dispense. A separate registration is NOT required for each place where a practitioner merely prescribes controlled substances; one valid CSR is sufficient for a practitioner to prescribe controlled substances throughout Indiana.

I, X , **will not** administer or dispense controlled substances; therefore, I **will not** obtain an Indiana Controlled Substance Registration license for the following locations:

1)

2)

3)

X _____
Provider's Name Provider's Signature & Date

ATTACHMENT F

CME Attestation Form

CME Attestation for Providers

Deaconess Health Plans requires that you meet the state minimal requirement of CME (Continued Medical Education) of AMA Category 1 related to your specialty within the preceding two years from your recredentialing cycle. CME credits **may not** be reused from previous CME cycles.

Recredentialing Group:
CME requirement:
Timeframe:

By my signature below, I attest that I am in compliance with the CME requirements and that I understand that random audits can be performed at any time by the state licensing board.

Signature: _____

Name: _____

Date: _____

Deaconess Health Plans also credentials for Deaconess Health System (Combined Medical Staff), Evansville Surgery Center (ESC), Gibson General Hospital (GGH), and OneCare, LLC. (OC).