

1 **Policy:** **Credentialing Program**
 2
 3 **Date of Implementation:** **February 18, 2003**
 4
 5 **Contact:** **Clinical Quality Management**
 6 **Health Services**
 7 **Provider Credentialing**
 8

9
 10 **SCOPE**

11 American Specialty Health Affiliates (ASHA) maintains independent credentialed
 12 networks of practitioners providing acupuncture, chiropractic, dietetic, manual
 13 manipulative therapy, massage therapy, naturopathic services, personal fitness training,
 14 physical therapy and occupational therapy. All practitioners wishing to provide these
 15 services must successfully meet the credentialing requirements prior to contract execution.
 16 Contracted practitioners must demonstrate an on-going ability to meet credentialing
 17 standards, including the recredentialing process. All practitioners must meet applicable
 18 educational requirements, having graduated from approved professional institutions or
 19 demonstrated appropriate training in the specified disciplines listed above. Recredentialing
 20 is performed every 36 months, or more frequently as mandated by state regulations or
 21 delegation agreements.

22
 23 Clinical services managers must meet applicable credentialing criteria and are continually
 24 reviewed per the guidelines in this policy including assessment of Medicare and Medicaid
 25 sanctions. All ASHA staff who perform medical necessity verification determinations must
 26 meet all ASHA credentialing criteria.

27
 28 Credentialing is performed for all applicants prior to appointment to the applicable
 29 network. ASHA does not perform provisional credentialing. Each practitioner has a
 30 confidential credentialing file that contains credentialing information. ASHA maintains
 31 separate confidential files for quality assurance information. Documents within these files
 32 are current at all times. The practitioner is contractually required to report immediately
 33 any change in status of the information maintained in the credentialing file. Documents for
 34 any applicant or re-applicant must be no more than 180 calendar days old at the time they
 35 are considered for participation or recredentialing. A practitioner file must be presented
 36 and reviewed by the Provider Quality and Credentialing Committee (PQCC) and
 37 notification of the decision must be sent to the practitioner within 90 days of receipt of a

1 complete credentialing application (Application). A complete Application includes the
 2 following:

- 3 • An accurate, fully completed and signed application, that includes an attestation
 4 and disclosure statement;
- 5 • Completed and signed Provider Services Agreement;
- 6 • Completed W-9 form;
- 7 • Completed site evaluation, as applicable; and
- 8 • Evidence of current professional liability insurance.

9
 10 However, the notification to the practitioner must be sent within 10 business days of the
 11 date of the decision.

12
 13 State and federal regulations, including Department of Labor (DOL) standards, as well as
 14 national industry standards established by the National Committee for Quality Assurance
 15 (NCQA) and URAC, are monitored continually to evaluate ASHA’s compliance with
 16 applicable standards. Health plan clients are notified and regulatory filings are updated
 17 when policies are revised, as applicable.

18
 19 Policies are maintained that define the credentialing and recredentialing criteria and
 20 process. The PQCC provides input into the development of new credentialing policies and
 21 reviews current credentialing policies and program. The credentialing program is annually
 22 reviewed, revised as needed and approved by the appropriate quality committee and the
 23 Corporate Quality Oversight Committee (CQOC). A designated clinical manager has
 24 direct responsibility for and participation in the credentialing program.

25
 26 **STAFF RESPONSIBILITIES**

27 ASHA’s organizational chart reflects the clinical services staff and reporting structures.
 28 Staff position descriptions and committee charters explain associated responsibilities and
 29 duties. Reporting relationships are clearly defined in the charters.

30
 31 **DESIGNATED STAFF RESPONSIBILITIES**

32
 33 **Clinical Staff Responsibilities**

34 **Chief Health Services Officer**

35 The Chief Health Services Officer (CHSO) oversees the Clinical Quality Management,
 36 Clinical Care Management, and Medical Services Departments and serves on the Board of
 37 Directors (BOD). The CHSO holds a current, unrestricted license to practice in his/her

1 respective healthcare field, meets ASHA credentialing criteria and is responsible for
 2 overseeing the Credentialing Program by developing key goals and quality strategies in
 3 conjunction with senior management and ASHA's clinical committees. This integral role
 4 includes directing, managing, and ensuring timely completion of clinical performance
 5 management activities. The CHSO, with support from officers and management, is
 6 responsible for the implementation and support of programs approved by the appropriate
 7 quality committee and Corporate Quality Oversight Committee (CQOC). As the
 8 chairperson of CQOC, the CHSO is responsible for the development and implementation
 9 of the Quality Improvement Program (QI Program) including development of key goals
 10 and quality strategies in conjunction with senior management and ASHA's clinical
 11 committees. This integral role includes directing, managing, and ensuring timely
 12 completion of clinical quality improvement activities. The CQOC oversees approval and
 13 adoption of the QI Program and supporting policies regarding the operations, outcomes,
 14 and quality improvement initiatives.

15
 16 The CQOC provides policy development, document control and content review oversight.
 17 The CHSO has the authority to approve credentialing policies when regulatory,
 18 accreditation or delegation requirements require urgent review and approval prior to
 19 CQOC adoption. Those approved policies are subsequently reviewed by CQOC for
 20 editing and adoption.

21 22 **Vice President of Clinical Services**

23 The Vice President of Clinical Services (VPCS) reports to the BOD by means of the
 24 CHSO and is responsible for oversight of all clinical operations and services. The VPCS
 25 holds a current and unrestricted license to practice chiropractic and meets ASHA
 26 credentialing criteria.

27
 28 Additional responsibilities include:

- 29 • Development and implementation of the Credentialing Program;
- 30 • Chairing the Clinical Provider Review Committee (CPRC);
- 31 • Oversight of the activities of the clinical staff and peer-review committees;
- 32 • Management of the clinical operational linkage between the corporate strategy and
 33 the implementation of the Credentialing Program;
- 34 • Development and implementation of clinical policy and guidelines, in conjunction
 35 with the clinical policy work groups and the Clinical Quality Team (CQT);
- 36 • Supervision of all credentialing decisions and the decision-making quality
 37 processes and outcomes;

- 1 • Provision of adequate resources to support and provide oversight of the
- 2 development of quality improvement activities related to the credentialing process;
- 3 and
- 4 • Analysis of the effectiveness of the Credentialing Program.

6 **Administrative Staff Responsibilities**

7 **Vice President of Network Management**

8 The Vice President of Network Management reports to the President/Chief Operations
 9 Officer and oversees the operational areas of Network Development, Provider
 10 Credentialing, Provider Relations and Provider Communications , and as such, is
 11 responsible for overseeing implementation of the operational components of the
 12 Credentialing Program and policies.

14 **Provider Credentialing Department**

15 The Provider Credentialing Department provides the administrative functions associated
 16 with the credentialing process, including practitioner interface. Representatives of the
 17 Provider Credentialing Department are responsible for collecting the core credentialing
 18 criteria and contractual requirements of the credentialing process.

20 **Staff Orientation**

21 The importance of staff orientation and ongoing training in job responsibilities is
 22 understood and supported by ASHA management. To achieve these ends, departments
 23 involved in the credentialing process develop ongoing training methods to educate staff
 24 regarding credentialing processes, accreditation and regulatory credentialing standards,
 25 and their role in supporting daily operations of the credentialing program. Completion of
 26 training and ongoing educational activities is documented and maintained by department
 27 managers.

29 **INITIAL CREDENTIALING**

30 Prior to acceptance into the network, all credentialing files are reviewed by the Provider
 31 Quality and Credentialing Committee (PQCC), which includes credentialed, peer,
 32 contracted practitioner representation and internal clinical managers. Representatives of
 33 the Provider Credentialing Department are responsible for collecting the core credentialing
 34 criteria and contractual requirements of the credentialing process. Appropriately licensed,
 35 peer specialty clinical staff reviews the file for areas of clinical concern or inadequate
 36 information.

1 Credentialing activities are completed within 180 calendar days of the date signed on the
 2 practitioner application . If the credentialing process exceeds 180 calendar days, the
 3 practitioner is required to review, re-sign, and date the application. Additionally, primary
 4 source verification activities greater than 180 calendar days are re-verified. The
 5 practitioner is notified of the outcome of the decision by PQCC within 10 business days of
 6 the date of the decision, not to exceed 90 days after receipt of a complete Application.

7
 8 In the event that ASHA is unable to complete primary verification within 90 days of
 9 receipt of the completed Application because of delays caused by a third party to provide
 10 necessary documentation, the timeframe may be extended, subject to notification to the
 11 practitioner of such extension. ASHA makes every effort to obtain the information from
 12 the third party as soon as possible. In no event shall the timeframe for completion of all
 13 credentialing activities exceed 180 days from the date of signature on the application.

14 **Credentialing Application: Attestation and Disclosure Statement Sections**

15 All practitioners are required to sign and date an industry standard credentialing
 16 application . Acceptable signature types include faxed, digital, electronic, scanned or
 17 photocopied signatures. Signature stamps are not acceptable. The PQCC reviews the
 18 Application within 180 calendar days of the date of the practitioner’s signature on these
 19 documents. The attestation contains at a minimum attestation to the completeness and
 20 correctness of the application. At a minimum, the disclosure statement includes:

- 21 • Reasons for inability to perform essential functions of the position with or without
 22 accommodation;
- 23 • Lack of present illegal drug use;
- 24 • History of loss of license/certification/registration and/or criminal convictions;
- 25 • History of loss or limitation of privileges or disciplinary action;
- 26 • Current professional liability (malpractice) insurance coverage; and
- 27 • Professional liability (malpractice) claims history.

28 **Protection of Practitioner Rights**

29
 30 Practitioners are given the right to review the information submitted in support of their
 31 credentialing or recredentialing application. All practitioners are notified of their right to
 32 correct erroneous information on the credentialing application. The recruitment materials
 33 and the “Instructions” section of the ASHA credentialing application states, “Applicants/
 34 Practitioners have the right to review and correct the information they submit in support
 35 of the Credentialing/Recredentialing application. If any information provided in this
 36 application varies substantially from the information received during the credentialing
 37

1 process, you will be notified in writing by the credentialing examiner, explaining the area
 2 of differing information and will be given the opportunity to respond or correct any
 3 erroneous information within five (5) days of receipt of the notice.”

4
 5 Applicants have the right, upon request, to be informed of the status of their Application
 6 by contacting the Provider Credentialing Department at any time during the credentialing
 7 process. Contracted practitioners may contact the Provider Credentialing Department for
 8 a status update on their recredentialing Application. Practitioners are informed of this right
 9 in the recruitment materials and the “Instructions” section of the ASHA credentialing
 10 application. Practitioners will be contacted by the Provider Credentialing Department via
 11 telephone within 24 hours of a practitioner request and informed of the status of their
 12 Application. ASHA does not allow a practitioner to review references, recommendations,
 13 or other peer review-protected information as defined in the Health Care Quality
 14 Improvement Act of 1986.

15
 16 Practitioners may review and correct information on their application at any time until a
 17 determination is made by the PQCC. If a practitioner desires to modify the application,
 18 ASHA returns a copy of the original application via mail or fax to the practitioner. The
 19 practitioner is instructed to make any changes directly on the application, initial the
 20 changes and return to the credentialing representative via mail or fax. The corrected
 21 application, initialed by the practitioner, is documented and retained in the practitioner’s
 22 permanent file for review by PQCC.

23
 24 If any information received during the credentialing process varies substantially from the
 25 information provided by the practitioner, the practitioner will be notified in writing by the
 26 credentialing examiner, explaining the area of differing information. The practitioner is
 27 given the opportunity to correct any erroneous information obtained by responding via
 28 letter or fax within five (5) days of receipt of the notice. The information returned to
 29 ASHA by the practitioner is documented as received and retained in the practitioner’s
 30 permanent file for review by PQCC.

31 **Primary Source Verification Elements**

32 All primary source verification will be conducted no more than 180 calendar days prior to
 33 the PQCC decision.
 34

35
 36 The verification is electronic, written or verbal. Electronic verification requires the run or
 37 processing date of the query and/or report and requires the initials and date of the person

1 running/verifying the report. If verification is from a website, the printed document must
 2 include the URL and date. Verbal verification requires a signed and dated document in the
 3 credentialing file documenting the agency/source and name of the person who provided
 4 the information.

5

6 The table on the following page outlines the primary source verification elements for each
 7 practitioner type credentialed by ASHA.

8

9

Specialty License	Legal Conviction	CMS Sanction	Professional Liability (Malpractice) History	Education	Board Certification	Hospital Privileges	License/Certification Status	License/Certification Actions
Acupuncturist	State Board	DHHS	Professional Liability (Malpractice) Carrier	State Board/Educational Institution	N/A	N/A	State Board	State Board
Athletic Trainer	State Board, if State licenses	N/A	Professional Liability (Malpractice) Carrier	NATA BOC or State Board	NATA BOC	N/A	NATA BOC and/or State Board	NATA BOC, and/or State Board
Dietetics	Choice Point	DHHS	Professional Liability (Malpractice) Carrier	CDR/State Board	N/A	N/A	State Board/CDR	State Board
Doctor of Chiropractic	State Board	NPDB/HIPDB or DHHS	NPDB or Professional Liability (Malpractice) Carrier	State Board/Educational Institution	N/A	N/A	State Board	State Board
Doctor of Medicine	State Board	NPDB/HIPDB or DHHS	NPDB or Professional Liability (Malpractice) Carrier	State Board	ABMS or AOA	Verbal/Letter of good standing from hospital, if applicable	State Board	State Board
Doctor of Naturopathy	State Board	DHHS	Professional Liability (Malpractice) Carrier	Educational Institution	N/A	N/A	State Board	State Board

Specialty License	Legal Conviction	CMS Sanction	Professional Liability (Malpractice) History	Education	Board Certification	Hospital Privileges	License/Certification Status	License/Certification Actions
Doctor of Osteopathy	State Board	NPDB/ HIPDB or DHHS	NPDB or Professional Liability (Malpractice) Carrier	State Board	AOA or ABMS	Verbal/ Letter of good standing from hospital, if applicable	State Board	State Board
Massage Therapist	Choice Point	DHHS	Professional Liability (Malpractice) Carrier	State Board/ Educational Institution	N/A	N/A	State Board (if applicable)	State Board
Occupational Therapist	State Board	NPDB/ HIPDB or DHHS	NPDB or Professional Liability (Malpractice) Carrier	State Board	N/A	N/A	State Board	State Board
Personal Trainer	Choice Point	DHHS	Professional Liability (Malpractice) Carrier	NASM, NSCA, ACSM, ACE, NCSF, NFPT	N/A	N/A	NASM, NSCA, ACSM, ACE	
Physical Therapist	State Board	NPDB/ HIPDB or DHHS	NPDB or Professional Liability (Malpractice) Carrier	State Board	N/A	N/A	State Board	State Board

- 1
- 2 Definitions:
- 3 • CMS: Centers for Medicare & Medicaid Services
- 4 • ABMS: American Board of Medical Specialties
- 5 • NASM: National Academy of Sports Medicine
- 6 • NSCA: National Strength & Conditioning Association
- 7 • ACSM: American College of Sports Medicine
- 8 • ACE: American Council on Exercise
- 9 • CDR: Commission on Dietetic Registration
- 10 • AOA: American Osteopathic Association
- 11 • NATA BOC: National Athletic Trainers Board of Certification
- 12 • NCSF: National Counsel on Strength and Fitness
- 13 • NFPT: National Federation of Professional Trainers
- 14 • NPDB: National Practitioner Data Bank
- 15 • HIPDB: Healthcare Integrity and Protection Data Bank
- 16 • DHHS: Department of Health and Human Services
- 17

1 **Transition of Existing Non-Licensed Practitioners**

2 In situations where a state changes practitioner licensing laws between recredentialing
3 cycles, practitioners will be afforded an 18-month transitional period to obtain the new
4 licensure, unless stipulated by state regulations. If the practitioner's anticipated
5 recredentialing date falls within the 18-month period, the new state licensing requirement
6 will be applicable and the new license will be primarily verified at the subsequent
7 recredentialing date.

8
9 **Medical Board Certification/Eligibility**

10 In order to participate in ASHA, medical physicians must be board certified or board
11 eligible in a direct patient care specialty. Board eligible physicians must complete
12 certification within twelve months of credentialing committee approval of their
13 Application. The board certification must be recognized by the American Board of
14 Medical Specialties (ABMS) or the American Osteopathic Association (AOA).
15 Applicants with board certification in non-direct patient care specialties will be evaluated
16 on a case by case basis.

17
18 **License/Certification/Registration**

19 All applicants must meet the applicable state requirements for
20 licensure/certification/registration. All practitioners must hold a current, valid license,
21 certification, or registration. Applicants are asked to provide a list of clinical licenses held
22 or previously held in all states.

23
24 Verification of license/certificate/registration (including sanctions and limitations) for a
25 minimum of the most current five (5) years is completed on all professional clinical
26 licenses, certifications, or registrations reported on the application by the practitioner,
27 regardless of the state in which the practitioner is practicing. Verification is performed for
28 current and previous licenses in all states when disclosed on the practitioner application.
29 Licensure/certification/registration status and actions against
30 licensure/certification/registration are verified with the appropriate clinical board(s) for all
31 clinical licenses/certificates/registrations, as applicable. Reported state board actions are
32 investigated.

33
34 Practitioners' license/certificate/registration(s) must be in good standing as determined by
35 the PQCC and in effect at the time of the credentialing decision. Practitioners are required
36 to report any adverse change in license/certificate/registration status to ASHA in a timely
37 manner. The details of this requirement are stipulated in the provider agreement.

1 **Professional Education and Training**

2 Practitioners must have completed the appropriate education, training, and administrative
3 requirements for licensure/certification/registration. For practitioners governed by a state
4 board or other agency, a letter is obtained annually from the state board or other agency
5 responsible for licensure/certification/registration verifying the primary verification activity
6 of education. This documentation is maintained on file. Where documentation of primary
7 verification by the entity responsible for licensure/certification/registration is not obtained,
8 ASHA performs primary verification of education with the educational institution.

9
10 **Professional Liability (Malpractice) Coverage**

11 A copy of the professional liability (malpractice) certificate is obtained from the
12 practitioner or the insurer and must be in effect at the time of review by PQCC. The
13 coverage indicated on the professional liability (malpractice) certificate must meet the
14 insurance limit required by the practitioner agreement or the state in which the practitioner
15 practices, whichever is greater. Verification of continued coverage is obtained as a
16 component of each recredentialing cycle or more often as needed.

17
18 If a practitioner maintains coverage as part of a group policy, the following is required:

- 19 • Either: 1) The carrier must supply a list of all practitioners that are covered under
20 the group policy, or 2) Where a list of all practitioners is unavailable, the carrier
21 must supply contractual evidence that all employees of the policyholder are
22 covered; and
- 23 • The carrier must verify that individual malpractice claims history is available for
24 each practitioner covered by the group policy.
- 25 • The carrier must verify that the applicant (each applicant, if more than one in the
26 group is applying) is covered by at least the minimum coverage required.

27
28 If a practitioner is employed by a provider group or entity that is self-insured, evidence of
29 coverage, either through a list provided by the carrier of all practitioners covered under
30 the group policy or, where a list of all practitioners is unavailable, through contractual
31 evidence that all employees of the policyholder are covered, must be supplied to meet the
32 requirements for credentialing.

33
34 **Professional Liability (Malpractice) History**

35 Written confirmation of at least five (5) years history of professional liability claims that
36 resulted in settlements or judgments paid by or on behalf of a practitioner is obtained from

1 the National Practitioner Data Bank (NPDB)/Healthcare Integrity and Protection Data
 2 Bank (HIPDB) or directly from the professional liability (malpractice) carrier.

3
 4 PQCC will review professional liability (malpractice) or claims information received from
 5 professional liability (malpractice) insurance carrier(s) if:

- 6 • There has been litigation and a settlement for any one (1) case of more than
 7 \$2,999.99, or
- 8 • There has been litigation and settlements for more than three (3) cases in the last
 9 two (2) years.

10 If there is any claims history, documented information is required about the case(s) from
 11 the practitioner and insurance carrier(s), if available, and will be provided to PQCC's for
 12 review and consideration.

13
 14 **National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank**

15 The NPDB is a federally established data bank that contains practitioner information,
 16 including but not limited to medical professional liability (malpractice) payments,
 17 licensure/disciplinary actions, and adverse actions that affect a practitioner's professional
 18 society membership. The HIPDB is a federally established data bank that contains
 19 practitioner information related to specific exclusions from state and federal programs
 20 (including Medicare and Medicaid), civil judgments, criminal convictions, and contract
 21 terminations as they relate to quality of patient care.

22
 23 At the time of initial credentialing, NPDB and HIPDB are queried on new applicants, if
 24 applicable. NPDB and HIPDB are also queried at recredentialing of contracted
 25 practitioners, if applicable. NPDB and HIPDB are also queried, as appropriate, during
 26 investigations related to quality of care.

27
 28 **Medicare and Medicaid Sanctions**

29 All practitioners who can provide Medicare eligible benefits to members are reviewed for
 30 Medicare/Medicaid sanctions. The review of Medicare/Medicaid sanctions will cover at a
 31 minimum the most recent 3-year period available through data sources.

32
 33 **Medicare Participation**

34 As stated in the Provider Services Agreement, in order to participate with ASHA, licensed
 35 practitioners who are Medicare eligible, may not opt out of Medicare participation and
 36 subsequently enter into private contracts with Medicare patients (Reference: Social
 37 Security Act; Section 1802/1861r).

Hospital Privileges

Hospital privileges will be queried for practitioners who indicate they have admitting or consulting privileges. Hospital privileges must be in good standing as verified by the hospital's Chief of Staff.

DEA or CDS Certificate

As applicable, ASHA verifies a DEA or Controlled Dangerous Substances (CDS) certificate in each state where a practitioner provides care to members.

ADDITIONAL ELEMENTS (Excluding Primary Source Verification)**Work History**

Applicants for initial credentialing must include professional work history from the most current five (5) years or as otherwise required by state and Federal laws and regulations. The practitioner is responsible for submitting post-licensure/clinical education work history information. Work history may be provided on the credentialing application or by curriculum vitae. Any gaps of six months (6) or more, or as otherwise required by state and Federal laws and regulations, must be explained in writing by the applicant. The explanation of the gap needs to be sufficient to ascertain that the gap did not occur as a result of adverse and/or reportable situations, occurrences, or activities. The work history must have been received within 180 calendar days of the practitioner's application signature date and forwarded to Provider Quality and Credentialing Committee (PQCC) for review.

Office Facility and Medical Records Standards and Thresholds

ASHA has established standards and thresholds for practitioner office facility and medical record keeping. As part of the contracting process, the practitioner agrees to abide by such standards and thresholds.

Failure to comply with the contractual standards and thresholds may lead to corrective actions up to and including termination.

1 **CANCELLED APPLICATIONS**

2 A practitioner may withdraw his/her Application at any time prior to committee decision.
3 ASHA will send a letter to the practitioner confirming the cancellation of the Application.
4 The practitioner may reapply at any time.

5
6 **RECREREDENTIALING**

7 Recredentialing is performed no later than every 36 months from the date of either the
8 initial credentialing approval or the last recredentialing approval, or more frequently as
9 mandated by state regulations or delegation agreements.

10
11 The cycle begins with the date of the previous credentialing or recredentialing decision by
12 the Provider Quality and Credentialing Committee (PQCC). Prior to continued
13 participation in the network, all recredentialing files are required to be reviewed by the
14 PQCC, which includes credentialed, peer, and contracted practitioner representatives.

15
16 **Recredentialing Application: Attestation and Disclosure Statement Sections**

17 All contracted and credentialed practitioners are required to sign and date an industry
18 standard recredentialing application. Acceptable signature types include faxed, digital,
19 electronic, scanned or photocopied signatures. Signature stamps are not acceptable. The
20 PQCC reviews the Application within 180 calendar days of the date of the practitioner's
21 signature on these documents. The attestation contains at a minimum attestation to the
22 completeness and correctness of the application. At a minimum, the disclosure statement
23 includes:

- 24 • Reasons for inability to perform essential functions of the position with or without
25 accommodation;
26 • Lack of present illegal drug use;
27 • History of loss of license/certificate/registration and/or felony convictions;
28 • History of loss or limitation of privileges or disciplinary action;
29 • Current professional liability (malpractice) insurance coverage; and
30 • Professional liability (malpractice) claims history.

31
32 The practitioner's credentials and qualifications are verified using primary source
33 verification as in the initial credentialing process, except for education, training, and work
34 history.

35
36 All recredentialing activities are completed (including a decision by the PQCC) within 180
37 calendar days from the date signed on the practitioner Application, including all primary

1 source verification described under “Initial Credentialing.” If the credentialing process
 2 exceeds 180 calendar days, the practitioner will be required to review and re-sign and date
 3 the Application . Additionally, primary verification activities greater than 180 calendar
 4 days will be re-verified. The practitioner is notified of the outcome of the decision by
 5 PQCC within 10 business days of the date of the decision, not to exceed 90 days after
 6 receipt of a complete Application. A complete Application includes the following:

- 7 • An accurate, fully completed and signed Application;
- 8 • Completed site evaluation , if applicable; and
- 9 • Evidence of current professional liability insurance.

10
 11 In the event that ASHA is unable to complete primary verification within 90 days of
 12 receipt of the completed Application due to delays caused by a third party in providing
 13 necessary documentation, the timeframe may be extended, subject to notification to the
 14 practitioner of such extension. ASHA makes every effort to obtain the information from
 15 the third party as soon as possible. In no event shall the timeframe for completion of all
 16 recredentialing activities exceed 180 days from the date of signature on the Application.

17 18 19 **Ongoing Monitoring of Sanctions and Complaints**

20 ASHA performs ongoing monitoring of practitioner quality to ensure ongoing compliance
 21 with credentialing standards and quality criteria.

22
 23 Policies and procedures are maintained to monitor quality-related practitioner activity on
 24 an ongoing basis between credentialing cycles. The following elements are monitored on
 25 an ongoing basis and are reported to PQCC, as appropriate:

- 26 • Medicare and Medicaid sanctions;
- 27 • State board and other regulatory agency actions and sanctions against a
 28 license/certificate/registration;
- 29 • Current, active license/certificate/registration status;
- 30 • Member or other customer complaints/grievances;
- 31 • Medical records documentation;
- 32 • Quality Performance Management Alerts; and
- 33 • Clinical Services Management Alerts.

34
 35 Practitioner sanctions, complaints, and adverse events between credentialing cycles are
 36 monitored on an ongoing basis, at least every 6 months, and appropriate action is taken
 37 when occurrences of poor quality of care or service are identified. Medicare/Medicaid and

1 state information regarding practitioners who have received sanctions or limitations on
2 licensure are reviewed monthly for any contracted practitioners listed.

3
4 Each practitioner is cross-referenced against the current List of Excluded
5 Individuals/Entities (LEIE) and any subsequent Monthly Exclusion and Reinstatement
6 Supplements issued by the Department of Health and Human Services (DHHS).

7
8 The review of information obtained from the above reports is conducted within 30
9 calendar days of the release of the report. Should a contracted practitioner be listed, a hard
10 copy of the documentation will be placed in the practitioner's credentialing/recredentialing
11 file and forwarded to PQCC for review. Practitioners excluded/sanctioned from Medicare
12 will be excluded from participation.

13
14 In the event of a sanction against a contracted practitioner, the Provider Credentialing
15 staff will request details of the sanction from the Department of Health and Human
16 Services or NPDB/HIPDB, if applicable, for documentation in the
17 credentialing/recredentialing file. The file will then be presented to the PQCC in a timely
18 manner to review the specifics of the sanction and make a determination regarding the
19 practitioner's continued participation in the network.

20
21 **License Re-verification**

22 State licenses are subject to expiration and renewal on a periodic basis that varies from
23 state to state. Provider Credentialing staff will conduct primary source verification of a
24 practitioner's license from the state-licensing agency in the state(s) in which the
25 practitioner practices at the time of license renewal, as well as each state in which the
26 practitioner reports an active license.

27
28 **Failure to Maintain Credentialing Requirements on an Ongoing Basis**

29 Failure of contracted practitioner or clinical staff to maintain ongoing credentialing
30 requirements may result in a Corrective Action Plan (CAP) or other appropriate action, up
31 to and including termination from ASHA's network of practitioners or termination of
32 employment, as applicable. Examples of ongoing credentialing requirements include, but
33 are not limited to, an active unrestricted license, certification, or registration (as applicable
34 to the clinician's specialty), evidence of adequate professional liability coverage,
35 unrestricted participation with applicable state and federal healthcare entities, and board
36 certification, as required.

37

1 Failure of contracted practitioner to maintain an active unrestricted license, certification,
2 or registration will result in immediate termination from ASHA's network of practitioners
3 and restriction from participating in peer review activities.

4
5 Failure of clinical staff to maintain an active unrestricted license, certification, or
6 registration will result in restriction from participating in peer review activities until such
7 time as their license, certification or registration is reinstated.

8
9 **Notification to Authorities and Practitioner Appeal Rights**

10 A process is in place for documentation and reporting of quality deficiencies to applicable
11 authorities, as appropriate. An appeal process has been established for instances in which
12 ASHA chooses to alter the conditions of a practitioner's participation based on quality of
13 care and/or service issues. The practitioner is notified in writing of the quality event and
14 appeal rights process.

15
16 **Procedures for Reporting to Authorities**

17 During the review or investigation of a quality of care issue or member complaint about a
18 contracted practitioner, the PQCC or Clinical Provider Review Committee (CPRC) may
19 encounter cases that necessitate submitting a report to the agency responsible for
20 licensing/certification/registration. When a majority vote of the members of the PQCC or
21 CPRC recommends a report be sent to the state agency, the PQCC or CPRC chairperson
22 or designee will issue a letter to the regulatory entity detailing the practitioner's alleged
23 violations of the rules adopted by the appropriate regulatory agency in the state where the
24 practitioner practices.

25
26 During the reporting process, confidential information, in accordance with ASHA policy,
27 will be shared on a need-to-know basis. Under no circumstances are any clinical quality
28 committee meeting minutes or any other peer review documentation disclosed to any
29 entity or individual unless ordered by subpoena or otherwise authorized for disclosure by
30 the Chief Health Services Officer (CHSO). Standard procedures for the protection of
31 patient/member confidentiality are followed. The Regulatory Compliance Department
32 addresses any further disclosure issues as they arise.

33

1 **NATIONAL PRACTITIONER DATA BANK/HEALTHCARE INTEGRITY AND**
 2 **PROTECTION DATA BANK REPORTING**

3 In accordance with NPDB and HIPDB guidelines, ASHA has determined that
 4 terminations or resignations during the course of an investigation related to professional
 5 competence or conduct are reported . As an eligible entity of NPDB and HIPDB, ASHA
 6 files a report within 15 calendar days (including Saturdays, Sundays, and Federal
 7 holidays) to NPDB or 30 calendar days (including Saturdays, Sundays, and Federal
 8 holidays) to HIPDB of the final adverse determination. The practitioner must have
 9 exhausted all options to appeal the initial determination prior to reporting or have had
 10 clinical privileges affected for at least 30 days prior to reporting; therefore, if an immediate
 11 termination has been in effect for over 30 days and the practitioner has appealed the
 12 action, the report is entered but it is noted in the report that the action is under appeal and
 13 the report is updated after the appeal is resolved.

14
 15 If a practitioner utilizes the appeal or hearing right and the adverse determination is
 16 upheld, a report is filed within 15 calendar days (including Saturdays, Sundays, and
 17 Federal holidays) for NPDB and 30 calendar days (including Saturdays, Sundays, and
 18 Federal holidays) for HIPDB of the final resolution of the adverse determination.

19
 20 **PRACTITIONER NOTIFICATION**

21 Practitioners who meet credentialing criteria and contracting requirements are activated as
 22 a participating practitioner in the network. Practitioners who are approved for
 23 participation by Provider Quality and Credentialing Committee (PQCC) are notified in
 24 writing of the committee's decision within 10 business days, not to exceed 90 days from
 25 receipt of the completed Application.

26
 27 Practitioners who fail to meet credentialing criteria are notified in writing of the
 28 committee's decision within 10 business days, not to exceed 90 days from receipt of the
 29 completed Application. The notification includes the basis for the decision and information
 30 regarding the practitioner's right to appeal the credentialing decision. When a practitioner
 31 has been denied participation, the practitioner may reapply after a six-month (6-month)
 32 period of time. Six (6) months will be calculated from the date of the PQCC's non-
 33 approval of the initial Application.

34
 35 Practitioners who meet recredentialing criteria remain as a participating practitioner in the
 36 network and are notified in writing of the committee's decision within 10 business days,
 37 not to exceed 90 days from receipt of the completed Application.

1 When the PQCC determines that a participating practitioner fails to meet recredentialing
 2 criteria, PQCC will terminate the practitioner’s participation. The practitioner is notified in
 3 writing within 10 business days of the decision, not to exceed 90 days from receipt of the
 4 completed Application. The notification describes the basis for termination and the
 5 practitioner’s right to appeal.

6 7 **PRACTITIONER DENIALS AND APPEALS**

8 New applicants who are not approved for participation in the network are afforded a one-
 9 level appeal process. The practitioner is notified in writing of the basis for non-approval of
 10 participation and appeal rights within 10 business days of the date of the Provider Quality
 11 and Credentialing Committee (PQCC) decision, not to exceed 90 days from receipt of the
 12 completed Application.

13 14 **PRACTITIONER TERMINATION AND APPEALS**

15 The Provider Quality and Credentialing Committee (PQCC) may terminate a contracted
 16 practitioner’s agreement “for cause” immediately or with 30 days notice as determined by
 17 state regulations or stipulated in the Provider Services Agreement. The practitioner is
 18 notified in writing of the basis for termination and appeal rights. Participating practitioners
 19 who are terminated from the network are afforded a two-level appeals process.

20 21 **COMMITTEE ACCOUNTABILITY**

22 The Board of Directors has empowered committees and formal work teams to support
 23 and oversee various components of ASHA credentialing related clinical or administrative
 24 operations activities. These committees are multi-disciplinary and are comprised of staff
 25 members and contracted practitioners, as applicable. Contracted practitioners participate
 26 actively in the Credentialing Program. The Corporate Quality Oversight Committee
 27 (CQOC) has been empowered by the BOD to review and approve credentialing
 28 programs, policies, and reports on its behalf.

29 30 **Provider Quality and Credentialing Committee**

31 A credentialing committee, (Provider Quality and Credentialing Committee [PQCC]),
 32 including credentialed, licensed/certified/registered, peer clinicians, has been designated to
 33 make determinations regarding credentialing and recredentialing decisions using a peer
 34 review process. PQCC reports to the BOD.

35

1 The PQCC reviews and makes the final decision regarding the participation of
 2 practitioners during the credentialing and recredentialing process. The PQCC is primarily
 3 responsible for the following peer review functions:

- 4 • Peer review and evaluation of information provided on the credentialing or
 5 recredentialing Application;
- 6 • Peer review of verifications of credentialing information;
- 7 • Peer review of medical record evaluations;
- 8 • Peer review of site evaluation results; and
- 9 • Ongoing peer review of incidents of member grievances, complaints, potential
 10 quality of care issues, and adverse outcomes.

11
 12 Committee structure, including membership, participation of contracted practitioners,
 13 voting rights, and quorum requirements, are included in the PQCC charter.

14
 15 **Clinical Provider Review Committee**

16 The Clinical Provider Review Committee (CPRC) is primarily responsible for the
 17 following peer review functions:

- 18 • Peer review for credentialing denial appeals.
- 19 • Peer review for termination appeals – 1st Level
- 20 • Peer review for Treatment Form Waiver Program tier appeals
- 21 • Review and approve clinical policy and clinical practice guidelines.

22
 23 Committee structure, including membership, participation of contracted practitioners,
 24 voting rights, and quorum requirements, are included in the CPRC charter.

25
 26 **Committee Chair Responsibilities**

27 The committee chairperson or official designee is responsible for:

- 28 • Effective meeting management;
- 29 • Priority setting for agenda items;
- 30 • Approval of guest attendance;
- 31 • Signing approved documents on behalf of the committee;
- 32 • Ensuring committee tasks are completed;
- 33 • Calling for votes and ensuring a quorum;
- 34 • Following up on committee issues;
- 35 • Ensuring that accurate meeting minutes are maintained; and
- 36 • Reporting to supervisory committees.

1 **Administrative File Review**

2 A mechanism is in place to review credentialing/recredentialing files to identify practitioner
3 files requiring additional information, further evaluation, or committee discussion.

4
5 Representatives of the Provider Credentialing Department are responsible for collecting
6 the core credentialing criteria and contractual requirements of the credentialing process.

7
8 **Clinical File Review**

9 If upon completion of the collection of prescribed documentation by the credentialing staff
10 the practitioner's credentialing file is determined to have issues, the file is reviewed by a
11 staff clinician. It is the responsibility of the clinician to identify areas of clinical concern or
12 inadequate information that may impede the PQCC from making a definitive decision.

13
14 Practitioner files that meet all clinical criteria may be presented for consensus approval.
15 Files that present questionable information are presented individually for committee
16 discussion and determination.

17
18 **Provider Quality and Credentialing Committee Decision Protocol**

19 Prior to acceptance into the network or approval for continued network participation,
20 practitioners' credentialing files are reviewed and accepted/approved by the PQCC. PQCC
21 has final decision-making authority for credentialing decisions that admit practitioners into
22 or maintain participation of contracted practitioners in the network. Contracted
23 practitioners who fail to meet credentialing criteria are terminated.

24
25 For practitioners not admitted or maintained in the network, CPRC has the final decision
26 making authority upon appeal.

27
28 PQCC evaluates applicants and contracted practitioners on the totality of information
29 provided. Decisions are not made solely on the basis of community knowledge.
30 Community knowledge is noted and investigated, and all documented evidence to support
31 the community knowledge is taken into account in the credentialing decision.

32
33 **Urgent Issues Between Meetings**

34 Ad hoc meetings may be called when issues require immediate resolution. The PQCC
35 chair reports the issue to the committee at the next meeting. Committee members may also
36 be reached via fax, email, or teleconference when committee input is necessary.
37 Documentation of such communication and comment will be maintained.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34

Guest Attendance at Committee Meetings

Health plan representatives and other guests may attend PQCC meetings with permission of the President/Chief Executive Officer and/or PQCC chair. All non-staff guests sign a confidentiality statement for each meeting they attend. Guests may only attend portions of the PQCC meeting pertinent to their business with ASHA.

Meeting Minutes

Contemporaneous minutes of PQCC meetings include discussion, decisions made by the committee, and documentation of all actions.

PQCC meeting minutes are dated, signed by the chair and recorder, and are available for review by health plan, regulatory, and accreditation auditors. Confidentially maintained minutes reflect additional committee decisions and actions, including review and evaluation of activities, tracking of key monitors, and review of policies.

Minutes also include actions instituted by the committee, including appropriate follow up, review of documents, and active practitioner participation.

Minutes are reviewed and approved by vote of the appropriate committee at the next scheduled meeting, if possible. Agendas, minutes, reports, and documents presented to committees are maintained in a confidential manner in the corporate office in San Diego, California. PQCC activity is reviewed and approved by CQOC on a regular basis.

Tracking and Trending Credentialing Activities

Credentialing activities related to the number of practitioners credentialed and not credentialed are routinely tracked. Data are collected regarding the reasons for failure to meet credentialing criteria and are reported to the CPRC on a quarterly basis. Evaluation of the data is used to identify improvement opportunities relating to the development and revision of credentialing criteria. A trend of increased non-approval rates relating to specific criteria is investigated to determine if ASHA criteria continue to be supported by professionally recognized standards of practice. Information relating to the credentialing process is reviewed and presented to the BOD on a regular basis.

1 **DELEGATION**

2 If any element of credentialing is sub-delegated to another entity such as a credentials
3 verification organization (CVO), ASHA will assure the entity meets or exceeds ASHA and
4 accreditation requirements and establish a mutually agreed upon document describing:

- 5 • The responsibilities of ASHA and the sub-delegated entity;
- 6 • The delegated activities;
- 7 • Semi-annual reporting (minimal);
- 8 • Process for evaluation the sub-delegated entity's performance; and
- 9 • The remedies, including revocation of the delegation, if the sub-delegated entity
10 does not fulfill its obligation.

11
12 If the delegation arrangement includes the use of member protected health information by
13 the delegate, the delegation document also includes the following provisions:

- 14 • A list of the allowed uses of member health information.
- 15 • A description of delegate safeguards to protect the information from inappropriate
16 use or further disclosure.
- 17 • A stipulation that the delegate will ensure that sub-delegates have similar
18 safeguards.
- 19 • A stipulation that the delegate will provide members with access to their
20 information.
- 21 • A stipulation that the delegate will inform the organization if inappropriate uses of
22 the information occur.
- 23 • A stipulation that the delegate will ensure protected information is returned,
24 destroyed, or protected if the delegation agreement ends.

25
26 The sub-delegated entity's capacity to perform the activities are evaluated prior to
27 delegation and evaluated annually whereto the sub-delegate's activities are being
28 conducted in accordance with ASHA policy, federal regulations, URAC, NCQA, and
29 DOL standards. If the delegate is NCQA certified and URAC accredited for credentialing,
30 annual file audit and evaluation is waived, provided that the delegate submits evidence of
31 current accreditation and certification. All delegates are required to submit reports at least
32 semi-annually. ASHA will monitor the effectiveness of the delegate's recertification
33 processes at least annually. Final decision-making authority regarding network
34 participation status for any practitioner is maintained by ASHA. The right to approve new
35 practitioners and sites and to terminate or suspend individual practitioners or sites is
36 retained by ASHA.

37

1 **Delegated Functions**

2 As of the date of this program, ASHA has not delegated any credentialing functions
3 except:

- 4 • CreDENTALs Services, Inc./VerifPoint – ASHA delegates primary verification of
5 credentials in limited states where physicians provide acupuncture services and
6 meet ASHA credentialing criteria. The results of the primary verification are
7 submitted to ASHA for review and determination by the ASHA credentialing
8 committee.

9
10 **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**

11 **(HIPAA)**

12 ASHA strives to comply with all applicable HIPAA requirements and maintains policies
13 relating to HIPAA compliance. All HIPAA-related policies are posted and accessible to all
14 employees for review on the ASHA Intranet site. Ongoing mandatory educational
15 seminars are afforded to staff.

16
17 **CONFIDENTIALITY**

18 ASHA defines confidential information as non-public, proprietary information. The
19 guidelines established in the ASHA Confidentiality Policy - QM 8 are followed to ensure
20 credentialing and peer review records and proceedings remain confidential. In accordance
21 with regulatory compliance, committee and peer review processes that include the review
22 of credentialing/recredentialing information, including medical records, are structured to
23 protect confidential information from inadvertent release and discovery.

24
25 **DISCRIMINATION**

26 ASHA does not discriminate against a practitioner for any reason, including but not
27 limited to age, sex, marital status, religion, ethnic background, national origin, ancestry,
28 race, sexual orientation, or health disability status. The criteria for practitioner selection,
29 evaluation, and retention do not discriminate against practitioners who serve high-risk
30 populations or specialize in the treatment of costly conditions. ASHA renders
31 credentialing/utilization management/quality management decisions in the same manner, in
32 accordance with the same standards, and within the same time availability to all
33 practitioners and applicants.

34

1 ASHA procedures for monitoring and preventing discriminatory credentialing decisions
2 include but are not limited to:

- 3 • Monitoring practitioner credentialing decision appeals to identify appeals relating
4 to discrimination; and
- 5 • Maintaining a multi-specialty credentialing committee membership and requiring
6 those responsible for credentialing decisions to annually sign an affirmative
7 statement to make decisions in a non-discriminatory manner.

8
9 **DATA CONTAINED IN MEMBER MATERIALS**

10 ASHA ensures that the practitioner information as submitted by the practitioner and
11 available to members is consistent with the credentialing data, which may include
12 education, training, certification, and specialty. The data collected from practitioners
13 through the credentialing/recredentialing process as well as any additional data received
14 from practitioners through direct communication outside the credentialing/recredentialing
15 process are captured electronically in ASHA's practitioner credentialing/recredentialing
16 database. This database is the sole source of content used to produce hardcopy and
17 electronic practitioner directories and any other member materials containing practitioner
18 information.