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**Overview**

Credentialing is the process by which the appropriate peer review bodies of the Plan evaluate an individual applicant's background, education, post-graduate training, experience, work history, demonstrated ability, patient-admitting capabilities, licensure, regulatory compliance and health status that may affect the applicant's ability to provide health care; and as applicable to non-individuals, accreditation status.

Information is obtained through a credentialing application which must be attested to by the applicant as being correct and complete. The application captures professional credentials and contains a questionnaire section that asks for professional liability claims history; and suspension or restriction of hospital privileges, licensure, DEA certification or Medicare/Medicaid sanctions. Primary source verifications are obtained in accordance with state regulatory agency requirements and Plan policy and procedure, and include a query to the National Practitioner Data Bank. Physicians, Allied Health Professionals and Ancillary Facilities/Health Care Delivery Organizations are required to be credentialed in order to be network providers of services to Plan members. Satisfactory site inspection evaluations are required to be made at the office locations of all Primary Care Physicians (PCPs) and Obstetrics and Gynecology specialist physician offices. Some facilities also need a site inspection evaluation to be completed, relative to accreditation status.

After the credentialing process has been completed, notification of the credentialing decision is forwarded to the provider within 60 calendar days of the committee's decision.

Credentialing may be done directly by the Plan or by an entity approved by the Plan for delegated credentialing. In the event that credentialing is delegated to an outside agency, the Plan is required to establish the credentialing capabilities of the delegated agency clearly meet state regulatory and Plan requirements. All participating providers or agencies delegated for credentialing are to use the same

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standards as defined in this section. Compliance is monitored on a regular basis and formal audits are conducted annually. Ongoing oversight includes regular exchanges of network information, and the annual review of policies and procedures and credentialing forms and files.

**Applicant's Right to be Informed of Credentialing Application Status**

Upon receipt of a written request, the Company will provide written information to the applicant of the status of the credentialing application within 15 business days. The information provided will advise of any items still needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared to information provided by the applicant.

**Applicant's Right to Review and Correct Erroneous Credentialing Information**

In the event the credentials verification process reveals information submitted by the applicant that differs from the verification information obtained by the Company, the applicant shall be notified in writing by the Company within 15 business days, and shall be allowed to submit a correction for the erroneous information.

The Company's notification to the applicant shall include:

- The nature of the discrepant information;
- The process for correcting erroneous information submitted by another source;
- The format for submitting corrections;
- The time frame for submitting the corrections;
- The addressee to whom corrections must be sent;
- The Company's documentation process for receipt of the correction information from the applicant; and

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- The Company's review process.

The applicant may review any documentation submitted by him/her in support of the application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies and certification boards.

The applicant may not review peer review information obtained by the Company.

The Committee shall review the correction information and explanation at the time of considering the applicants credentials for provider network participation.

### Baseline Criteria

Baseline criteria for provider network participation:

#### License to Practice

Practitioners must have a current valid license to practice;

#### DEA Certificate

Physicians (M.D., D.O., D.P.M.), as applicable to specialty must have a current DEA Certificate;

#### Board Certification

Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a provider for the Plan; or accredited training that renders a physician eligible to sit for the board certification examination;

#### Hospital Admitting Privileges

Specialist practitioners shall have hospital admitting privileges at a Plan participating hospital (as applicable to specialty). PCP's may have hospital admitting privileges or may enter into a formal agreement with another Plan participating practitioner who has admitting privileges at a Plan participating hospital, for the admission of members.

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#### **Professional Liability Insurance**

Plan providers (all disciplines) shall be required to carry and continue to maintain professional liability insurance in the following required limits:

Individual Practitioners

\$1 million per occurrence; \$3 million aggregate.

Facilities

\$1 million per occurrence; \$3 million aggregate.

#### **Covering Physicians**

PCPs in solo practice must have a Plan participating covering physician willing to care for their members in their absence.

#### **Allied Health Practitioners**

Allied Health Professionals (AHPs), both dependent and independent, are credentialed by the Plan.

Dependant AHPs include the following and are required to provide collaborative practice information to the Plan:

- Advanced Registered Nurse Practitioner (ARNP)
- Certified Nurse Midwife (CNM)
- Physician Assistant (PA)
- Osteopathic Assistant (OA)

Independent AHPs include, but are not limited to the following:

- Licensed clinical social worker
- Licensed mental health counselor
- Licensed marriage and family therapist
- Physical therapist
- Occupational therapists
- Audiologist
- Speech/Language therapist/pathologist

#### **Ancillary Health Care Delivery Organizations**

Ancillary Facility/Health Care Delivery Organizations must complete a credentialing application and provide information on accreditation, licensure, regulatory status and general liability insurance coverage. In addition, depending on accreditation and/or Medicaid

status, a site inspection evaluation may be required as part of the credentialing process.

**Re-Credentialing**

In accordance with the formal Illinois state requirements and Plan policy and procedure, re-credentialing of all provider types shall be conducted at least once every three years.

**Updated Documentation**

Providers must maintain current license, DEA certification, board certification CDS, and accreditation (as applicable to provider type) and furnish copies of current professional liability insurance to the Plan prior to or concurrent with expiration. Control Substance Certificate must be provided and maintained in the state of Illinois.

**Office of Inspector General Medicaid Sanctions Report**

On a regular and ongoing basis, the Plan accesses the listings from the Department of Health and Human Services, Office of Inspector General Medicaid Sanctions (exclusions and reinstatements) Report of excluded providers for the most current available information. This information is crosschecked against the network of Plan providers. If providers are identified as being currently sanctioned, such providers are subject to immediate termination.

Notifications of termination are given in accordance with contract and Plan policies and procedures.

**Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials**

On a regular and ongoing basis, the Plan accesses the listings from state licensure disciplinary action Web sites for the most current available information. This information is crosschecked against the network of Plan providers. If a provider is identified as being currently under sanction, appropriate action is taken in accordance with Plan policy and procedure. If the sanction imposed is revocation of license, the provider is subject to immediate termination.

Notifications of termination are given in accordance with contract and Plan policies and procedures.

In the event a sanction imposes a reprimand or probation, written communication is made to the provider requesting a full explanation which is then reviewed by the Credentialing/Peer Review Committee. The Credentialing Committee will make a determination as to whether the provider should continue participation, or whether termination should be made.

### **Hearing and Appellate Review**

A practitioner whose provider status with the Plan is recommended for termination for reason(s) that may require a report to be made to the National Practitioner Data Bank shall be entitled to a hearing and appellate review.

Notification of the termination recommendation, together with reasons for the action, hearing and appellate review rights, and the process for obtaining a hearing and appellate review, shall be provided to the practitioner within 30 days of the date of the termination recommendation. Notification to the practitioner shall be mailed by certified return receipt mail.

The practitioner shall have a period of 30 days in which to file a written request for a hearing and appellate review. The request shall be mailed via certified return receipt mail.

Upon timely receipt of the request, the chief executive officer or his designee shall notify the practitioner of the date, time and place of the hearing. Such hearing shall not take place less than 30 days from the date of the notice of the hearing.

The personal appearance of the practitioner requesting the hearing and appellate review shall be required. A practitioner who fails, without good cause, to appear and proceed at such hearing, shall be deemed to have waived rights to a hearing and appellate review.

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The practitioner and the Plan shall be entitled to legal representation at the hearing. The practitioner has the burden of proving by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis, or that such basis or the conclusion(s) drawn there-from, are arbitrary, unreasonable or capricious.

The Hearing and Appellate Review Committee shall consider and decide the case objectively and in good faith. Within 30 days after final adjournment of the hearing and appellate review, the Committee shall make a written report and forward its decision to the QI Committee. Notification of the Plan's final decision will be provided to the practitioner within 30 days.