

NHP/NHIC-Credentialing Process

Abstract/Purpose:

The purpose of credentialing is to provide a thorough review of physicians and other licensed practitioners or certified practitioners to ensure that prospective plan practitioners are qualified by education and experience and reflect commitment to high quality, cost effective medical care for participation in Network Health Plan/Network Health Insurance Corporation (NHP/NHIC).

I. **POLICY:**

The purpose of credentialing is to provide a thorough review of physicians and other licensed or certified practitioners to ensure that prospective plan practitioners are qualified by education and experience and reflect commitment to high quality, cost effective medical care for participation in Network Health Plan/Network Health Insurance Corporation (NHP/NHIC).

Credentialing is conducted in a manner that does not discriminate on the basis of age, sex, race, creed, color, national origin, or religion. A review will be conducted on every file that is denied by the credentials committee to ensure that the denial was non-discriminatory. The Medical Director or Designee will appoint a peer to review the denial to ensure that the decision was made in a non-discriminatory manner. Practitioners shall be notified within 60 calendar days of the committee's credentialing decision. Practitioners have the right, upon request, to be informed of the status of their credentialing application. In situations where there is a question regarding any primary source verification findings or if requested by the Credentialing Committee, additional investigation or review may be initiated. This policy applies to all practitioners including PPO practitioners when applicable (see related document Network Health Plan/Network Health Insurance Corporation PPO "When Applicable" Definition). This policy is consistent with Affinity Health System's mission and values of integrity, teamwork, service, and justice.

II. **Scope:**

NHP/NHIC will credential practitioners who have an independent relationship with the Plan. An independent relationship exists when Network Health Plan/Network Health Insurance Corporation selects and directs its members to see a specific practitioner or group of practitioners. Practitioners to which credentialing applies include:

- Doctor of Medicine (M.D.); Doctor of Osteopathic Medicine (D.O.); Doctor of Dental Science (D.D.S.) who provide care under the medical benefit program; Doctor of Podiatric Medicine (D.P.M.); Doctor of Chiropractic (D.C.); and Doctor of Optometry (O.D.).

- Behavioral Health care practitioners to include Psychiatrists and Physicians who are certified in Addiction Medicine; doctoral and/or master's level Psychologists (PhD, PsyD) who are state certified or state licensed; master's level Clinical Social Workers who are state certified or state licensed; master's level Clinical Nurse Specialists or Psychiatric Nurse Practitioners who are nationally or state certified or state licensed; and other Behavioral Health Care Specialists who are licensed, certified, or registered by the state to practice independently.
- Nurse Practitioners and Physicians Assistants who work in primary care settings, who provide direct patient care and make referrals to specialists or have prescriptive duties.
- APNP and Midwives who are licensed, certified or registered by the state to practice independently.
- Urgent care physicians and anesthesiologist who work outside the hospital setting.
- Genetic Counselors
- Audiologist

NHP/NHIC does not credential practitioners who practice exclusively within the in-patient hospital setting or within free standing facilities (e.g. surgical centers) who provide care for NHP/NHIC members only as a result of the member being directed to the hospital/facility. Practitioners to which credentialing does not apply includes:

- Anesthesiologists without Pain Management Practice
- Assistant Surgeon
- Athletic Trainers
- Critical Care
- Dieticians
- Emergency Medicine
- Hospital based urgent care
- Hospitalists
- Locum tenens
- Medical Toxicology
- Neonatal-Perinatal Medicine
- Nuclear Medicine
- Nutritionist
- Occupational Therapists
- Physical Therapists
- Speech/Language Therapists
- Pathologists
- Radiologists
- Radiation-Oncology
- Radiology-Vascular interventional

- NP/PA/RN/Surgical Techs in specialty practices

NHP/NHIC maintains the right to do an assessment of need on any given prospective practitioner requesting participation. This is based on number of practitioners per member, geographic location, and services provided.

All prospective plan practitioners must successfully complete the credentialing process before contract is executed. NHP/NHIC will not allow provisional or temporary credentialing of practitioners on the basis of incomplete credentials verification.

Only credentialed practitioners are included in the Network Health Plan/Network Health Insurance Corporation Provider Directory. No practitioner who falls within the scope of NHP/NHIC's credentialing will be listed individually by name in NHP/NHIC's Directory unless they have been credentialed for their specialty or subspecialty of practice. All listings in provider directories and other member materials shall be consistent with credentialing data, including education, training, certification, and specialty. Processes to ensure consistency include:

- A. obtaining complete information related to education, training, and board certification for each specialty or subspecialty in which the practitioner intends to practice
- B. auditing the accuracy of credentialing information in the Credentialer database, which is the source of provider directory information.

Network Health Plan/Network Health Insurance Corporation reserves the right to delegate credentialing and/or recredentialing activities as outlined in the Delegation and Oversight Policy and Procedure. Current credentialing/recredentialing delegated activities are outlined in Description Of Delegation Activities. (See related document.)

Credentialing Data Collection and Primary Source Verification:

Affinity Health System (AHS), the parent corporation in which NHP/NHIC is its wholly-owned subsidiary, includes the AHS Credentialing Verification Office (CVO). The AHS CVO collects credentialing data and conducts primary source verification, and as such is strictly a data gathering and verification resource for NHP/NHIC. The AHS CVO application and verification process is outlined in the Credentials Information Collection/Coordination/Dissemination policy and procedure (See related AHS policy Credentials Information Collection/Coordination/Dissemination). Completed credentialing applications and verified data are forwarded to the Medical Staff Services Department for assessment and are considered by the Credentials Committee. Information and verification is to be no more than 180 days old at the time of review and decision by the Credentials Committee.

Confidentiality:

All credentialing information received and all credential files, minutes, reports and any other material used to determine a credentialing decision is confidential and stored in a secure area in the Medical Staff Services Department. Disclosure of such information will not be granted unless consent for release of information has been signed by the applicant.

Office Site Visit/Medical Recordkeeping Practices:

(See Policy Site Visit and Medical Recordkeeping Practices.) Office site visits/medical recordkeeping practices are completed on all practitioners on a complaint basis within 60 (sixty) days of the complaint being filed.

Practitioner Notification:

The credentialing application includes a statement that notifies the practitioner of his/her right to review information obtained by the AHS CVO and the Medical Staff Services Department to evaluate their credentialing application. This evaluation includes information obtained by any outside primary source (e.g., malpractice insurance carriers, state licensing boards). A practitioner is not allowed to review references or recommendations or other information that is peer review protected. The credentialing application also notifies the practitioner of his/her right to correct erroneous information obtained from other sources that varies substantially from that provided by the practitioner, e.g. actions on a license, malpractice claims history or board certification decisions. Practitioners are informed of their right to request the status of their application. This right is found on the attestation page of the application. The AHS CVO will notify the practitioner by letter within ten (10) days of receipt of information and this notification will be documented in the practitioner's credentials file. The AHS CVO is not required to reveal the source of information if the information is not obtained to meet the requirements of the credentialing verification requirements or if disclosure is prohibited by law. The practitioner will be given ten (10) days to correct erroneous information submitted by another party. Corrections and/or additional information to the application must be submitted in writing to the AHS CVO and the receipt of such will be documented and retained in the practitioner's credentials file.

Approval Process:

The decision to accept a practitioner is based on the information available, including but not limited to, the information gathered through a completed

application and the verification of all collected information. Credentialing criteria is used to establish consistent, clear objectives for the credentialing of prospective practitioners. The following criteria are prerequisites for consideration by the Credentials Committee for participation as a practitioner of NHP/NHIC:

- General Credentialing Criteria:
To be credentialed, and recredentialed within Network Health Plan/Network Health Insurance Corporation for a specialty/subspecialty, all physicians, podiatrists, dentists and other practitioners must meet one of the criteria below:
 - Current board certification in the specialty or subspecialty in which the practitioner intends to practice, by ABMS, AOA, American Board of Podiatric Surgery, or Dental Specialty Certifying Board or
 - Completion of residency required for admission to the examination of such a certifying board in the specialty or subspecialty in which the practitioner intends to practice or
 - Satisfactory training and experience in the specialty or subspecialty, as measured by a $\frac{3}{4}$ majority vote of Credentials Committee practitioners who are present at the meeting.

Additional Credentialing Criteria for Physicians (M.D. and D.O.):

- Must hold a current, valid, unencumbered license to practice Medicine and Surgery in the State of Wisconsin. A license is unencumbered if it has not been subject of any adverse action, including but not limited to probation, suspension, revocation, imposition of conditions such as supervision of periodic reporting, restrictions on nature or scope of practice, or public or private censure.
- Must hold a current, unrestricted Federal Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate if applicable and with a state of Wisconsin address or evidence that the applicant does not require a DEA certificate in order to deliver appropriate care. An applicant with a pending DEA or CDS certificate may be credentialed provided that the applicant provides a written statement signed by a contracted NHP practitioner with a valid DEA or CDS certificate indicating that he/she will sign-off on all prescriptions requiring a DEA number until the applicant's DEA or CDS certificate is finalized.
- Must hold current malpractice coverage in which coverage pertains to area of practice or profession and meets the minimum limit requirement as specified by the Wisconsin Department of Regulations and Licensing. Must be current with Wisconsin Patient Compensation Fund assessments. New practitioners to the State of Wisconsin and who otherwise meet all other credentialing criteria may receive a ninety (90) day grace period from start date to become current with their Wisconsin Patient Compensation Fund assessments. Failure to become current with the Wisconsin Patient Compensation Fund within the time period

specified may result in termination.

- Must show absence of a history of professional liability claims including, but not limited to, lawsuits, arbitrations, settlements or judgments, or must show evidence that history of professional liability claims does not demonstrate probable future substandard professional performance.
- Must show absence of history of denial or cancellation of professional liability insurance or, must show evidence that history of denial or cancellation of professional liability insurance does not demonstrate probable future substandard professional performance.
- Must hold current permanent or temporary admitting privileges, in good standing and with appropriate/approved inpatient coverage arrangement; or must show evidence that the applicant does not require hospital privileges in order to deliver satisfactory professional services, e.g., practicing in immediate care service only or inpatient radiologist. If practitioner has not obtained plan hospital privileges and practitioner may potentially have the need to admit patients, the practitioner must have a written formal inpatient coverage arrangement agreed by contracted NHP/NHIC practitioner(s). The inpatient coverage arrangement must be approved by the NHP/NHIC medical director or designee.
- Must show absence of history of loss or limitation of privileges or disciplinary activity by a hospital or other health care facility or must show evidence that history of loss or limitation of privileges does not demonstrate probable future substandard professional performance.
- Must demonstrate an appropriate work history with acceptable explanations of any break in professional training and/or experience. Any work history gap of three months or more needs to be explained by the practitioner. Any gap that exceeds one year must be clarified in writing. Explanation of work history gaps must show evidence that this history does not demonstrate probable future substandard professional performance, conduct or business practices.
- Must show absence of history of any professional disciplinary action or sanctions by federal, state and local authorities, including each jurisdiction in which the practitioner practices or previously practiced to include, but not limited to:
 - being placed on probation, reprimanded, fined or having medical practice restricted by any agency that disciplines practitioners
 - Medicare or Medicaid reprimand, censure, disqualification, suspension or have voluntarily opted out
 - conviction of or indictment for a felony In the case of such history, must show evidence that this history does not demonstrate probable future substandard professional performance or probable

future unacceptable business practices

- All practitioners must demonstrate appropriate office and medical recordkeeping standards acceptable to Network Health Plan/Network Health Insurance Corporation or must show evidence of compliance to action plan to improve office sites and/or medical/treatment recordkeeping practices and to ultimately meet the standards should there be a complaint filed.
- Must show absence of a chemical dependency or substance abuse problem that might adversely affect practitioner's ability to competently and safely perform the essential functions of a practitioner in the same area of practice and applicant shows absence of physical or mental condition that may impair the practitioner's ability to practice within the full scope of licensure and qualifications, or may pose a risk of harm to patients. (See related policy Range of Actions to Improve Performance/Altering the Conditions of Participation)
- Absence of falsification of the application or material omission of information requested in the application.

Specific criteria for prospective practitioners other than M.D.'s and D.O.'s are listed as Specific Credentialing Criteria to this policy. (See related document.)

The application, attestation and primary source verification information is to be no more than 180 days old at time of the credentialing decision. If application/attestation becomes older than 180 days, the application is to be returned to the applicant for any updates and a new attestation form is to be signed and dated by the applicant attesting the application is correct and complete. If primary source verification becomes older than 180 days, the information will be re-verified by the primary source. State license, DEA certificate, and malpractice insurance policy must be current at time of credentialing decision.

Once the complete credentialing application and primary source information has been assessed against the established criteria, the application and file is forwarded to the NHP/NHIC Medical Director or designee for review. The Medical Director or designee will review the file and determine whether it meets credentialing criteria, and recommend the applicant's approval to the Credentials Committee at the next scheduled meeting or to pend recommendation for further review and discussion by the Credentials Committee.

A summary of all applications will be presented at the Credentials Committee meeting. Any credential files of practitioners will be made available and can be reviewed upon request at the Credentials Committee meeting. The Credentials Committee may accept the recommendations made by the NHP/NHIC Medical Director or designee or pend for further review and discussion. The final credentialing decision to approve or deny the applicant will be made by the Credentials Committee and shall be documented in the applicant's file and the

Credentials Committee meeting minutes.

The Medical Staff Services Department will notify the applicant of the credentialing decision by letter. If an applicant is rejected, if, and only if, for reasons related to quality of care, competence or professional conduct, Medical Staff Services Department will inform applicant of his/her right to an appellate review and may be required to report such findings to the State of Wisconsin Department of Regulation and Licensing, the National Practitioner Data Bank and/or the Healthcare Integrity and Protection Data Bank. (See related policy Fair Hearing and Appellate Review Process, Reporting to Proper Authorities).

NHP/NHIC Board of Directors has delegated accountability for credentialing/recredentialing decisions to the Credentials Committee, the Credentials Committee reports to the Quality Management Committee. In the case of an appeal, the Board of Directors makes the final decision. The Medical Director is ultimately accountable for the credentialing program and serves as a member of the Credentials Committee. The Medical Director reports through the Quality Management Committee to the Board of Directors on all credentialing activities. (See related policy Credentials Committee Membership & Responsibility.)

The application and supporting documents must be kept as a permanent record in the Medical Staff Services Department. The credentialing files on a participating practitioner are retained throughout the time period that the contract with NHP/NHIC remains effective. They are kept for a minimum of seven years after the date of contract termination. The identity of rejected applicants will also be retained.

NHP/NHIC-Recredentialing Process

Abstract/Purpose:

The purpose of recredentialing is to assure that Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) practitioners show continued competence by education, experience and continued commitment to high quality, cost effective medical care for continued participation in NHP/NHIC.

I. **POLICY:**

Recredentialing is conducted in a manner that does not discriminate on the basis of age, sex, race, creed, color, national origin, or religion. A review will be conducted on every file that is denied by the credentials committee to ensure that the denial was non-discriminatory. The Medical Director or designee will appoint a peer to review the denial to ensure that the decision was made in a non-discriminatory manner. Practitioners shall be notified within 60 calendar days of the committee's Recredentialing decision. Practitioners have the right, upon request, to be informed of the status of their recredentialing application. Review of information to evaluate continued participation of practitioners is ongoing and periodic. In situations where there is a question regarding any primary source verification or quality issue or if requested by the Credentialing Committee, additional investigation or review may be initiated. This policy applies to all practitioners including PPO practitioners when applicable (see related document Network Health Plan/Network Health Insurance Corporation PPO "When Applicable" Definition). This policy is consistent with Affinity Health System's mission and values of integrity, teamwork, service, and justice.

All credentialed NHP/NHIC practitioners as identified in the Credentialing Process must successfully complete the recredentialing process within a 36 month timeframe for a continued contract as a NHP/NHIC practitioner. However, practitioners whose credentialing or recredentialing required special consideration by the Credentials Committee are required to be reevaluated on an annual basis (every 12 months) or as determined by the Credentials Committee. (*See Range of Actions to Improve Performance/Altering the Conditions of Participation*).

Only practitioners who are currently credentialed are included in the Network Health Plan/Network Health Insurance Corporation Provider Directory. Education, training and certification relevant to each specialty/subspecialty in which a practitioner desires to practice will be assessed with each recredentialing cycle. If a practitioner desires to change his/her specialty/subspecialty between recredentialing cycles, this change would need to be presented to the Credentialing Committee for approval. No practitioner will be listed individually by name in

NHP/NHIC's Directory unless they have been approved by the committee for their specialty or subspecialty of practice. All listings in provider directories and other member materials shall be consistent with credentialing data, including education, training, certification, and specialty. Processes to ensure consistency include (a) obtaining complete information regarding education, training, certification, and specialty for each specialty or subspecialty in which the practitioner intends to practice, (b) auditing the accuracy of credentialing information in the Credentialer database, which is the source of provider directory information.

II. **Recredentialing Data Collection and Primary Source Verification:**

Affinity Health System (AHS), the parent corporation in which NHP/NHIC is its wholly-owned subsidiary, includes the AHS Credentialing Verification Office (CVO). The AHS CVO collects recredentialing data and conducts primary source verification, and as such is strictly a data gathering and verification resource for NHP/NHIC. The AHS CVO recredentialing application and verification process is outlined in the Recredentialing Information Collection/Coordination/Dissemination policy and procedure. Completed recredentialing applications and verified data are forwarded to the Medical Staff Services Department for assessment and are considered by the Credentials Committee. Information and verification is to be no more than 180 days old at the time of review and decision by the Credentials Committee.

Confidentiality:

All recredentialing information received and all recredentialing files, minutes, reports and any other material used to determine a recredentialing decision is confidential and stored in a secure area in the Medical Staff Services Department. Disclosure of such information will not be granted unless a consent for release of information has been signed by the applicant.

Practitioner Notification:

The recredentialing application includes a statement that notifies the practitioner of his/her right to review information obtained by the AHS CVO and NHP/NHIC to evaluate their recredentialing application. This evaluation includes information obtained by any outside primary source (e.g., malpractice insurance carriers, state licensing boards). A practitioner is not allowed to review references or recommendations or other information that is peer review protected.

The recredentialing application also notifies the practitioner of his/her right to correct erroneous information obtained from other sources that varies substantially from that provided by the practitioner, e.g. actions on a license, malpractice claims history or board certification decisions. Practitioners are informed of their right to request the status of their application. This right is found on the attestation page of the application. The AHS CVO will notify the practitioner by letter within ten (10) days of

receipt of information and this notification will be documented in the practitioner's credentials file. The AHS CVO is not required to reveal the source of information if the information is not obtained to meet the requirements of the credentialing verification requirements or if disclosure is prohibited by law. The practitioner will be given ten (10) days to correct erroneous information submitted by another party. Corrections and/or additional information to the application must be submitted in writing to the AHS CVO and the receipt of such will be documented and retained in the practitioner's credentials file.

Process for Ongoing Monitoring of Sanctions, Complaints, Adverse Events and Quality Issues:

Network Health Plan/Network Health Insurance Corporation monitors for sanctions and tracks complaints and quality issues against practitioners throughout the 36 month time frame between formal recredentialing. This is consistent with the Affinity mission and the Affinity values of service and integrity. This is done through monthly queries and reports from the Office of the Inspector General, the State of Wisconsin Department of Regulation and Licensing and Network Health Plan/Network Health Insurance Corporation's Complaint Database and Proactive Disclosure Service (PDS). This process is done on an automatic continuous monitoring basis with reports from the NPDB/HIPDB. This process means that as new information is received on an enrolled practitioner NHP/NHIC's Medical Director or Designee is alerted and appropriate action is taken in accordance with related NHP/NHIC policies. Also queried on a quarterly basis is the Medicare Opt Out Report. Findings of sanctions are reported to the Credentials Committee. Significant quality of care issues are reviewed by the Peer Review Committee which submit biannual reports to the Credentialing Committee for review and discussion. A corrective action plan is approved by the Committee as appropriate.

Approval Process:

The decision to retain or not retain a current practitioner is based on the information available, including but not limited to the information gathered through a completed recredentialing application and the verification of all collected information. Sanctions, complaints, adverse events and quality information are also used to evaluate the current practitioner. See Process for Ongoing Monitoring of Sanctions, Complaints, Adverse Events and Quality Issues. Recredentialing criteria is used to establish consistent, clear objectives for the recredentialing of current practitioners. The following criteria are prerequisites for consideration by the Credentials Committee for continued participation as a practitioner of NHP/NHIC.

III. Recredentialing Criteria:

To be recredentialed within Network Health Plan/Network Health Insurance Corporation for a specialty/subspecialty, all physicians,

podiatrists, dentists and other practitioners, such as but not limited to chiropractors and psychologists, must meet one of the criteria below:

- A. Current board certification in the specialty or subspecialty in which the practitioner intends to practice, by American Board of Medical Specialties (ABMS) , American Osteopathic Association (AOA) , American Board of Podiatric Surgery, or Dental Specialty Certifying Board or
- B. Completion of residency required for admission to the examination of such a certifying board in the specialty or subspecialty in which the practitioner intends to practice or
- C. Satisfactory training and experience in the specialty or subspecialty, as measured by a $\frac{3}{4}$ majority vote of Credentials Committee practitioners who are present at the meeting.

IV. **Additional Recredentialing Criteria for Physicians (M.D. and D.O.)**

- A. Must continue to hold a current, valid, unencumbered license to practice Medicine and Surgery in the State of Wisconsin.
- B. Must continue to hold a current unrestricted Federal Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate if applicable and with a State of Wisconsin Address or must show evidence that the applicant does not require a DEA or CDS certificate or does not require an unrestricted DEA or CDS certificate in order to deliver appropriate care.
- C. Must hold current malpractice coverage in which coverage pertains to area of practice or profession and meets the minimum limit requirement as specified by the Wisconsin Department of Regulations and Licensing. Must be current with Wisconsin Patient Compensation Fund assessments.
- D. Must continue to show absence of a history of professional liability claims including, but not limited to, lawsuits, arbitration, settlements or judgments; or must show evidence that history of professional liability claims does not demonstrate probable future substandard professional performance.
- E. Must continue to show absence of history of denial or cancellation of professional liability insurance or, must show evidence that history of denial or cancellation of professional liability insurance does not demonstrate probable future substandard professional performance.
- F. Must continue to hold current clinical privileges, in good standing, at a plan hospital; or must show evidence that the applicant does not require hospital privileges in order to deliver satisfactory professional services, i.e., practicing in immediate care service only. If plan hospital privileges are not held and practitioner may potentially have the need to admit patients, the practitioner must have a current written formal inpatient coverage arrangement agreed by contracted NHP/NHIC practitioner(s).
- G. Must show absence of history of loss or limitation of privileges or disciplinary activity by a hospital or other health care facility or,

must show evidence that history of loss or limitation of privileges does not demonstrate probable future substandard professional performance.

- H. Must continue to show absence of history of any professional disciplinary action or sanctions by federal, state and local authorities, including each jurisdiction in which the practitioner practices or previously practiced to include, but not limited to:
 - being placed on probation, reprimanded, fined or having medical practice restricted by any agency that disciplines practitioners
 - Medicare or Medicaid reprimand, censure, disqualification, suspension or have voluntarily opted out.
 - conviction of or indictment for a felony In the case of such history, must show evidence that this history does not demonstrate probable future substandard professional performance or probable future unacceptable business practices.
- I. Must continue to show absence of a chemical dependency or substance abuse problem that might adversely affect practitioner's ability to competently and safely perform the essential functions of a practitioner in the same area of practice and practitioner shows absence of physical or mental condition that may impair the practitioner's ability to practice within the full scope of licensure and qualifications, or may pose a risk of harm to patients. (*See Range of Actions to Improve Performance/Altering the Conditions of Participation*)
- J. The Absence of falsification of the recredentialing application or material omission of information requested in the application.

Specific criteria for practitioners other than M.D.'s and D.O.'s are listed as Specific Recredentialing Criteria to this policy. (*See related document.*)

The application, attestation and primary source verification information is to be no more than 180 days old at time of the recredentialing decision. If application/attestation becomes older than 180 days, the application is to be returned to the practitioner for any updates and a new attestation form is to be signed and dated by the practitioner attesting that the application is correct and complete. If primary source verification becomes older than 180 days, the information will be re-verified by the primary source. State license, DEA certificate, and malpractice insurance policy must be current at time of recredentialing decision.

Once the complete recredentialing application and primary source information has been assessed against the established criteria, the recredentialing application and file is forwarded to the Medical Director or designee. The Chairperson will review the Recredentialing file determine whether it meets recredentialing criteria, and recommend the practitioner's approval for continued participation to the Credentials Committee at the next scheduled meeting or to pend recommendation for further review and discussion by the Credentials

Committee.

A summary of all recredentialing applications will be presented at the Credentials Committee meeting. Any recredentialing files of practitioners will be made available and can be reviewed upon request at the Credentials Committee meeting. The Credentials Committee may accept the recommendations made by the Chairperson or pend for further review and discussion. The final recredentialing decision will be made by the Credentials Committee. In the instance of providers who fail to meet all recredentialing criteria, the Credentials Committee may approve, request submission of an action plan for improvement by the practitioner, limit recredentialing with further review, or terminate.

Recredentialing decisions shall be documented in the practitioner's file and the Credentials Committee meeting minutes.

The Medical Staff Services Department will notify the practitioner of the recredentialing decision by letter. If a practitioner is terminated for, if, and only if, reasons related to quality of care, competence and professional conduct, NHP/NHIC will inform the practitioner of his/her right to a fair hearing/appellate review and may be required to report such findings to the State of Wisconsin Department of Regulation and Licensing, the National Practitioner Data Bank and/or the Healthcare Integrity and Protection Data Bank. (*See Range of Actions to Improve Performance/Altering the Conditions of Participation, Fair Hearing and Appellate Review Process, and Reporting to Proper Authorities*).

NHP/NHIC Board of Directors has delegated accountability for credentialing/recredentialing decisions to the Credentials Committee, the Credentials Committee reports to the Quality Management Committee. In the case of an appeal, the Board of Directors makes the final decision. The Medical Director or Designee is ultimately accountable for the credentialing program and serves as a member of the Credentials Committee. The Medical Director reports through the Quality Management Committee to the Board of Directors on all recredentialing activities.

The recredentialing application and supporting documents must be kept as a permanent record in the Medical Staff Services Department. The credentialing files on a participating practitioner are retained throughout the time period that the contract with NHP/NHIC remains effective. They are kept for a minimum of seven years after the date of contract termination. The identity of terminated practitioners will also be retained.

Participation Reinstatement of Practitioners Who Terminated With NHP/NHIC

If a practitioner was successfully credentialed/recruentialed by NHP/NHIC, leaves NHP/NHIC, and then NHP/NHIC or the practitioner wants to reinstate participation in NHP/NHIC, the following procedure will be conducted:

- Practitioner will review and update most current application to include any additional training/work history and explanation of any gaps from time practitioner left NHP/NHIC to present.

- Practitioner will sign and date attestation form attesting that updated application is complete and correct.
- The AHS CVO will ensure that all previously verified information is still correct and will re-verify any time limited information.
- The complete application, attestation, and primary source information will be assessed against NHP/NHIC recredentialing criteria and forwarded to the Credentials Committee Chairperson for review and recommendation.
- A summary of the practitioner's reapplication will be presented to the Credentials Committee, along with the recommendation by the Chairperson. The Credentials Committee shall make the final decision on the practitioner's participation in NHP/NHIC.
- The practitioner must complete the above process before a contract is executed.

If leave extends beyond the next scheduled recredentialing cycle, the practitioner will need to complete a credentialing application and complete the credentialing process before a contract is executed.