	Tenet Physician Resources Policy Job Aid	No: JA.TPR.OPS.136.00
	Title: DELEGATED CREDENTIALING JOB AID	**Page:** 1 of 17 **Effective Date:** 12-10-18 **Retires Job Aid Dated:** 06-18-18 **Previous Versions Dated:** 01-15-18; 08-25-17; 12-15-16

I. JOB AID DEFINITIONS – unless otherwise defined in the corresponding Delegated Credentialing Policy TPR.OPS.136.00:

A. "**Clean File**" for a physician Provider means the credentialing file for Provider that meets the criteria set forth for employment under Tenet's Physician Employment Arrangements policy (L-10), the criteria for which is set forth as Exhibit A. "Clean File" for a non-physician Provider means the credentialing file for Provider meeting the same criteria for a physician Provider, as applicable for a non-physician Provider.

B. "**CMO**" means Tenet Physician Practice Chief Medical Officer or his/her designee.

C. "**Credentialing Committee**" or "**Committee**" means the committee, chaired by Tenet Physician Practice's Chief Medical Officer (CMO) or his/her designee, comprised of primary care providers and specialists, as deemed appropriate and as appointed by the Credentialing Committee Chair. Additional providers may be added to the Committee on an ad hoc basis at the request of the Credentialing Committee or its Chair.

D. "**Credentialing Committee Chair**" means a Tenet Physician Practice's Chief Medical Officer (CMO) or his designee.

E. "**Credentialing Team**" means employees or contractors of a Tenet Physician Practice responsible for gathering, obtaining, and maintaining documents and information for credentialing purposes.

F. "**Primary Source Verifications**" means the act of obtaining the Provider's credentials directly from the original or primary source.

G. "**Provider**" means a patient care provider employed by or contracted with a Tenet Physician Practice to provide patient care and has assigned his/her rights to bill and collect to the Tenet Physician Practice subject to these policies and procedures. Provider includes, but is not limited to, Medical Doctors (MD), Doctors of Osteopathy (DO), Doctors of Podiatric Medicine (DPM), Certified Physician Assistants (PA), Certified Nurse Practitioners (NP), Certified Registered Nurse Anesthetists (CRNA), Certified Nurse Midwife (CNW), and Registered Dietician/Diabetic Educators (RD/DE).

II. PROCEDURE:

A. Application for Participation

1. Each Provider for participation in a Tenet Physician practice's managed care plan must complete, in full, an Application for Participation ("Application") provided by the Tenet

Physician Practice's Credentialing Team, or its designee, within 30 calendar days of original request. Providers who practice exclusively in a hospital setting or free-standing facility do not need to be credentialed.

2. A CAQH Provider Application, State Mandate Application or Uniform Application will be completed and attested to within 180 days (120 days if using CAQH) prior to Committee review at the time of initial credentialing and re-credentialing. Addendum A – Additional Requirements will outline specific State Mandate Application.

3. The Application includes a current and signed attestation, within a 180-day timeframe, by the applicant as to the correctness/completeness of the application. The application must include, at minimum, the following information along with supporting documentation as appropriate, in addition to meeting the Provider Qualifications Criteria under Law Department policy L-10 Physician Employment Arrangements outlined in Exhibit A of the Delegated Credentialing policy and job aid:

   a. An attestation regarding the lack of illegal drug use.

   b. An attestation regarding any history of loss or restriction of medical license and/or felony conviction or any misdemeanor conviction involving health care fraud.

   c. An attestation regarding any history of loss or limitation of privileges or disciplinary activity.

   d. An attestation regarding any reasons for any inability to perform the essential functions of the position, with or without accommodations.

   e. A history of pending or resolved malpractice claims, filed within the past five years. If the Credentialing Committee judges a claim to warrant further investigation, Provider will make available all documents related to the case for evaluation and review, as requested by the Committee or its designee. The Committee may also request a more extensive claims history.

   f. Provider must have an absence of history of lapse, denial or cancellation of professional liability insurance; or, in the case of a Provider with this history, evidence to the satisfaction of Committee that this history does not indicate an unreasonable risk of future professional performance beneath the Tenet Physician Practice's desired standards.

   g. An attestation regarding qualifications to participate in any federal health care program(s) and any former or present charges of health care fraud or status as an excluded Provider.

h. Evidence of malpractice insurance with limits no less than $1,000,000/$3,000,000 unless the state defines specific claim limits as defined on Addendum A.

i. A signed release authorizing the Committee or its designees to consult with any medical organizations with which Provider has been associated and with any individuals who may have relevant information concerning Provider's qualifications or competence.

j. A description of at least 5 years of relevant work history including the beginning and end month and year for each work experience. Any gaps exceeding 6 months will be reviewed and clarified either verbally or in writing. An oral explanation of a gap must be documented in the credentialing file. Gaps that exceed one year must be clarified in writing.

k. Such other information and documentation for clean files as the CMO or Committee may request. No Application will be acted upon until the CMO or Committee determines, to its satisfaction, that it is complete.

4. Additional Minimum Criteria for Certified Nurse Practitioners and Certified Physician Assistants

a. In order for Provider's Application to be reviewed and approved by the Credentialing Committee, Provider must satisfy and continue to meet, at all times, at minimum, each of the following criteria:

1) Provider must have graduated from an accredited educational program.

2) Provider must provide copy of current Drug Enforcement Agency (DEA)/ Controlled Dangerous Substance (CDS) certificate, if applicable, or certification by Provider that no controlled substances will be prescribed by Provider. If the DEA/CDS is not registered in the state Provider is actively practicing, Provider may be taken to the Committee, but cannot begin seeing patients until such DEA/CDS certificate has been obtained/changed to the applicable Tenet Physician Practice address.

III. CREDENTIALING COMMITTEE

A. Information from Recognized Monitoring Organizations

1. The committee may consider relevant data which is available to it from hospitals, HMOs, PPOs, IPAs and other health care organizations concerning Provider's quality of care, including:

a. A history of professional disciplinary action, if any.

b. Patient satisfaction data or any complaints regarding Provider.

2. For non-clean Files, the Committee will also request and consider data from NPDB, the appropriate state licensing board, and any information regarding Medicare or Medicaid from any other appropriate source.

3. For non-Clean Files, the Committee will review the relevant concern logs and any Tenet Physician Practice peer review actions.

B. The Credentialing Committee retains the right to approve new providers and to terminate or suspend or recertify individual providers, on an individual basis, regardless of their hospital medical staff status or affiliation with any other organization.

C. Discrimination Monitoring

1. Credentialing decisions are not made based solely on the applicant's disability, race, ethnic identity, national origin, gender, age, sexual orientation, gender identity, religion or marital status. Decisions will not be based on serving high-risk populations or specializing in treatment of costly conditions. The Credentialing Team will continually monitor and prevent discrimination in the following manner:

a. All members of the Credentialing Committee will sign a statement affirming that they do not discriminate when making credentialing decisions.

b. Annual audits of credentialing files in all stages (denied, in process, approved, pending) will be performed to ensure practitioners are not discriminated against.

c. Provider's race, ethnic/national identity, gender, age, marital status and sexual orientation will be blinded by the Credentialing Team prior to being presented to the Credentialing Committee.

D. Credentialing Committee Decisions

1. The Committee and Credentialing Team will use best efforts to credential all new applicants prior to rendering services to patients.

2. Providers are notified of the initial and re-credentialing decision within 60 days of Credentialing Committee via electronic submission if approved.

3. Providers are notified of the initial and re-credentialing decision within 60 days of Credentialing Committee via certified mail if denied. The notification will include the reason of denial.

E. Credentialing Committee Meetings

1. Meetings may take place in real-time, virtual meetings (i.e., through video conference or Web conference with audio), but may not be conducted only through email.

2. Minutes of committee meetings are maintained in a confidential matter and the action(s) taken by the committee are documented and will indicate discussion of all applicants with any adverse findings. Minutes will be approved by the Credentialing Committee Chair or designee by signature as well as date of approval.

F. This Job Aid and the Delegated Credentialing Policy TPR.OPS.136.00 will be reviewed, revised and approved by the Credentialing Committee on an annual basis.

IV. INITIAL CREDENTIALING PROCESS:

A. The Credentialing Committee has delegated primary source verification process to the Credentialing Team.

B. The Tenet Physician Practice's credentialing staff, delegated entity or contracted National Committee Quality Assurance (NCQA), Certified Credentialing Verification Organization (CVO) conducts primary source verification as follows:

1. A current valid and unrestricted license to practice in the state(s) where the Provider provides care for the organization's members – an electronic query, written verification or oral verification is obtained from the appropriate state licensing agency.

2. A valid, unrestricted DEA/CDS certificate, if applicable – a copy of the DEA certificate or an electronic query of the National Technical Information Service (NTIS) database is obtained. Providers must have a DEA license with their practicing state address.

   Pending DEA Certificates – if the Provider is pending a DEA certificate, the provider may be credentialed by filling out a DEA waiver allowing another Tenet Physician Practice Provider with a valid DEA certificate to write all prescriptions requiring a DEA number on his/ her behalf until the Provider has a valid DEA certificate.

3. Board Certification – Verification will be used to verify the highest level of education and training obtained for the Provider as long as the Provider is board certified in the contracted specialty. Verification of a board certification is required only if the Provider states on the application that he or she is board certified. Indication of expiration or lifetime certification will be verified. If there is no expiration date for certification, the Board certification will be verified that certification is current and date of verification will be documented. Board certification is verified by one of the following methods, as applicable:

    a. American Board of Medical Specialties (ABMS) Compendium;

    b. American Medical Association (AMA) Master file, including American Academy of Physician Assistants Profile provided through the AMA Master file;

    c. American Osteopathic Association (AOA) Directory of Osteopathic Physicians;

    d. American Board of Physician Specialties (ABPS)

4. Non-Physician certification is verified by one of the following methods, as applicable, or confirmation from the state licensing agency (with proof of primary verification):

    a. American Board of Audiology (ABA)

    b. The American Midwifery Certification Board (AMCB)

    c. The American Board of Physical Therapy Specialties (ABPTS)

    d. American Association of Critical Care Nurses (AACN)

    e. American Association of Nurse Practitioners (AANP)

    f. ~~American Midwifery Certification Board (AMCB)~~ –

    g. American Nurses Credentialing Center (ANCC)

    h. American Speech-Language Hearing Association (ASHA)

    i. Board of Certification for the Athletic Trainer (BOC)

    j. Certified Hospice and Palliative Nurse (CHPN)

    k. Commission on Dietetic Registration (CDR)

    l. National Board of Certification in Occupational Therapy (NBCOT)

m. National Board on Certification and Recertification of Nurse Anesthetists (NBCRNA)

n. National Certification Board of Diabetes Educators (NCBDE)

o. National Certification Corporation (NCC)

p. National Commission for Certification of Anesthesiologist Assistants (NCCAA)

q. National Commission on Certification of Physician Assistants (NCCPA)

r. Pediatric Nursing Certification Board (PNCB)

s. The National Board for Certification of Orthopedic Physician's Assistants (NBCOPA)

5. Education and Training – For Providers who are not board certified, or if the certifying board does not perform primary source verification of education, verification of completion of residency or graduation of medical school shall be performed by one of the following methods:

   a. Oral Surgeons will need to have graduated from a Commission on Dental Accreditation (CODA) accredited training program;

   b. Confirmation from the residency or verify graduation of medical school directly from the institution;

   c. American Medical Association (AMA) profile, including: American Academy of Physician Assistants Profile provided through the AMA profile.

   d. American Osteopathic Association (AOA) profile

   e. Education Council Foreign Medical Graduates (ECFMG)

   f. Confirmation from the state licensing agency if the agency conducts primary verification or residency or graduation of medical school to include but are not limited to the Provider submitting transcripts that are in the institution's sealed envelope with an unbroken institution seal. If confirmation from the state licensing agency is used, a screenshot from the licensing agency website, indicating the primary source verification for education will be obtained and included in the provider's file.

6. Work History – The Credentialing Team will obtain a minimum of most recent five years of relevant work history through Provider's Application or Curriculum Vitae (CV). The Application must include the beginning and end month and year for each position the Provider has held

   The Credentialing Team will clearly identify each gap in employment that exceeds six (6) months and will clarify, in writing, all gaps in work history that exceeds one year.

7. Malpractice History – The Credentialing Team will obtain a minimum of the most recent five (5) years of Malpractice History through NPDB query. ~~Provider's Application or CV In addition, a query of the NPDB is performed.~~

   When Provider reports pending or paid claims and/or it is reported through the NPDB query, the information is flagged by the Credentialing Specialist and a "Claim Form" is completed by the Provider.

8. Malpractice Liability Insurance – a copy of the current malpractice liability insurance certificate that meets the coverage requirements required by a Tenet Physician Practice is obtained with the completed application (if coverage certificate is not yet available, a verbal verification form is completed by the Credentialing Specialist after direct contact with the malpractice carrier). The Tenet Physician Practice requires all Providers to attest to the dates and amount of their current malpractice coverage.

9. Hospital Admitting Privileges, if applicable – direct verification with facility or privilege letter sent to Provider. Date of appointment, scope of privileges, restrictions and recommendations are verified. If Provider does not have Admitting privileges, verification of admitting arrangements coverage may be obtained via a conversation with practice, physician or other sources and documented in the Provider file.

   a. Provider must provide documentation of medical staff membership and admitting privileges at a hospital, if applicable. Provider will be approved to perform inpatient services to the extent that he/she has been approved to perform such services by the hospital. If practice is limited to ambulatory medicine, inpatient coverage is to be available for Provider's patients 24 hours per day, seven days per week.

10. State Sanctions and Restrictions on Licensure and limitation on scope of practice via NPDB or an electronic query, including the State specific Sanctioned Provider List, written verification or oral verification is obtained from the appropriate licensing agency for the most recent 5-year period available in each state where the Provider provides care.

The Medical Board "Hot Sheet" and summary of administrative action reports to determine if any restrictions have been placed on the Provider's license, up to and including revocation.

11. Medicare/Medicaid Sanctions and Medicare Opt-Out

    a. List of Excluded Individuals and Entities maintained by the US Department of Health and Human Services Office of Inspector General (OIG) and National Practitioner Data Bank (NPDB) confirmation.

    b. General Services Administration (GSA) System for Award Management (SAM)

    c. The Medicare Opt-Out Report via https://data.cms.gov to determine if Provider has chosen not to participate in the Medicare reimbursement program for two (2) years.

12. National Plan and Provider Enumerations System (NPPES) National Practitioner Identifier (NPI) query

13. Social Security Administration's Death Master File

C. Site Visits, if required by state or Plan:

1. Initial Visit to Provider's Office: A representative of the Physician Integration/Onboarding Team or designee will conduct an initial visit to each potential Provider's office if mandated by state or Plan. The Physician Integration/Onboarding Team member or designee will conduct a structured review of the practice site and of the medical record-keeping practices to ensure compliance with NCQA standards and State regulations. These site visits will be completed prior to the physician being presented to committee.

2. Sites must meet performance standards and thresholds listed below (See attachment Site Audit Tool and Corrective Action Plan):

    a. Physical accessibility

    b. Access to the building is adequate, as evidenced by reasonable parking and/or feasible public transportation within walking distance

    c. Accommodations for persons with disabilities are available, evidenced by designated parking, loading zone, and/or public transportation within close proximity to the building such as:

        1) An external ramp (if applicable)

2) Automatic entry option or alternative access method

3) Elevator for public use (if applicable)

4) Restroom equipped with large stall and safety bars or other reasonable accommodation

d. Physical Appearance

1) Waiting room is clean and safe; well-lit; exam rooms are clean and orderly

2) Inside exit signs are clearly visible

3) Evacuation plan is posted inside building in a visible location

e. Adequacy of waiting and examining room space

1) Waiting room: no smoking is allowed in the office waiting area; there are posted office hours; there is adequate seating based on the number of patient visits per hour

2) Exam room: there are exam rooms provided for physical and auditory privacy for patients; there is adequate number of exam rooms per provider; there are separate containers for needle disposal and bio-hazardous waste

f. Adequacy of medical/treatment record keeping

1) Patient medical records are in a secure/confidential filing or electronic system

2) Patient medical records have legible file markers

3) Forms and methodology for filing within a chart is consistent

4) Patient medical records can be easily located

3. If deficiencies are identified, the site will be reevaluated, and if necessary, actions for improvement will be implemented. Evidence of a Corrective Action Plan (CAO) is documented. Recurring quality issues or complaints are deemed critical areas and must be met at 100% compliance.

a. Follow up must be conducted within 60 calendar days of the reasonable complaint threshold being met

b. Documentation of the site visit will be kept in the credentialing database

4. Any area deemed critical by the Physician Integration/Onboarding Team member or designee and failing to meet compliance must be corrected within 24 hours. Non-critical areas failing to meet compliance must be corrected within sixty (60) working days. Follow-up site visit will be conducted to ensure all areas have been brought into full compliance.

5. The Physician Integration/Onboarding Team or designee will follow the procedure as for an initial site visit with primary care Provider relocates or opens a new site, if required by state or Health Plan.

D. If Provider's employment terminates and the break in participation is more than 30 calendar days, the Provider must go back through initial credentialing.

E. Should Provider's practice be inactive for a 6 month period of time or greater, Provider will be asked to complete an Initial Application and will be processed as an Initial Credentialing file.

F. Temporary or Provisional credentialing may be granted within 14 days from the receipt of a complete application, accompanied by the documents identified in Section IV.B required for initial credentialing. Temporary or Provisional credentialing will only be considered at the request of a Health Plan when there is an identified network need.

V. RE-CREDENTIALING PROCESS

A. Provider will be required to continuously satisfy the Tenet Physician Practice's standards and criteria outlined under Section II and IV. Continued acceptance as a participant in managed care contracts entered into by a Tenet Physician Practice will be reviewed and renewed, at the Tenet Physician Practice's option, at least every three (3) years (36 months), or as state law requires outlined in Addendum A , for each participating Provider. The Provider will be contacted in writing as well as email transmission regarding the re-credentialing process at least ninety (90) days in advance to assure timely completion. The provider will be contacted a total of three (3) times with request to return documentation. If Provider fails to return required documents following the 3rd contact, Provider will be deemed inactive and prohibited to practice under the managed care plans impacted by this job aid and will be required to go back through the initial credentialing process. If Provider cannot be re-credentialed timely because Provider is on active military assignment, medical leave or sabbatical, Provider's file must be documented and re-credentialed within 60 calendar days of Providers return to practice.

B. Verification Process

1. Primary source verification addressed in Section IV.B will be followed at the time of re-credentialing.
2. Verification of work history and verification of education will not take place at the time of re-credentialing
3. Verification that a site evaluation has occurred for primary care Providers if required by state or Health Plan.

C. Quality and Performance Monitoring

1. Provider quality monitoring will be conducted and presented as part of the re-credentialing process to include performance issues and member complaints. The re-credentialing monitoring will be required as part of the Committee decision making process.

VI. DELEGATION OF CREDENTIALING ACTIVITIES

A. Tenet Physician Practices do not currently delegate any credentialing functions.

VII. ONGOING MONITORING

A. There will be on-going monitoring of provider sanctions, exclusions and complaints between re-credentialing cycles. Sanctions, exclusions and/or complaint data will be collected, reviewed within 30 days of release, and maintained in the Credentialing Team files. Appropriate action will be taken against Providers when occurrences of poor quality are identified. Ongoing monitoring will include:

1. Federal program sanctions list

   a. The OIG and GSA/SAM databases will be reviewed monthly for sanctions and exclusions to participate in any federally funded programs for all initial and re-credentialed providers; a copy of this verification will be included in Provider's credentialing file prior to being taken to committee.

2. Medicare Opt-Out Report

   a. Medicare Opt-Out Reports from Data.CMS.Gov will be queried and reviewed at the time of initial and re-credentialing application and will also be reviewed monthly by the Credentialing Team.

   b. The Credentialing Team will report to all contracted payers (insurance plans) within 15 days after the Credentialing Committee meets in writing of any reduction, suspension or termination action taken in accordance with applicable laws.

3. Sanctions or limitations on licensure

    a. State licensure board and State Sanctioned Provider activity will be monitored ongoing by the Credentialing Team for evidence of action taken against a provider.

        1) State licensing agencies: The Credentialing Team member will pull the most current sanction reports, including but not limited to:

            a) Applicable State Medical Board

            b) Applicable State Board of Osteopathic Examiners

            c) Applicable Board of Podiatry Examiners

            d) Applicable State Board of Nursing

            e) Applicable Board of Physician Assistants

            f) Medicare and Medicaid Sanctions

    b. For entities that do not publish sanction reports on a set schedule, information is queried at least every six months.

    c. Continuous query of National Practitioner Data Bank (NPDB) may also be used.

4. Complaint / QI Monitoring

    a. Complaint and QI monitoring is on-going by the Credentialing team. Data will be collected monthly and any trends reported to the Tenet Physician Practice's CMO, as well as when Providers are re-credentialed. At the CMO's direction, matter will be raised to the Committee. When the Committee deems it appropriate, complaints and concerns will be shared with the patient's health plan. Performance indicators collected may include one or more of the following:

        1) Utilization management system

        2) Member satisfaction surveys

        3) Medical documentation and record keeping audits

        4) Access studies

        5) Adverse events

6) Grievances/Complaints to include Health Plan complaints

7) Quality issues

b. When trends related to quality of care and/or service are identified, Tenet Physician Practice's CMO may work with Provider's to establish a corrective action plan (CAP) to improve performance prior to or in lieu of suspending or terminating Providers participation status. A written CAP may include but is not limited to the following:

1) Identify performance issues that do not meet expectations.

2) Identify actions/processes that will be implemented for correction

3) Determine how improvements will be assessed

4) Schedule follow-up, ongoing monitoring, not to exceed six months.

If corrective actions are resolved within the designated timeframe, the Tenet Physician Practice's CMO will determine the need to continue monitoring Provider's performance, as deemed appropriate. If the corrective actions are not adequately resolved within the designated timeframe, the Tenet Physician Practice's CMO may recommend that the Provider's continue on a CAP, recommend suspension or termination and/or present case to Credentialing Committee for review and decision.

5. Expirables

a. Update expired state licensure for providers upon expiration.

b. Update expired DEA and CDS for providers upon expiration

c. Updated expired COI for providers upon expiration

6. Internal OIG and GSA (SAM) Exclusion Screenings

a. All Credentialing Team employees, including temporary employees, interns, volunteers, consultants and any other Credentialing Team member who handles credentialing files will be screened against OIG and GSA (SAM) listing prior to hire and at least monthly thereafter. Any individual found on either exclusion list will not be offered a position and/or hired directly to work on Medicare or Medicaid business.

b. Any individual/entity found on either exclusion listing will be immediately removed from all Medicare or Medicaid business and plan sponsors will be notified.

VIII. CONFIDENTIALITY

A. The information gathered by the Credentialing Team and the resulting credentialing file for each Provider shall be confidential to the extent such information is not available to the public. Primary Source documentation available to the public at large shall not be considered confidential for the purposes of this Delegated Credentialing Job Aid or the associated Delegated Credentialing Policy (TPR.OPS.136). Practitioner authorization is required before any credentialing information is released to third parties, unless otherwise permitted or required by law.

B. All Credentialing Team members must review this Delegated Credentialing Job Aid as well as the associated Delegated Credentialing Policy (TPR.OPS.136) and acknowledge understanding of the security and confidentiality policies and procedures contained in these documents. All Credentialing Team members will also be required to sign the Tenet Physician Practice Confidentiality Agreement affirming that they will protect, during and after employment, any confidential information personally handled and will follow security procedures outlined.

IX. OVERRIDING STATE-SPECIFIC REQUIREMENTS

A. Notwithstanding the above provisions and to the extent this Job Aid does not otherwise align with the State-Specific requirements, including but not limited to those set forth in Addendum A to this Job Aid, the State-Specific requirements should be followed.

X. MEASUREMENTS

A. At minimum, quarterly audits of data elements, productivity metrics, accuracy and adherence to the Delegated Credentialing Job Aid will be performed by the Director, Manager or other designated individual of Tenet Physician Practice Credentialing. The National Director of Credentialing will audit adherence to this Delegated Credentialing Job Aid as part of random report query, process audits, reported issues and an annual review. Audit results will be presented to the Credentialing Committee quarterly.

B. Each member of the Credentialing Team will be placed on a probation period of 30 days or until all standards defined in section X have been consistently met with 99% accuracy. 100% of the credentialing files touched during the probation period will be audited by a designated individual of the Credentialing Team prior to being presented to the Credentialing Committee. After the 30 day probation period, if the Credentialing Team member has still not met the 99% accuracy requirement, re-training will be required.

C. An annual review of NCQA standards will be performed by the Credentialing Team. This Job Aid as well the corresponding Delegated Credentialing Policy TPR.OPS.136.00 will be updated accordingly. Review dates as well as outcomes will be documented in Credentialing Team files and presented to the Committee for approval prior to implementation.

XI. STANDARDS

A. Proof of Verification

1. If an oral verification is obtained, the credentials staff member must sign and date the document

2. If an internal or electronic verification is obtained, the Credentialing Team member must electronically sign and date the document. The Credentialing Team has an automated system that identifies each staff member with their own unique identifier number and a password is needed to access the system. The automated system identifies the credentialing staff member, date the individual verifies the information, the source and the report date is all captured.

B. 100% of credentialing factors will be no more than 180 days at the time of the credentialing decision.

XII. REFERENCES:

A. Law Department Policy L-10 Physician Employment Arrangements

B. Addendum A – Additional Requirements

C. Addendum B – Additional Process Information – NPDB and State Licensing Agencies

D. Addendum C – Health Plan Specific Contractual Requirements

E. Policies and Procedures

F. TPR.OPS.136.00 – Delegated Credentialing

XIII. ATTACHMENTS:

A. Site Audit Tool and Corrective Action Plan (CAP)

B. Credentialing Committee Minutes Template