



University of Utah Health Plans Credentialing Policy

Principles:

University of Utah Health Plans (U of U Health Plans) shall incorporate a credentialing program into the application procedures for network participation. U of U Health Plans has the right to make the final determination about which practitioners may participate in its provider networks.

Decisions about network participation are based upon the business needs of U of U Health Plans and the practitioner's credentials. U of U Health Plans does not discriminate based on race, gender, nationality, age, sexual orientation, or the type of procedure or patient in which the practitioner specializes.

The policy also includes procedures for verifying the Practitioners and Organizational Providers when they have met eligibility standards and requirements such as education, licensure, professional standing, services, accessibility, utilization, accreditation and quality. U of U Health Plans has an internal application system that tracks credentialing information.

Purpose:

To ensure, through reasonable efforts, the caliber, appropriate licensure and credentials, and quality of the practitioners who are allowed to provide treatment and services to U of U Health Plans members.

Scope:

Applies to All Lines of Business including Mountain Health Coop. Health Choice Utah (HCU) was acquired by U of U Health Plans in January 2021. If HCU credentials a provider, U of U Health Plans may or may not choose to use their credentialing verifications and vice versa, but these two plans will maintain separate credentials committees and policies.

- A. University of Utah Health Insurance Plans
 - 1. Medicare Advantage
 - 2. Commercial
 - 3. CoOP

- B. University of Utah Health Plans

1. Healthy U
 2. Healthy U Behavioral
 3. Healthy U Integrated
 4. H.O.M.E.
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Description:

A. Credentialing requirements must be met for any of the following:

1. Practitioners who have an independent relationship with University of Utah Health Plans (U of U Health Plans). An independent relationship exists when U of U Health Plans selects and directs its members to see a specific practitioner or group of practitioners, including all practitioners who members can select as primary care practitioners.
2. Practitioners who see members outside the inpatient hospital setting or outside freestanding, ambulatory facilities.
3. Practitioners who are hospital based, but who also see U of U Health Plans members as a result of their independent relationship from the organization.
4. Non-physician practitioners who have an independent relationship with U of U Health Plans and who provide care under Health Plans' medical benefits.
5. When rental network practitioners are used as part of U of U Health Plans' primary network and U of U Health Plans has members who reside in the rental network area. If the rental network is specifically for out of area care and members may see only those practitioners or are given an incentive to see rental network practitioners, they too will be credentialed.

B. Types of practitioners who need to be credentialed and re-credentialed:

1. Practitioners and group of practitioners with whom U of U Health Plans contracts must be credentialed prior to seeing patients. With the exception of Medicaid providers, practitioners must have successfully completed a master's level degree in the practice specialty and be licensed, certified or registered by the state to practice independently.
2. Providers may include unlicensed mental health workers or bachelor degree trained behavioral health practitioners as determined by regulatory requirements and/or as defined in Summary Plan Descriptions or U of U Health Plans administrative policy.
3. Providers who are licensed facilities will be credentialed as an organizational provider.
4. Table 1 identifies the types of medical and behavioral health practitioners that will be credentialed and the credentials that shall be present in the file.
5. Providers who are contracted for our Medicare line of business will be screened for Medicare Preclusions plus Medicare Opt Out in addition to NPDB and other routine Medicare sanction checks (OIG/GSA) to determine eligibility for participation in Medicare.

C. Practitioners who do not need to be credentialed include:

1. Covering practitioners (e.g. PRNs or short term locum tenens) who do not have an independent relationship with U of U Health Plans. If the provider is a locum tenens and is scheduled for a long term assignment with 3 or more months of consecutive work, health plans may choose to credential the provider, assuming the provider discloses this on his/her application.
2. Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner unless contracted to provide services for Medicaid
3. Students, residents, fellows unless contracted for Medicaid and providing behavioral health services or working in a 'moonlighting' or independent practice circumstance
4. Rental networks specifically rented for out-of-area care; whereby members are not directed or incentivized to see the rental network practitioners, (e.g. Multiplan, American Well, Universal Health Network and First Health practitioners)
5. Practitioners who practice exclusively within the inpatient setting, who provide care for Health Plans members only as a result of members being directed to the hospital or an ambulatory behavioral health setting credentialed as an organization or any other inpatient setting (commonly referred to as No Choice Providers), or who are not masters level degree trained but certified/licensed and require supervision by the state license agency. This list is a subset of these provider types:
 - i. All Acute Care In-Patient Providers
 - ii. Hospital Based Anesthesiologists
 - iii. Certified Registered Nurse Anesthetist (CRNA)
 - iv. Direct Entry, Lay Midwives (Doulas)
 - v. Emergency Room Physicians
 - vi. First Surgical or Medical Assistants
 - vii. Hospitalists
 - viii. Pathologists
 - ix. Hospital Based Radiologists
 - x. Dentists for primary dental care only under a dental plan or rider
 - xi. Pharmacists for pharmacy benefits management or utilization; if contracted for medication therapy management and/or diabetes education services pharmacists are subject to credentialing
 - xii. Board-certified consultants who do not provide traditional care
 - xiii. Contracted vendors for Huntsman Mental Health Institute (HMHI) Behavioral Health Network or the Miners Trust who are credentialed elsewhere

D. Practitioners credentialed through other entities:

1. Practitioners credentialed through Medicare Advantage supplemental vendor agencies fall outside scope of this credentialing policy. Such arrangements are within purview of the U of U Health Plans First Tier, Downstream and Related Entities oversight process.

Table 1 * Indicates that an exemption may be extended dependent upon providers practice specialty and care setting.

Provider Type by Degrees Known	States that License	States that do not License	License Verification Produced Y/N	Hospital Privileges/Admit Plan Required	DEA Required	Education /Training Deferred to Board	Board Certification Required	Work History	NPDB & Sanctions
Acupuncture ACU	MT, NV	WY, UT, CO, MT, ID	YES	NO	NO	YES	NO	YES	YES
Audiologist AuD	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Advanced Practice Nurse APRN/APN	UT, WY, ID, MT, NV, CO		YES	YES*	YES	YES	YES	YES	YES
Behavioral Analysts BCBA, ABCBA	UT, MT	ID, CO, NV	YES	NO	NO	YES	YES	YES	YES
Nurse Midwife CNM	UT, WY, ID, MT, NV, CO		YES	YES*	YES	YES	YES	YES	YES
Clinical Practice Nurse Practitioners CPNP	UT, WY, ID, MT, NV, CO		YES	YES*	YES	YES	YES	YES	YES
Clinical Nurse Specialists CNS	UT, WY, ID, MT, NV, CO		YES	YES*	YES	YES	YES	YES	YES

Provider Type by Degrees Known	States that License	States that do not License	License Verification on Produced Y/N	Hospital Privileges/ Admit Plan Required	DEA Required	Education /Training Deferred to Board	Board Certification Required	Work History	NPDB & Sanctions
Chiropractor DC	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Family Nurse Practitioners FNP	UT, WY, ID, MT, NV, CO		YES	YES*	YES	YES	YES	YES	YES
Occupational Therapists OT	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Optometrists OD	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Dentists & Dental Surgeons DDS/DMD	UT, WY, ID, MT, NV, CO		YES	DDS NO DMD YES*	YES	YES	YES	YES	YES
Osteopathic Physicians DO	UT, WY, ID, MT, NV, CO		YES	YES*	YES	YES	YES	YES	YES
Allopathic Physicians MD	UT, WY, ID, MT, NV, CO		YES	YES*	YES	YES	YES	YES	YES
Podiatrists DPM	All states		YES	YES*	YES	YES	YES	YES	YES
Licensed Clinical Social Workers LCSW, LMSW	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES

Provider Type by Degrees Known	States that License	States that do not License	License Verification Produced Y/N	Hospital Privileges/Admit Plan Required	DEA Required	Education /Training Deferred to Board	Board Certification Required	Work History	NPDB & Sanction
Physical Therapists PT, MPT DPT	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Physician Assistants PA, PA-C	UT, WY, ID, MT, NV, CO		YES	YES*	YES	YES	YES	YES	YES
Certified Diabetes Educators CDE, RD/ CDE PharmD/ CDE, RN/CDE	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES- BS OR MS TRAINING ACCEPTED FOR RN AND RD'S	NO	YES	YES
Speech Language Pathologists SLP	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Nurse Practitioners NP, DNP	UT, WY, ID, MT, NV, CO		YES	YES*	YES	YES	YES	YES	YES
Naturopathic Doctors ND	CO, MT, UT	ID, NV, WY	YES	YES*	YES	YES	YES	YES	YES

Provider Type by Degrees Known	States that License	States that do not License	License Verification Produced Y/N	Hospital Privileges/Admit Plan Required	DEA Required	Education /Training Deferred to Board	Board Certification Required	Work History	NPDB & Sanctions
Professional Counselors LCPC PC	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Licensed Marriage Family Therapists LMFT	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Addiction or Substance Abuse Counselors LAC LADC ADC CASUDC LAT	MT/ID	WY, UT, NV, CO	YES	NO	NO	YES	NO	YES	YES
Clinical Psychologist PhD PSYD	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Mental Health Counselors CMHC LCMHC MHC CMH	UT, WY, ID, MT, NV, CO		YES	NO	NO	YES	NO	YES	YES
Unlicensed Mental Health Workers for Medicaid		UT	NO	NO	NO	NO	YES Peer Support Specialists & Care Managers	NO	NO

- E. Verification source and application elements include:
1. All applications are reviewed by the Credentialing Staff and/or Chief Medical Officer or his/her designee as appropriate for accuracy and completeness. The application must be signed and attested to the correctness and completeness by the health care professional within 180 days of the credentials committee decision. In rare cases a release date may be older than 180, but not older than 360 days old.
 2. Prior to sending applications to committee for consideration, U of U Health Plans staff shall document that the Credentialing Verification Organization (CVO) has completed verification by NCQA approved primary sources for the following elements within specified time limits:
 - i. Valid, current and unrestricted license to practice in State(s) where U of U Health Plans has contracted with the provider. Verification completed with each state's licensing agency. (e.g. in Utah - www.DOPL.utah.gov.) Must be effective at the time of credentialing decision. Verification time limit: 180 calendar days.
 - ii. DEA or CDS Certificates if applicable – will be checked via an approved third-party verification service authorized by the DEA. Certificate is an acceptable source and needs to be current at the time of the credentialing decision. Verification time limit: Prior to credentialing decision.
 - iii. Hospital Privileges or Admission Plan if applicable – will be checked via application as U of U Health plans contractually obligates certain practitioners to have hospital privileges in good standing and admit members to a participating hospital, or have an admission plan in place with a participating physician who can admit members to a participating hospital. Exemptions to having hospital privileges shall be extended to any provider in a care setting that has a formal agreement with a participating hospital system and their hospitalist teams to manage the plan's members cared for by the provider. Urgent care providers will be exempt if they refer to participating emergency room providers. Verification of privileges in good standing can be by application attestation or primary source; if a primary source letter is obtained the verification time limit will be 365 calendar days.
 - iv. Education and Training (Initial only) – Highest level of education must be primary source verified. This includes Board Certification if applicable, Residency or Medical School. Acceptable Verification Sources for Education – State licensing agency, specialty board or registry, if it performs primary source verification, sealed transcripts, AMA, AOA, FCVS for closed residency programs. If a practitioner requests a change in specialty mid-cycle, the highest level of Education/Training and License will be primary source verified. Verification time limit: Prior to decision date.

- v. Board Certification is preferred, but not required – A sample list of accepted Boards is provided in another section of the policy. Verification time limit: 180 Calendar days and effective on decision date if the practitioner includes it on their credentialing application.
- vi. Work History – (Initials Only) via CV or credentialing application which should include the past 5 years and should be relevant to the position being sought. Primary source verification is not required. If fewer than 5 years, the period should start at the time of initial licensure. Should include the beginning and ending month and year. Gaps greater than 6 months must be explained in writing. Verification time limit: 365 calendar days.
- vii. Professional Liability Coverage – via credentialing application or certificate of coverage if supplied. Must state coverage amounts and date coverage expires. Coverage must be current at the time of attestation. Verification time limit: 180 calendar days.
- viii. Malpractice History –via www.NPDB.hrsa.gov, www.OIG.hhs.gov and www.SAM.gov. NPDB will be queried to verify a history of professional liability claims resulting in settlements or judgments paid on behalf of the practitioner or state licensing sanctions and the other sources will be queried for Medicaid or Medicare sanctions. Verification time limit: 180 calendar days.
- ix. Eligibility to participate in Medicare will be verified using NPDB, OIG, GSA and the pre-exclusion and opt out listings in the public domain. The CVO currently produces an inclusive verification called FACIS that retrieves information on an ongoing basis to this effect. Verification time limit: 180 calendar days.
- x. Applications submitted to the credentials committee will include questions and applicable explanations if the practitioner has any limitations to perform functions of the position with or without accommodation; history of loss of license and/or felony convictions and history or loss or limitation of privileges or disciplinary activity. Verification time limit: 365 calendar days.

F. Criteria for Credentialing and Re-credentialing include:

1. At its sole discretion, U of U Health Plans will determine whether the practitioner/organizational provider meets the minimum requirements prior to the credentialing or re-credentialing application being processed. A determination that an individual does not meet minimum requirements constitutes a dismissal of the credentialing request and does not constitute a denial of network access.
2. An individual who raises any Category IV issues (below) by definition does not meet minimum requirements for network eligibility.
3. A re-credentialing application is processed every 36 months. An extension will be granted to any provider who is on active military assignment, medical leave

(e.g. maternity leave) or on sabbatical. A documented return date to practice would be captured in the U of U Health Plans provider data base and the provider would be re-credentialed within 60 days of his/her return to practice. Otherwise, if a provider does not meet their re-credentialing date they will be notified and treated as an initial applicant.

4. Recredentialing files may include performance indicators such as results from site visits stemming from complaints, appeals or grievances from customers, fraud, waste or abuse audit results conducted by the health plans' special investigations units if any were conducted and if any potential quality of care incidents where the practitioner was involved in the past 36 months.
5. Solo practitioners who fail to re-credential within 30 days of their reappointment date will result in a full contract termination. Practitioners affiliated with a group contract, will be unaffiliated, but the group contract will remain in force. If 30 days or more transpire post termination, providers must reapply and will be treated as initial applicants.
6. All practitioners who require Credentialing shall be required to successfully complete the Category I (Clean file) requirements prior to being deemed a participating practitioner, providing care to members, being listed in the provider directories and submitting claims for services provided to members.
7. Practitioners/Organizational Providers who do not satisfy a specific requirement for participation may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed the criteria in question. U of U Health Plans may grant waivers after considering the specific qualifications of the individual in question, and the best interests of the community the provider serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals. No individual/organizational provider is entitled to a waiver or a hearing if U of U Health Plans determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a denial of network access.
8. U of U Health Plans uses the following categories to determine how to process each file:
 - i. Category I File (Clean) - Applicants for U of U Health Plans panel participation must be able to meet the following minimum requirements to be considered a Category I:
 - If applicable, the applicant has successfully graduated from an accredited school of medicine, osteopathy, podiatry or dentistry.
 - If applicable, the applicant has successfully completed an internship and residency program.
 - The applicant has a current unrestricted license in good standing to practice medicine, osteopathy, podiatry, or dentistry in State(s) where contracted to practice, and where

applicable, has a current, unrestricted DEA registration and state controlled substance license.

- A completed Council for Affordable Quality Healthcare (CAQH), CVO, or U of U Health Plans Organizational Provider credentialing application with a signed attestation that has not been flagged category III or IV. The applicant attests to the correctness and completeness of all information furnished and acknowledges that any significant misstatement or omission from the application constitutes grounds for a discovery that the Practitioner/Organizational Provider did not meet criteria for participation in the provider network, agrees to abide by the policies and procedures. U of U Health Plans accepts faxed, scanned, digital, electronic and photocopied signatures. Signature stamps will not be accepted.
- There are no discrepancies in information received from the applicant or references.
- The applicant has no malpractice history.
- The applicant has valid, professional liability insurance coverage satisfactory to U of U Health Plans, with limits of dollar amounts, name of company and expiration date. Insurance coverage must be current at the time of attestation.
- Preferred board certification in the specialty(s) in which they practice medicine. U of U Health Plans will verify board certification as the highest level of Education if it is included in the credentialing application. **A practitioner may be considered for participation if they have completed a residency program in the specialty in which they are practicing. ***Practitioners who are not board certified and have not only completed 1 year of postgraduate training will ONLY be eligible for participation as a General Practitioner. The practitioner is responsible to notify the Credentialing Committee of any additions to or loss of his/her board certification.
- A sample of accepted Board certifying entities are listed in Table 2

Table 2

ABMS.org	ABPMED.org	NURSECREENTIALING.org	AASM.org
AOA.org	AANPCERT.org	BOARDCERTIFIEDDOCS.org	ABIM.org
ABOMS.org	ABSURGERY.org	AMCBMIDWIFE.org	BACB.com
ABFAS.org	AANP.org	ABFM.org	NCCPA.net

- ii. Category II (Fast Track) For an applicant's file to be considered Category II, the credentialing cycle must be in danger of expiring, or one of the primary source documents must be in danger of expiring. Category II files must also meet Category I criteria, under Category I (Clean Files), in order to be considered for "Fast Track". The Credentialing Committee Chair/Chief Medical Officer or his/her designee will have the authority to approve and fast track approve Category I and II files for network participation when the situation warrants.
- iii. Category III (Consent) For a file to be considered Category III, the applicant's file will be flagged for Committee by a U of U Health Plans Credentialing Consultant, but does not warrant a Category IV designation. These files will be flagged Category III for informational purposes for committee review and approval. Category III files also enable the Credentialing Committee to watch for patterns of aberrant behavior and or license disciplinary actions or sanctions.
- iv. Category IV (Discussion) Evidence of one or more of the following may cause the provider's application to be flagged for committee discussion as a Category IV:
 - The applicant has had a license to practice revoked (includes with a stay of revocation), suspended, or placed on probation by any state licensing agency within the past 5 years for an Initial applicant, or since the last re-credentialing cycle. Some license actions may result in disqualification from the U of U Health Plans Provider Network if the necessary rehabilitation has not been completed. Providers with encumbered licenses do not meet credentialing criteria but may be considered for a credentialing waiver
 - The applicant has in the past 10 years had their medical staff appointment or privileges denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct. In addition, applicant has resigned medical staff privileges in the face of an investigation or to avoid an investigation.
 - The applicant has in the past 10 years been convicted of any felony, or of any misdemeanor relating to the practice of medicine, including controlled substances, governmental or private health insurance fraud or abuse, or violence, and does not have a current Medicare or Medicaid sanction imposed restricting treatment of Medicare or Medicaid members. Applicants with felony convictions that are greater than 10 years old may be eligible for network participation at the sole

discretion of U of U Health Plans. Applicants whose sanctions have been cleared may re-apply as initial applicants, so long as it can be proven that the provider is no longer excluded by Medicaid/Medicare, and the State Medicaid Agency acknowledges the health plan is permitted to proceed with the credentialing application.

- The applicant's history of medical malpractice claims or professional liability claims must not reflect what, in the sole discretion of U of U Health Plans, constitutes a pattern of excessive claims history either due to the number of claims, the amount of the claims, or a pattern of similar issues as specified in Table 3.

Table 3

Specialty	Claim Threshold	or	Claim Frequency
	Any Settlement in Past 5 Years involving a death or Greater Than:		Number of Settlements in the Last 5 Years Incident Date
Allergy & Immunology	\$200,000		
Dermatology	\$200,000		
Internal Medicine	\$200,000		
Family Medicine			3
Pediatrics	\$200,000		
Physician Assistants	\$200,000		
Endocrinology, Diabetes & Metabolism	\$200,000		
Gastroenterology	\$200,000		3
Infectious Disease	\$200,000		
Psychiatry	\$200,000		3
Cardiovascular Disease	\$200,000		
Emergency Medicine	\$200,000		
Hematology	\$200,000		
Hematology & Oncology	\$200,000		3
Nephrology	\$200,000		
Neurology	\$200,000		
Pulmonary Disease	\$200,000		
Surgery	\$250,000		3
Physical Medicine and Rehabilitation	\$250,000		
Urology	\$250,000		3
Ophthalmology	\$500,000		
Otolaryngology			3
Podiatry			
All Behavioral Health Providers	\$500,000		
Thoracic Surgery (Cardiothoracic Vascular)	\$1,000,000		
Gynecology	\$1,000,000		
Neurological Surgery	\$1,000,000		3
Orthopedic Surgery	\$1,000,000		
Plastic Surgery	\$1,000,000		
Vascular Surgery	\$1,000,000		
Obstetrics & Gynecology Nurse Practitioner/Advanced Practice Registered Nurse/Clinical Nurse Specialist/ Certified Nurse Midwife	\$1,000,000		3

G. Process for Making Credentialing and Re-Credentialing Decisions

Prior to a Practitioner/Organizational Provider seeing a U of U Health Plans member, it is U of U Health Plans' practice to ensure all applicants are credentialed. The following process is followed to ensure all applicants are reviewed and/or voted on by the Credentialing Committee.

1. Credentialing Consultants will flag the file before sending it to U of U Health Plans for committee review, if there are issues
2. Files determined to fall under Categories III and IV are taken to committee for review
3. Those files that the Committee Chair/CMO or their designee determines need further review or do not have enough information will be put on the next credentialing meeting agenda for discussion
4. A pre-meeting review with Credentials Committee Chair/CMO or their designee, as well as a Director of Provider Network Management to get input may be held prior to the committee meeting
5. All primary source verified files get uploaded into the U of U Health Plans provider database before committee, and a credentialing staff member(s) runs Clean Files Report from the U of U Health Plans provider database, as well as Malpractice Files Report from the U of U Health Plans provider database.
6. Credentialing Committee reviews files presented according to category:
 - i. For Category I – Approval for clean files assigned a Category I can occur in one of two ways; first the U of U Health Plans CMO or their designee and/or current chair of the credentials committee can receive and sign off on a report of clean files. Evidence of review and approval will include a digital signature that has a unique electronic identifier to show appropriate controls for ensuring that only the designated medical director or qualified physician can enter the electronic signature. The other option is to present a full report of the files to the committee and have them approved by unanimous vote. All approvals will be uploaded into the U of U Health Plans provider database after the committee has adjourned.
 - ii. For Category II – All fast track files will be ratified by vote of the Credentials Committee and all approvals will be uploaded into the U of U Health Plans provider database after the committee has adjourned.
 - iii. For Category III – All consent agenda files will be reviewed and voted on during committee. All approved will be uploaded into the U of U Health Plans provider database after the committee has adjourned.
 - iv. For Category IV – After a committee discussion of each individual file, all decisions will be uploaded into the U of U Health Plans provider database after the committee has adjourned

7. After decisions have been entered, all applicants with a final decision will have their status deactivated at CAQH.
8. For those applicants who did not meet minimum eligibility criteria, they will be marked as “Denied” in the provider database, as well as removed from the CAQH rosters.
9. Any applicants whose decision has been tabled for more information by the committee will be researched to get the applicable information before the next committee meeting.
10. Within 30 days, approval letters will be generated and sent to each applicant notifying them if they were approved or did not meet criteria.

H. Process for Delegating Credentialing or Re-credentialing

U of U Health Plans delegates its credentialing to approximately 30 entities, in an effort to avoid duplicating the credentialing process undertaken by another organization and maximize efficiency. U of U Health Plans shall enter into a delegation agreement with an organization already performing credentialing of practitioners and organizations shared by both entities. The following requirements must be met prior to entering into an agreement:

1. Group must pass a pre-assessment policy review, if entering into a new delegation agreement.
2. Automatic Credit for the pre-assessment of files may apply if delegated entity is an NCQA Accredited Group, fully complies with U of U Health Plans credentialing requirements, and criteria for practitioner selection follows NCQA and CMS Standards.
3. Once the pre-assessment policy review has been successfully completed and U of U Health Plans has signed the delegation agreement the following requirements apply:
 - i. Delegated Entity provides U of U Health Plans with a roster of all participating practitioners including information specified in delegation agreement
 - ii. Delegated Entity submits annually written Policies and Procedures that correspond to NCQA and CMS Standards
 - iii. Delegated Entity performs verification of credentialing elements specified in delegation agreement
 - iv. Delegated Entity provides evidence that re-credentialing of practitioners is completed within the three year time frame and credentialing control standards are met on an on-going basis
 - v. Delegated Entity provides U of U Health Plans with updates on providers at least semi-annually
 - vi. Delegated Entity agrees to assume responsibility for penalties for non-compliance with the delegation agreement

- vii. Upon request the Delegated Entity shall be required upon request to submit to U of U Health Plans redacted minutes of their credentialing meetings
 - viii. Delegated Entity shall be required to report all adverse events to U of U Health Plans within 30 days after notification of the adverse event.
 - ix. On a quarterly basis, the Delegated Entity shall submit sufficient information to U of U Health Plans for U of U Health Plans to set up the approved practitioners in the claims system, add them to its directories and term practitioners no longer with the Delegated Entity
 4. Delegation agreements are entered into on a case by case basis and each Delegated Entity must follow steps identified above, as well as maintain complete credentialing files on all practitioners covered by the agreement and make files available to the U of U Health Plans credentialing team upon request.
 5. At least once a calendar year, U of U Health Plans will audit every delegate's policies and any delegate who is not currently NCQA accredited, must present credentialing files to ensure that at minimum they are meeting the current NCQA credentialing standards. U of U Health Plans will use the 8/30 methodology of reviewing audit files and a Corrective Action Plan (CAP) shall be required from the Delegated Entity if the audit score is less than 90%. A report of each delegation audit will be presented to the next available credentials committee for review and approval.
- I. Process for Ensuring that Credentialing and Re-Credentialing are Conducted in a Non-Discriminatory Manner
 1. U of U Health Plans does not make contracting or credentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type in which the applicant specializes. Additionally U of U Health Plans does not prohibit or restrict providers from acting within their lawful scope of practice or discriminate against health care professionals who serve high-risk populations or who specialize in the treatment of costly conditions. U of U Health Plans follows these steps in an effort to prevent discrimination:
 2. Each January, credentialing staff members review committee minutes from the prior calendar year, and/or reports from the U of U Health Plans provider database to identify patterns of acceptance / non-acceptance that would indicate possible discrimination.
 3. A report of the findings is reviewed and signed by a Director of Provider Network Management annually shall be placed with a print out of the log sheets in the Discrimination Monitoring binder.
 4. If it was determined that discrimination based on one of the characteristics or situations listed above may have taken place, the following steps will be taken:

- i. A more detailed review of the affected providers' applications will be conducted by the CMO or their designee and a Director of Provider Network Management to gather supporting facts.
 - ii. If the facts support the alleged discrimination:
 - iii. a corrective action plan will be developed and implemented, and
 - iv. an additional audit of the current year's applicants will be reviewed 6 months later
- J. Process for Notifying Practitioners if Information Obtained During the Credentialing Process Varies Substantially from the Information Provided
 1. If information obtained during the credentialing verification, process varies substantially from information the practitioner submitted in the application, staff will request clarification from the provider via e-mail, phone or through our CVO.
 2. Practitioners are notified of this and how to submit corrections via U of U Health Plans' website: www.uhealthplan.utah.edu, as well as in the Provider Manual available on the U of U Health Plans website.
- K. Process for Ensuring that Practitioners are Notified of Credentialing Decisions within 30 Calendar Days of the Credentialing Committee's Decision
 1. Initial applicants shall be notified in writing via letter by a member of the Credentialing team regarding the Credentialing Committee decision. This notification shall be made within sixty (60) days of the committee's decision.
 2. In situations where the applicant did not meet criteria, the Committee Chair/CMO or their designee will notify the applicant via a certified letter, detailing reasons for the decision.
 3. If the Credentialing Committee tables an applicant, this is noted in the U of U Health Plans provider database and U of U Health Plans requests the missing information via email or certified letter. Re-credentialing applicants are considered approved unless they are notified otherwise.
- L. CMO or Other Designated Physician's Direct Responsibility and Participation in the Credentialing Program
 1. The Committee Chair is appointed by the University of Utah Health Plans Chief Medical Officer. The Committee Chair has the authority to appoint committee members unless otherwise specifically provided.
 2. The Committee Chair approves the credentialing committee minutes, as well as chairs the committee meeting. In preparation for the monthly committee meetings, the Credentialing Manager and select members from the Contracting team review all sanctioned applicant files and make recommendations.
 3. Additionally, the Committee Chair has the authority to fast track approve Category II files (those files whose credentialing will expire before the next committee meeting) and approve Category I "clean" files for network

participation when the situation warrants as outlined in approved Committee policies

M. Process for Ensuring Confidentiality of all Information Obtained in the Credentialing Process, Except as Otherwise Provided by Law

1. U of U Health Plans maintains the confidentiality of all records, discussions, and deliberations obtained in the credentialing process, peer review and quality improvement activities, pursuant to Utah Code Annotated §26-25-1, for the purpose of evaluating health care rendered by hospitals or physicians and is NOT PART of the medical records. It is also classified as "protected" under the Government Records Access and Management Act, Utah Code Annotated §63G-2-101 et seq.
2. Disclosure of any information or documentation contained in practitioner credentials files will be permitted only as described in this policy. All minutes, reports (including those from outside consultants), recommendations, communications, and actions made or taken pursuant to this Policy shall be treated as confidential; provided that reports of actions taken pursuant to this Policy shall be made by the University Legal Counsel to such governmental agencies as may be required by law.
3. Any breach of confidentiality may result in a professional review action, and/or appropriate legal action to ensure that confidentiality is preserved. The committees and members charged with making reports, findings, recommendations, or investigations pursuant to this Policy shall be considered to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq., and are intended to be covered by the provisions of Utah Code Ann. §26-25-1; §26-25-3; §26-25-4; §58-13-4; and §58-13-5, or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.
4. Members of the Credentialing Committee are educated regarding state and federal peer review statutes by which they are bound, and annually sign and abide by the U of U Health Plans Confidentiality and Nondiscrimination Attestation.
5. Historically, all electronic files were stored on secured network drive. Presently, copies of a practitioner's credentialing application, verifications and any other documents necessary to the credentialing process for Category III, IV and facility files are stored in the practitioner's electronic file on the secured network. All credentialing primary source verifications are stored securely within our CVO's electronic platform. The credentialing operation at U of U Health Plans is completely paperless.

N. Process for Ensuring Listings in Practitioner Directories or Other Materials for Members are Consistent with Credentialing Data

1. To ensure that printed materials are consistent with data collected during the credentialing process, U of U Health Plans follows processes as outlined in the credentialing workflow. Provider Data Management Coordinators do roster reconciliations with rosters from contracted groups as well as updates from provider directory attestations and self-reported demographic changes. Self-reported demographic changes related to credentialing data are verified with the Credentialing department. U of U Health Plans makes sure that practitioners who should be listed in the printed directories have correct information by proofing each directory at least monthly, or as required, and through provider directory attestations. Typically, only practitioners that a patient would make an appointment to see are listed in the directories. "No Choice" practitioners such as Radiologists, Emergency Medicine, Pathologists, Anesthesiologists and Hospitalists are not usually listed.
2. Provider directories and updated provider search engine are generated from the U of U Health Plans provider database as needed and available on our website www.uhealthplan.utah.edu.
3. Members can also call Customer Service at 801-587-6480, opt 2 for assistance finding a practitioner.
4. Members may request a printed provider directory by contacting Customer Service at 801-587-6480, opt 2.

O. Practitioner Rights

1. The applicant shall have the right to be informed of their application status (Ready for Committee, App In-process, App Incomplete or Missing Information) upon request. The request shall be made via email to: provider.credentialing@hsc.utah.edu, or by phone to 801-587-2838, opt 3.
2. Information on Practitioner Rights can be found in the Provider Manual on our website: www.uhealthplan.utah.edu. Emails and voicemails will be responded to within 2 business days.
3. The Practitioner will have the opportunity to correct any erroneous information, as applicable, during the 2-3 month credentialing process. Applicants are notified of this right through our Provider Manual and website: www.uhealthplan.utah.edu
4. Erroneous information must be changed on the CAQH application or facility application and re-signed/re-dated. Any necessary corrections will be communicated to our CVO within 2 business days
5. Re-verifying primary source verifications if necessary. Corrections can be submitted to: provider.credentialing@hsc.utah.edu or facility.credentialing@hsc.utah.edu

6. Upon request, applicants may review the information they have submitted in support of their credentialing or re-credentialing application, including but not limited to:
 - i. information from outside sources
 - ii. malpractice insurance carrier face sheet
 - iii. state licensing board
 - iv. DEA agency verification
 - v. education verification letter from a school
 - vi. board certification verification, if applicable
7. U of U Health Plans is not required to reveal sources of information that are not part of our verification requirements or if federal or state law prohibits us, such as NPDB reports. The applicant may view their file in the presence of the U of U Health Plans Credentials Committee Chair and a member of the credentialing team. Applicants are notified of these rights in the Provider Manual and website: www.uhealthplan.utah.edu

P. Access to Records

1. All requests for access to credentialing records will be presented to an authorized representative of the U of U Health Plans credentialing team, who will keep a record of requests made and granted. Unless otherwise stated, an individual permitted access under this section will be afforded a reasonable opportunity to inspect the records, and to make notes regarding the requested records in the presence of an authorized representative.
2. The U of U Health Plans credentialing team and CMO or their designee may have access to all records as needed to fulfill their responsibilities.
3. Consultants or attorneys engaged by the University of Utah or U of U Health Plans may be granted access to records that are necessary to enable them to perform their functions provided that he or she has signed and dated the appropriate "Confidentiality Agreement." The original agreement will be retained by U of U Health Plans.
4. All subpoenas pertaining to credentials records will be referred to the Credentialing Manager who will consult with legal counsel regarding the appropriate response. Representatives of regulatory or accreditation agencies may have access to records as required by law or accrediting rules.
5. Should a file review be requested, staff will set an appointment at the U of U Health Plans office for the practitioner to review the submitted materials in his or her credentialing file under the following circumstances:
 - i. The request is approved by the U of U Health Plans Credentials Committee chairperson

- ii. Review of the file is accomplished in the presence of the U of U Health Plans Credentialing Committee chair and a Provider Credentialing Consultant
 - iii. The practitioner understands that he or she may not remove or delete any items from the credentialing file
 - iv. The practitioner understands that he or she may add an explanatory note or other document to the file for the purpose of correcting erroneous information
6. The applicant attests to the correctness and completeness of all information furnished and acknowledges that any significant misstatement or omission from the application is reason to find that the applicant no longer meets criteria.

Q. Credentialing Committee Composition & Responsibilities

1. The Credentialing Committee is composed of members from U of U Health Plans' contracted provider network and other community providers who reflect multiple specialties, including but not limited to Pediatrics, Surgery, OB/GYN, Family or Internal Medicine and Behavioral Health, who provide input during discussion of applicants to the U of U Health Plans provider panel. U of U Health Plans staff members serve as non-voting members of the committee as does the University General Counsel. A quorum shall consist of 50% +1 of the voting members of the Committee. The Committee Chair votes if needed for quorum or tiebreaker.
2. The committee reviews and approves the U of U Health Plans Credentialing Policies & Procedures which is then sent to the U of U Health Plans Policy Committee for final approval.
3. Evaluates completed applications of all applicants for initial and re-credentialing admittance to the U of U Health Plans provider network and meets monthly to discuss Category I-IV files. Meetings may be held in person or virtually. As necessary, a secure e-mail may be sent for electronic file review and committee vote to meet a practitioner's deadline if prior to the meeting.
4. Ensures the proceedings of each Credentialing Committee meeting are summarized in minutes and reported to the U of U Health Plans Provider Network Management Directors, Provider Network Team Members and Medical Directors.
5. All members of the credentials committee shall keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.
6. The Credentials Committee members will be provided certain minutes, credentialing reports and other relevant information to review before each regularly scheduled meeting in preparation for Committee meetings. Such materials are confidential and must be returned at the relevant meeting, or

shredded if printed for a virtual meeting. A master copy of each informational item sent will be maintained by the credentialing team.

7. The Credentialing Committee reviews the “Organizational Provider Report”, “Clean File Report” and “Penalties Report” at the next regularly scheduled meeting, and votes to either approve for participation, table the application or find the applicant not to meet criteria.
 - i. If approved, Credentialing staff sends notification to the practitioner within 60 days of meeting.
 - ii. If tabled, the application for further consideration must, except for good cause, be followed up on within 30 days, by a decision to approve or not meet network criteria. Provider Credentialing Consultant will promptly send the applicant special notice of any action to table and include an explanation of the reason for postponement, as well as a request for the specific information, release or authorization or other material, if any, required from the applicant to make a final decision. A timeframe for response will be specified and will not exceed 30 days. If the applicant fails, without good cause, to respond or appear before the Committee in a satisfactory manner within the specified time frame, it is deemed a voluntary withdrawal of the application.
 - iii. If the Committee determines the applicant does not meet criteria, the Committee Chair sends notification via certified letter to the applicant within 30 calendar days and if applicable, includes the process for appealing the decision.
 8. The Credentialing Committee Chair ensures files that meet criteria are reviewed and approved. The Credentialing Committee Chair also has authority to fast track and approve network participation when the situation warrants, providing the applicant file meets criteria per policies established and approved by the Credentials Committee. If the Credentials Committee Chair is unavailable to approve files, the approval decision may be deferred to an ad hoc chairperson appointed by the CMO or chief medical officer.
- R. Ongoing Monitoring and Interventions
1. Medicare and Medicaid Sanctions - Within 30 days of release from the reporting entity, U of U Health Plans will review the Medicaid and Medicare Sanctions report. All practitioners and organizational providers who have been sanctioned or otherwise debarred from participation with Medicare & Medicaid do not meet Health Plans criteria for participation in the Health Plans network and shall be documented in committee minutes.

2. Practitioners or organizational providers discovered to have sanctions are given to the Committee chairperson for review. Based upon his/her recommendations, the sanctioned practitioner/organizational provider is then taken to the next Credentialing Committee for review. If the provider has a history of sanctions or disciplinary action, and the previous issues are related to a recently identified sanction, the provider's entire penalty history shall be brought to committee. Committee will determine if any action is necessary. If necessary, the determined action will be carried out by the Senior Provider Credentialing Consultant and/or Credentialing Manager. If nothing is new and all is resolved, then file will not be brought back to committee and the Committee chairperson has the authority to sign off on the file as a clean file. Table 4 identifies websites that will be searched for all active U of U Health Plans participating providers:

Table 4

Sanction Type	Source	Website URL
Medicare Sanction	OIG	http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp and https://eftp2.cms.hhs.gov:11443/cfcc/login/login.jsp
Medicare Opt Out	Noridian	https://med.noridianmedicare.com/web/jeb/enrollment/opt-out/opt-out-listing
Medicare Preclusion	CMS	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList
Federal Government	GSA	https://www.sam.gov/SAM/
Licenses	FACIS	https://verisys.com/product/facis/
Licenses	NPDB	https://www.npdb.hrsa.gov/

3. Providers are enrolled in the National Practitioner Data Bank's Continuous Query Service by the CVO upon initial credentialing and annually thereafter. Providers are also being monitored by the CVO product FACIS. This service informs the health plan of sanctions on licensure, limitations on scope of practice, malpractice judgements or settlements and ongoing monitoring of Medicare or Medicaid sanctions.
4. The Credentialing team is responsible for:
 - i. reviewing the reports generated from these sites, verifying whether or not the listed practitioner/organizational provider is participating in the U of U Health Plans network
 - ii. storing them on a secure e-storage system (currently S-drive and/or BOX)
 - iii. initiating the termination process for each participating practitioner/organizational provider should there be a match

- iv. terminating the practitioner/organizational provider from the U of U Health Plans provider database, removing from CVO and CAQH rosters, and creating SmartSheet requests to alert the Systems and Operations team of the termination so members can be re-assigned
- v. documenting all findings and actions taken in the U of U Health Plans provider database so a logged report can be generated and submitted to stakeholders including the credentials committee
- vi. sending notification if appropriate such as a “does not meet criteria” letter

S. Complaints and Adverse Events

1. Members can go to the U of U Health Plans website: uhealthplans@utah.edu to log a complaint. Once submitted, complaints and adverse events are sent electronically to the Managed Care Coordinators, who are part of the QI/Appeals and Grievance Team. Once the Managed Care Coordinators have logged it, the complaint/adverse event is forwarded to the Credentialing Manager who logs it in the U of U Health Plans provider database.
2. Review of complaints and adverse events occur on a monthly basis. A monthly report is run by the Credentialing Manager before the Credentialing Committee meeting, looking for any practitioner/provider with a history of 3 or more complaints/adverse events within the past year. Those that have 3 or more within the past year or who have a significant quality of care incident are taken to committee for discussion.
3. Possible Actions might include:
 - i. Removal from Network
 - ii. Corrective Action Plan
 - iii. Site Visit from Provider Relations team
 - iv. Approval if actions are not deemed as egregious
 - v. A letter to the practitioner asking for additional information

T. Site Visits

1. Site visits may occur after receiving a member complaint to evaluate the physical accessibility, physical appearance, or adequacy of waiting and exam room space related to settings in which member care is delivered. Site visits may also occur if a facility loses its accreditation, licensure in good standing or discontinues meeting U of U Health Plans quality of care criteria.
2. Standards are set for these site visits in accordance to CMS and NCQA criteria and should occur when possible within 60 days of a valid complaint.

3. Medical record keeping practices may also be evaluated at the time of site visit to ensure providers are maintaining confidentiality of member information and for keeping information in a consistent organized manner for ready accessibility.
4. A structured documented review of the office to determine compliance with selected criteria will be presented to the Credentials Committee on the appropriate assessment checklist.
5. Improvement suggestions if identified will be documented for the provider in writing. Deficiencies with an unresolved solution will require the provider to present a corrective action plan and the effectiveness of such a plan will be evaluated at least every 6 months until deficiencies are resolved.
6. The Credentials Committee retains the right to disapprove corrective action plans and may determine the provider does not meet criteria and recommend termination for non-compliance.

U. Notification to Authorities and Practitioner Appeal Rights

1. Upon contracting with a Practitioner Group, U of U Health Plans Contracting Coordinator sends a Welcome Packet directing applicants to our Provider Manual on the U of U Health Plans website. More specific Credentialing information and policies are found in the U of U Health Plans Credentialing Policies, available to applicants by e-mailing provider.credentialing@hsc.utah.edu. In addition, the information outlining the process an applicant would follow to appeal a credentialing or re-credentialing decision in the event that an applicant disagrees with the Credentialing Committee's consensus regarding their participation status with the network, is included in the group's Welcome Packet and online at www.uhealthplan.utah.edu
2. In the event a decision is made to remove the provider from the network and requires a fair hearing or reporting to the National Practitioner Databank, U of U Health Plans will follow its stand alone Fair Hearing Policy..
3. In order to ensure the health and well-being of our members, U of U Health Plans monitors sanctions on a monthly basis to remain aware of the quality of practitioners/organizational providers we panel. The U of U Health Plans Customer Complaint Form for members to offer feedback is found on the U of U Health Plans website at the following link:
<https://app.secure.uuhsc.utah.edu/uhealthPlans/forms/complaint>. Upon receipt of a complaint, the issue is investigated and appropriate action taken to protect our members.

V. Assessment of Organizational Providers

To provide quality of care for our members, before contracting with new organizational providers, U of U Health Plans ensures that each applicant meets established standards. U of U Health Plans will re-credential each organizational provider at longest every 36 months provided the criteria for participation are being met on an on-going basis. Credentialing will be conducted according to licensure. Failure to provide proof of meeting established standards will make the application ineligible and will result in not being admitted to the network, or an administrative removal from the network. To be credentialed, organizational providers must meet the following criteria and the verifications produced by U of U Health Plans and/or its designated CVO as identified in a later section of this policy:

1. Completion of the organizational provider application. In the event corrections are necessary, corrected applications must be re-signed/re-dated.
2. If applicable, the applicant has been accredited or certified by a U of U Health Plans accepted accrediting body. Please see Accepted Accrediting Bodies Table, which is part of the Assessment of Organizational Providers standard.
3. If accredited, must submit an acceptance letter and/or report survey stating the organizational provider was reviewed and passed with the completed application. An attestation stating an organizational provider is accredited will not be accepted.
4. If not accredited, a CMS certification survey would be acceptable if no more than 5 years old, and an acceptance letter and/or report survey stating the organizational provider was reviewed and passed must be submitted with completed application. A state license inspection would also be acceptable if no more than 3 years old, with an acceptance letter and/or report survey stating the organizational provider was reviewed and passed must be submitted with completed application. An attestation stating an organizational provider is certified will not be accepted. CMS or State Survey findings with designations A-F are deemed acceptable. Survey findings with designations G and above will be sent to the Credentials Committee for review if a plan of correction (POC) has not been accepted and the organizational provider is not showing as compliant. If a POC is available, it will be included. Survey findings which include designations G and above with an accepted POC and/or showing in compliance will be considered as part of a clean file, and do not need committee discussion.
5. Each location will be assessed, and if the parent company is accredited, but not the satellite locations, only the parent company accreditation will be used. If not accredited or does not have a completed CMS certification survey, or has not had a recent state license inspection, an onsite quality assessment will be performed by a Provider Relations Consultant and UM team member to determine if NCQA standards are being met. This requirement may be waived if the organizational provider is located in a rural area, as defined by the U.S. Census Bureau. Acceptable accrediting bodies are in Table 5.

6. If an organization’s site visit by their state licensing board or other recognized accreditation agency is over three years old, and has not been scheduled or has been delayed for a plausible reason (i.e. pandemic of 2020-2023), the credentials committee may consider issuing an approval less than but up to the standard three years pending obtaining updated information from state, federal or accrediting agencies.
7. U of U Health Plan staff may randomly audit the credentialing files of organizations for compliance to these standards set above.

Table 5

(AAAH)	Accreditation Association for Ambulatory Health Care
(ACHC)	Accreditation Commission for Health Care
(AAAASF)	American Association for Accreditation of Ambulatory Surgery Facilities
(ABCOP)	American Board for Certification in Orthotics/Prosthetics
(ACR)	American College of Radiology
(ASHI)	American Society for Histocompatibility and Immunogenetics
(BOC)	Board of Certification / Accreditation, International (O&P or DMEPOS)
(CAP)	College of American Pathologists
(CARF)	Commission on Accreditation of Rehabilitation Facilities
(COLA)	Committee of Laboratory Accreditation
(CHAP)	Community Health Accreditation Program
(CT)	The Compliance Team
(COA)	Council on Accreditation
(DNV)	Det Norske Veritas
(HFAP)	Healthcare Facilities Accreditation Program – AOA
(HQAA)	Healthcare Quality Association on Accreditation
(IAC)	The Intersocietal Accreditation Commission
(NABP)	National Association of Boards of Pharmacy
(NBAOS)	National Board of Accreditation for Orthotics Suppliers
(NCQA)	National Committee for Quality Assurance
(TJC)	The Joint Commission
(URAC)	URAC, (aka, American Accreditation Healthcare Commission)
(CABC)	Commission for the Accreditation of Birth Centers
(PPFA)	Planned Parenthood Federation of America

8. The employees performing the assessment will use U of U Health Plans’ Physical Facility Assessment Checklist pertaining to the specific Organizational Provider Type being credentialed. Checklists are tailored for each facility type, based on the following evaluation categories:
 - i. Physical accessibility
 - ii. Physical appearance
 - iii. Adequacy of space
 - iv. Privacy/HIPAA compliance

- v. Registration process
 - vi. Medical record keeping
 - vii. Staff/patient interaction
 - viii. Facility Personnel conduct
9. During the onsite quality assessment, it will also be determined that the organizational provider has a process in place to credential its practitioners. If not, U of U Health Plans will create a CAP, which outlines the credentialing process and the time frame in which to start credentialing. U of U Health Plans will contact the organizational provider 6 months after the CAP is instituted for follow-up.
10. A site visit may only be done at a parent location if all satellite sites follow the same policy and procedures as the parent company.
11. U of U Health Plans Credentialing Staff reviews application documentation, confirming the following criteria are current and free from sanctions:
 - i. Copy of current valid license, certification or registration as applicable to type of organizational provider type, which is used to confirm good standing with state requirements
 - ii. Current professional malpractice liability insurance face sheet or included in the credentialing application. Must be current at the time of attestation.
 - iii. Absence of any license or Medicare/Medicaid sanctions and eligible to receive payment
 - iv. Signed and dated attestation/release. U of U Health Plans will accept electronic, scanned, photocopied, digital and faxed signatures. A signature stamp will not be accepted.
 - v. Current CLIA in good standing (for hospitals & laboratories)
12. Depending on line of business U of U Health Plans credentials various types of facilities.
13. NCQA requires the following organizational providers to be credentialed:
 - i. Hospitals
 - ii. Home Health/Personal Care Agencies
 - iii. Skilled Nursing Facilities
 - iv. Free-standing Surgical Centers with more than one surgical suite
 - v. Residential Treatment Facilities – A live-in health care facility providing therapy for substance abuse, mental illness, or other behavioral problems.
 - vi. Inpatient – Inpatient Services can be defined as 24-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both.
 - vii. Ambulatory Behavioral Healthcare – Outpatient Services provided for mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner’s office.

14. In addition to NCQA, CMS requires the following organizational providers to be credentialed:
 - i. Comprehensive Outpatient Rehabilitation Facilities (CORF's)
 - ii. Diabetes Education Centers
 - iii. Diabetes Supply Centers
 - iv. Dialysis (End-Stage Renal Disease Services)
 - v. Hearing Centers
 - vi. Home Infusion Services
 - vii. Home Medical Supplies/Durable Medical Equipment (DME)
 - viii. Independent Diagnostic Testing Facilities
 - ix. Indian Health Services Facility
 - x. Infusion Suites
 - xi. Intensive Cardiac Rehabilitation Suppliers
 - xii. Laboratory/Pathology
 - xiii. Mammography Screening Centers
 - xiv. Organ Procurement Organization
 - xv. Portable X-ray Suppliers
 - xvi. Public Health Centers/Clinics Radiology/Imaging Centers
 - xvii. Radiation Therapy Centers
 - xviii. Sleep Study Labs

15. Once the U of U Health Plans Credentialing Coordinator is given the contract, he/she is responsible for contacting the organizational provider to determine whom the credentialing contact is, obtain an email/phone number and update the U of U Health Plans provider database with this information. When the completed application and supporting documents are received, credentialing staff will begin processing the file. If there is missing information and it is not obtained within a 2 week time frame, the credentialing staff will follow-up with the organizational provider.

16. Verifications must be completed within 120-calendar days. Refer to Table 6 for information about the verification results. The website for the accrediting/certifying body will be checked; licenses will be verified through the license copy or the licensing board for the state in which the organizational provider resides (Surgical Centers with only one surgical suite may be exempt from licensure by CMS, and some states do not issue a license for surgical centers.) Sanctions will be verified through SAM/OIG; CLIA's will be verified through the appropriate state agency or certificate copy; if applicable, all rosters will be checked for Medicare/Medicaid sanctions. An on- time NPDB will be run at initial and reappointment, as NPDB doesn't allow for continuous queries on facilities.

17. The credentialing staff will create an electronic file for each organizational provider that will be stored on a secure network drive. Each credentialing document and verification will be saved with the staff person's name and date verified. Files will be

kept confidential, and only those employees needing access to ensure network participation will be allowed to view and maintain the file.

18. When verifications are complete and a file is deemed "Clean", the Senior Credentialing Consultant will be notified to take it to the next Credentialing Committee Meeting for review and approval.
19. If an Organizational Provider is discovered on one of the sanction lists, the file will be reviewed by the Committee chairperson and Director of Provider Network Management pre-committee meeting for review and determination of next steps.
20. Any file deemed by the Credentialing Consultant as needing a site visit will be sent directly to the Provider Relations Consultant (PRC) over the territory and they will be required to set-up a site visit with the organizational provider. The PRC must take a member of the UM team with them to the Site Visit. Based on the site visit findings, the PRC and UM team member will recommend the file is now ready, or "Category I" for credentialing committee approval, or recommend denial/removal from network participation.
21. If, after the site visit, the Organizational Provider still does not meet criteria, the Contracting Team will be notified. If they determine that they want to keep the Organizational Provider in the Network, or add them as an initial, they must create a CAP (Corrective Action Plan) so the Organizational Provider can work towards meeting U of U Health Plan's network participation criteria. Contracting will present the CAP to the Organizational Provider, and follow-up with them again after 3-months. When it is time for CAP follow-up, the Contracting team will notify the PRC and UM team member to do a follow-up site visit. They will alert the appropriate parties of their findings. At this point, they will recommend that the Credentialing Consultant start the verification process again or denial/removal from the network by the Contracting team. If the Contracting team decides to remove from the network or deny network participation due to not meeting criteria, they will send a term/denial letter. They will also term the contract; create a SmartSheet request if necessary to alert systems and operations, and term the provider from the U of U Health Plans provider database.
22. The applicant shall have the right to be informed of their application status upon request as noted in the Provider Manual and on the U of U Health Plans website. The request shall be made via email to: provider.credentialing@hsc.utah.edu. All correspondence will be responded to within 24 hours, and voice mails returned within 48 hours.
23. The applicant shall also have the right to review the information s/he has submitted in support of their credentialing or re-credentialing application, and will have the opportunity to correct any erroneous information, as applicable, during the 2-3 month credentialing process. Applicants are notified through the website, as well as the Provider Manual. Corrections can be submitted to:
provider.credentialing@hsc.utah.edu

Table 6

Verification Required	Circumstances Requiring Committee Discussion
State or Medicare survey present in file; a corrective action plan if/as necessary is also present; ratings on survey have quality findings = > G	<ul style="list-style-type: none"> • Survey results with identified deficiencies, cumulative fines = \$75,000 and/or no corrective action plan in the file will not meet criteria. • If the corrective action plan is present but there is no evidence it has been accepted by the state or federal authority it will be reviewed by the committee for a decision.
Organization has Star Rating from CMS >= 2	<ul style="list-style-type: none"> • Star ratings = 1 will not meet criteria. • Ratings = 2 or average < 3 are subject to discussion. • Providers who are too new or have not seen enough patients to have a star rating are subject to discussion.
If accredited, evidence from accreditation agency	<ul style="list-style-type: none"> • If not accredited, state or Medicare survey and/or acceptance letter must be present in file. • If no state or Medicare survey present in the file, provider relations will conduct a site visit. If facility scores <= 45% on site visit the facility will not meet criteria. • Facility scores > 46% but <= 75% will be reviewed by the committee for a decision.
Organization is free of sanctions from any government agency and is not listed on OIG/SAM	<ul style="list-style-type: none"> • Presence of any ongoing sanction activity including any open or pending case, or recent activity < 36 months with no plan for corrective action will not meet criteria.
Organization attests they have never been convicted of a criminal offense related to healthcare	<ul style="list-style-type: none"> • An organization subject to an open or pending criminal offense related to healthcare or has been convicted in the past 5 years of a felony offense will not meet criteria; offenses > 5 years are subject to discussion.
License or certification to do business must be current and in good standing with evidence present in file	<ul style="list-style-type: none"> • A license status = pending, suspended, revoked or denied will be reviewed by the committee for a decision. • Any license subject to disciplinary action within the last 5 years will be reviewed by the committee.
Organization attests they have never been involved in any legal actions excluding medical malpractice	<ul style="list-style-type: none"> • Any pending or recent legal actions (within last 5 years) are subject to discussion. • The committee reserves the right to consider the egregiousness of legal actions and determine if the legal action will impact the organizations ability to deliver quality care to members.
Evidence of medical malpractice/professional liability insurance is present in the file	<ul style="list-style-type: none"> • Any facility unable to produce a certificate of insurance or attest to coverage will not meet criteria. • Any facility that is self-funded will be subject to discussion.

References:

NCQA 2023 CR Standards: CR 1, CR 2, CR 3, CR 4, CR 5, CR 6, CR 7, CR 8

Medicare Manual Chapters 4 & 6

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Approval Body:

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Organizational Area:

University of Utah Health Plans

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Previous Approval Dates:

2/10/16, 8/24/16, 7/21/17, 10/17/17, 2/4/19, 3/14/22

Previous Review dates:

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