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Objective:

- I. To ensure that Tuality Health Alliance (THA) follows an objective process to credential facilities that provides services to THA members.
- II. To ensure the development and maintenance of a safe, convenient and easily accessible panel from which members receive service.

Policy:

- I. A facility/organization is an entity that is contracted with THA and has the necessary license, accreditation and /or certification to operate under law.
- II. Prior to initial organizational credentialing and recredentialing, THA will assess the health care provider for the following criteria:
 - A. The provider is in good standing with state and federal regulatory bodies
 - B. The provider has been reviewed and approved by an accrediting body if appropriate or relevant.
 - C. The organization may provide a copy of the license, accreditation report or letter from the regulatory and accrediting body regarding the status of the provider. These may be provided in lieu of an onsite review.
 - D. If the provider is not accredited, THA will conduct an onsite review prior to the credentialing decision.
- III. A facility/organizational provider will not be appointed or reappointed to THA's panel when the facility/organizational provider or principal(s) has been subject to:
 - A. CMS Sanctions-listed on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) or the Excluded Parties List System.
 - B. Sanctions against license
 - C. History of criminal charges

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- D. Active sanctions, probation or loss of accreditation, licensure or certification
- IV. Credentialing elements
- A. Current documentation of the required credentialing elements is obtained at the time of initial credentialing and every three years thereafter.
 - B. Each provider will complete and submit the standard Organizational Provider Credentialing Application.
 - C. If applicable, a copy of accreditation certification from one of the following applicable recognized accrediting bodies should be included:
 - 1. Copy of a current valid state or local healthcare business license
 - 2. Copy of last CMS inspection report and findings, and documentation submitted to explain any corrective actions necessary
 - 3. Copy of State certification and/or valid accreditation along with a copy of the most current report of findings, and documentation submitted to the accrediting body to explain corrective action taken as necessary if applicable by any of the following accrediting bodies:
 - a. The Joint Commission (TJC)
 - b. Accreditation Association for Ambulatory Health Care (AAAHC)
 - c. Commission on Accreditation of Rehabilitation Facilities (CARF)
 - d. Commission for Health Care, Inc (home health)
 - e. American Osteopathic Association (AOA)
 - f. American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
 - g. Council on Accreditation
 - h. Community Health Accreditation Program (CHAP)
 - i. Continuing Care Accreditation Commission
 - 4. Copy of the Policy and Procedure index, scope of services, quality management plan and physician or provider roster including anesthesiology if applicable.
 - 5. Copy of facility's policy on restraint and seclusion if relevant
 - 6. Verification that the organizational provider has met and is in good standing with all federal and state regulatory agencies.
 - 7. Evidence of Professional Liability coverage and comprehensive general liability insurance.

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8. All verifications must be current within 180 calendar day time limit.
- D. In lieu of accreditation a CMS or state survey can be used. If the provider is not currently accredited or certified by a recognized accrediting organization, an on-site quality assessment will be completed. The following is required in the on-site review process. A copy of this review must be available prior to credentialing approval.
1. The organizational provider will be sent a packet which includes the survey tool and the requirements for the on-site visit.
 2. During the on-site visit the reviewer will tour the facility, interview facility staff and review medical records and appropriate documentation.
 3. If there are quality issues or other concerns identified, these issues will be discussed with the THA Medical Director for a recommendation. The determination made by the Medical Director may include the following:
 - a. No further action
 - b. Review of medical records
 - c. Notification/query letter to the organizational provider regarding the issues,
 - d. Referral to the THA Quality Management Committee (QMC) for review and determination.
- V. Application Approval or Denial
- A. The Medical Director reviews the completed application by utilizing the verification checklist and applicable documents and makes one of the following recommendations:
1. Completed application without exceptions is approved
 2. The application is pended for further requested information
 3. The Medical Director refers it to the QMC for review and recommendation.
 4. The QMC can approve, pend or deny the application.
 5. The provider is notified in writing of the decision within 10 business days of the decision.
- VI. Ongoing Monitoring
- A. THA Medical Services Manager monitors the facilities on an ongoing basis through member grievances and appeals, case management, adverse outcomes and external sources. If the facility meets any one of the following criteria, the facility is reviewed by the THA QMC.
1. Member grievances or complaints regarding the quality of care or

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communication issues. Meets a threshold of a minimum of three grievances or complaints filed by a member in any rolling twelve month period.

2. Coordination of Care Concerns
 - a. A minimum of three documented nursing staff concerns relating to compliance with THA standards.
 - b. A minimum of three potential adverse outcomes in any rolling twelve month period.
3. External Sources
 - a. Accreditation entities
 - b. Licensing boards
 - c. CMS list of Excluded Individuals and Entities (LEIE) and the Opt-Out List

VII. Recredentialing

Each organizational provider will be reviewed at least every three years to ensure continuing compliance with the established criteria. The following steps will be taken during the re-credentialing process:

- A. THA will verify that the organizational provider has a current license and current liability insurance as required by THA.
- B. THA will verify current CMS certification and current accreditation.
- C. Verifications will be completed to confirm the organizational provider has met and is in good standing with all federal and state regulatory agencies.
- D. If the organizational provider is not currently accredited, a site visit may be completed as above.
- E. A CMS or state review may be used in lieu of a site review. A copy of this review will be collected prior to the recredentialing decision. The CMS or state review must have been completed within this 3 year time period.
- F. The organizational provider is required to provide evidence of current professional liability insurance with liability limits and comprehensive general liability insurance.
- G. THA may review the organizational provider's liability claims history and current status with the licensing board.

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Refer: NCQA 2011 HP Standard CR 11
Medicare Managed Care Manual Chapter 6 Relationships with Providers
Providence Health Plan Policy QM CS 11.0
ODS Policy Organizational Providers

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THA Plan Director

THA Medical Director