Practitioner Recredentialing Overview & Performance Monitoring Policy

1. Purpose

This policy describes the general recredentialing process, the decision-making process, and the process to review information from quality improvement activities.

2. Policy

Recredentialing is the process through which Priority Health updates and verifies all pertinent information, reviews the practitioner's performance, and examines the clinical competence of the practitioner. It is Priority Health's policy to include in the recredentialing process, an objective reappraisal of a practitioner's experience with Priority Health since the most recent recredentialing or credentialing decision. This evaluation will include information about member complaints, quality reviews, including under and over utilization issues, and results from any QI activities.

It is Priority Health's policy to recredential every practitioner at least every third year. The recredentialing process will be initiated prior to the end of the practitioner's three-year period and will be completed in a timely manner (within 120 days) to ensure verification elements are current.

Priority Health will not consider a practitioner's gender, race, religion, creed, national origin, age, sexual orientation, types of procedures or types of patients the practitioner specializes in or any other criteria lacking professional or business justification in determining whether the practitioner may continue participation in the Priority Health provider network. Priority Health Credentialing Committee will review an annual report of all initial applications processed and recredentialing applications recredentialed. The annual report submitted to the Credentialing Committee will include, but not be limited to, information regarding, age and gender, to ensure that recredentialing files are being reviewed in a non-discriminatory manner. All members of the Priority Health Credentialing Committee will sign a confidentiality and non-discrimination statement.

Priority Health Managed Benefits, Inc., and Priority Health Government Programs, Inc., corporations related to Priority Health, also relies on Priority Health's recredentialing process to determine which practitioners serve within its network.

A. Application of Policy

This recredentialing policy shall apply to, at a minimum, physicians, dentists, podiatrists, chiropractors, optometrists, physician assistants, nurse practitioners, certified nurse midwives, psychologists, social workers and counselors. It will include all practitioners who have an independent relationship with Priority Health or are listed in Priority Health's provider directory, practitioners who see members outside the inpatient hospital setting or outside ambulatory freestanding facilities, practitioners who are hospital-based but who see Priority Health members as a result of their independent relationship with Priority Health, and dentists who provide services covered by Priority Health's medical benefits.

B. Criteria

As outlined in the Provider Manual, practitioners are recredentialed every 3 years. Practitioners for renewal to Priority Health's provider network must submit a completed Priority Health recredentialing

application or a Council for Affordable Quality Healthcare (CAQH) application including a signed and dated attestation* and release of information form to Priority Health and continue to fulfill all acceptance/continued participation criteria that are part of the criteria for participation as defined in the appropriate practitioner-specific Appendix. Additionally, the applicant must agree to allow Priority Health to submit personal data, i.e. name, date of birth, license number, or other required identifier, via a secure electronic transmission to the Council for Affordable Quality Healthcare (CAQH) and authorize Priority Health access to the data supplied by applicant on the Universal Credentialing Data Source (UCD) online application. The recredentialing application also requires the applicant to disclose information about health status and any history of issues with licensure or privileges that may have occurred since the most recent credentialing or recredentialing decision and that may require additional follow-up. The signed Attestation asserts that the practitioner has completed the recredentialing application in good faith. The practitioner will complete a recredentialing process, during which the Credentialing Committee will assess the practitioner. Only after the Credentialing Committee has determined that the practitioner satisfactorily fulfills all criteria might the practitioner's status be renewed. The Priority Health Practitioner Rights Policy is outlined in the Provider Manual.

* Attestation signature must be no more than 180 days old at the time of the recredentialing decision

C. Recredentialing Process

1. Throughout the recredentialing process, the practitioner is responsible for:

   a. Responding to requests for information made by the Credentialing Committee, Medical Affairs Committee, or the Board of Directors; and

   b. Keeping Priority Health informed of any changes in his or her status relative to the criteria. For example, a practitioner should notify the Committee regarding any:

. (i) Judgment, settlement, or compromise in a professional liability action;

   (ii) Action limiting or suspending the practitioner's license to practice a profession, or his or her authority to prescribe medication;

   (iii) Federal Indictments where the practitioner has been named;.

   (iv) Sanction, Preclusion, or Exclusion from the Medicare or Medicaid programs;

   (iv) Cancellation of professional liability coverage; or

   (v) Loss or significant curtailment of clinical privileges at a licensed hospital.

2. Credentialing staff will review the recredentialing application for completeness and verify certain information with its primary source. This includes, but is not limited to, information regarding:

   a. a current valid license to practice verified directly via internet (hrrp://www.cis.state.mi.us/pay/ and/or https://license.ohio.gov/lookup/default.asp and/or https://mylicense.in.gov/everification/Search.aspx?facility=N) with the State Licensing Board*;

   b. clinical privileges in good standing, as applicable, (this includes all membership and privilege status categories of Active, Courtesy, Provisional, etc.) at all hospitals with which the practitioner has a current affiliation, as attested to on their CAQH application or as verified directly by mail/fax/phone;

c. drug enforcement agency registration, as applicable, verified via the internet with the DEA Agency or a photocopy of the original DEA certificate (certificate must be in effect at the time of the credentialing decision). Credentialing staff reviews DEA registrations to ensure that practicing states are reflected on the certificate or on the verification;

d. current, adequate malpractice insurance as attested to on their CAQH application or as verified by obtaining a copy of the current liability face sheet from the practitioner (coverage must be in effect at the time of the credentialing decision);

e. professional liability claims and insurance history will be verified by querying the National Practitioner Data Bank (NPDB)*****. A liability questionnaire may be mailed/faxed directly to carrier(s) as desired by Priority Health and/or the Credentialing Committee;

f. board certification* verified directly with the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Foot and Ankle Surgery (ABFAS) (formerly known as American Board of Podiatric Surgery), American Board of Podiatric Medicine (formerly known as American Board of Podiatric Orthopedics and Primary Podiatric Medicine), American Board of Oral and Maxillofacial Surgery, American Board of Sleep Medicine, American Academy of Hospice and Palliative Medicine, or American Board of Addiction Medicine (or American Society of Addiction Medicine if certified prior to 2009);

3. Credentialing staff will gather additional information from primary sources relating to the practitioner to assess malpractice experience and/or sanction activity. The following sources will be consulted to obtain any history:

    a. OIG (Office of Inspector General) List of Excluded Individuals and Entries database (LEIE)

    b. OIG List of Excluded Individuals and Entities database (LEIE) Monthly Supplements

    c. FEHB Program Department Record, published by the Office of Personnel Management, Office of the Inspector General. (Debarred Provider List)

    d. Applicable State Sanctioned Providers Cumulative Lists and/or Monthly Lists as available.

    e. Applicable State Preclusion Providers Cumulative Lists and/or Monthly Lists as available

    f. Applicable State Disciplinary Action Reports (DAR)

    g. Applicable State licensing agencies

    h. Board Certification/Accreditation bodies

    i. Applicable State news releases

    j. Medicare Opt-out listings. Any provider on the regional carrier website listed as opting out of Medicare participation will not be eligible to participate with Priority Medicare product and will not be offered a Medicare contract. See Ongoing

Monitoring of Practitioner Sanctions and Complaints Policy for details on ongoing monitoring of the Opt-out report.

k. Quality Concern Committee member complaint data

l. Credible media sources

m. Priority Health employees

n. Other credible sources

o. National Practitioner Data Bank (to include sanction activity by Medicare/Medicaid and malpractice claims payment information);

p. Malpractice carriers (if deemed necessary by Priority Health and/or the Credentialing Committee);

q. Community Health Automated Medicaid Processing System (CHAMPS)

CHAMPS participation requires any person who has ownership or control interest in the provider or is an agent or managing employee (as defined in 42 CFR 455.101) of the provider disclose if they have ever been convicted of a criminal offense involvement in any involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of these programs.

r. System Award Management System (SAMS), formerly Excluded Parties List System (EPLS)

4. If, during the verification and information gathering process, the Credentialing staff identifies any issues of concern, a Credentialing staff will consult with the Chief Medical Officer (CMO) or physician staff designee. The CMO or designee will provide guidance on further clarification, follow up or other necessary action to the Credentialing staff prior to presenting the file to the Credentialing Committee for review. The CMO or designee is available to the Credentialing staff at any time for issues of concern regarding recredentialing applicants.

D. Credentialing Committee Review and Decision Process

1. In the case of a practitioner being recredentialed, the recredentialing checklist and any supporting documents will include the results from malpractice activity, sanction activity, disciplinary action, member complaints, inpatient quality management codes and specific inquiries regarding practitioners' quality of care and any other information reflecting on the effectiveness or efficiency of practitioner's work with Priority Health's members and Managed Benefits' participants. The recredentialing checklist will also contain the results of all primary source verified elements described in Section C., 2 & 3 above.

2. All practitioner recredentialing applications that are assessed by Credentialing staff and determined to be “clean” files will be presented to the CMO or physician staff designee responsible for credentialing for final determination of “clean” status. The CMO or physician staff designee will review and approve the “clean” files upon

distribution of an electronic or hard copy signature list. A “clean” file is defined as one in which the practitioner has met all applicable practitioner specific appendences and the Priority Health Credentialing Clean File Criteria, which may be revised from time to time. Those practitioners who meet all practitioner specific criteria and the following requirements: 1) no new malpractice activity or negative actions by a carrier; 2) no new disciplinary actions, including revocation, suspension, denial, or reductions regarding licensure, hospital privileges or memberships, membership in a medical society or organization, or membership in another HMO/PPO; 3) no new felony convictions; 4) no new information in the National Practitioner Data Bank; and, 5) no quality issues, do not require individual review by the Credentialing Committee. Those files approved by the CMO or physician staff designee will be considered approved as of the date of their signature or via electronic approval and Priority Health. Any practitioner file that is not determined to be a “clean” file will be presented to the Credentialing Committee for review and decision.

3. For those files reviewed by the Credentialing Committee, they will take into consideration results of primary source verification and information regarding malpractice history or sanction activity as well as information about a practitioner’s health status and any history of loss or limitation of privileges or disciplinary activity, or other information which may be deemed relevant by Priority Health.

4. After review by the Credentialing Committee, the Committee will either:

    a. Recommend that the practitioner be approved without conditions;

    b. Recommend that the practitioner be approved with conditions;

    c. Recommend that the practitioner **not** be approved; or

    d. Defer a decision regarding the practitioner’s status pending further investigation.

    If the Committee:

    a. Recommends approval of the practitioner, participation will continue.

    b. Recommends approval of the practitioner with a condition, Priority Health will notify the practitioner and state the condition and requested follow up.

    c. Does not recommend the practitioner’s recredentialing application for continued participation in Priority Health’s provider network, unless the Medical Affairs Committee or Board of Directors reverses the decision of the Credentialing Committee. If the decision is to not recommend i, the practitioner will be offered the right to a hearing in accordance with the Disciplinary Action & Practitioner Appeal Policy. In the event an appeal is requested, the practitioner is required to complete and return a ‘Disciplinary Network Termination Practitioner Appeal Request’ form to Priority Health within 30 days upon notification of the termination.

    d. Defers its recommendation, the Committee will undertake further investigation, reconsider the practitioner’s file, and make a final decision within 90 days.

5. Any negative action to be taken against a practitioner by the Committee must be approved by a majority of the members present.

6. The Medical Affairs Committee and the Board of Directors will review all decisions made by the Credentialing Committee regarding practitioners.

7. All practitioners who do not meet Priority Health Clean File Criteria will receive written notice within 30 calendar days after the Credentialing Committee has rendered a final decision.

E. Corrective Action for Recredentialing Decisions with Contingencies

The Credentialing Committee will determine the appropriate method, if any, of intervention based on all results from the primary source verification elements and any results from the QI Summary and Detail Reports. Action plans may then be implemented under the direction of any of the following: Credentialing Manager, Chief Medical Officer, Director of Corporate QI, or Director of Network Management. The following are possible courses of action available to the Credentialing Committee:

1. Notification and education with the practitioner or office staff. Common issues at this step would include office identified concerns, member complaints, clinical concerns, and malpractice litigation.

2. A written response to the issue/concern is requested from the practitioner. Common issues at this step would include office identified concerns, member complaints, clinical concerns, and malpractice litigation.

3. A recredentialing time frame less than the standard three (3) year period will be imposed based on the issue/concern and its level of severity. The early recredentialing will include a focused review and evaluation of the issue/concern. Priority Health's Legal department would be notified of all decisions and actions taken at this step.

4. The following actions may be initiated if there are still concerns after implementation of an action item from steps 1-3 or may be initiated as a first step of action based on the issue/concern and level of severity:

    a. PCP is closed to new members
    b. Referrals to a Specialist are restricted
    c. PCP may no longer be eligible for the Physician Incentive Plan

    Common issues at this level would include quality (including malpractice and licensure issues) or service concerns. Priority Health's Legal department would be notified of all actions taken at this step.

5. Termination of the practitioner (refer to Disciplinary Action & Practitioner Appeal and Ongoing Monitoring of Practitioner Sanctions and Complaints policies). Priority Health's Legal and Special Investigation Unit (SIU) departments would be notified of any termination, as applicable.

    Any action taken will be documented in writing by the responsible party and/or department and maintained in the practitioner's confidential credentialing file. Documentation of follow up and tracking of all activity to monitor and improve practitioner performance will be done in one of the following ways: the symplr Payer provider data management system, LENS inquiry or with signed documentation in the practitioner file, by the party assigned responsibility for follow up and it will be maintained by the Credentialing staff.

***** Attestation time limit: 180 days and Verification time limit: 120 days

3. Revisions

12**/**98 annual review; 5/99 revisions; 8/99 revisions, 11/99 revisions & annual review, 12/00 revision & annual review, 8/01 revisions & annual review, 12/01 revisions, 9/02 annual review, 10/02 revisions, 6/03 revisions, 9/03 revisions & annual review, 4/04 revisions, 8/04 revisions and annual review, 1/5/05 revisions, 2/1/06 revisions, 7/1/09 CMS revisions, 12/7/11, 8/15/19, review 4/5/23, revised 8/29/23, revised 2/7/24, revised 6/20/24, Revisions 7/1/2025.

Priority Health reserves the right to alter, amend, modify or eliminate this policy at any time without prior written notice.

Policies Superseded and Replaced: Formerly part of Policy #2/0030/R3 – Practitioner Credentialing, Recredentialing and Hearing Policy & Procedure and replacement of Procedure #2/5009/RO – Recredentialing Compliance with Thresholds.

4. References

Practitioner Specific Criteria, NCQA Credentialing Standard
Priority Health adheres to CMS requirements as outlined and/or defined in the Medicare Managed Care Manual (Chapter 6: Relationship with Providers)
Credentialing Clean File Criteria

Disciplinary Network Termination Practitioner Appeal

Requirements:

- Appeals submitted without this form will be returned unprocessed.
- All pertinent supporting documentation must be attached

Deadline: 30 days from date of termination notice

Submitter Contact Information

Provider/facility name	Date of Submission	Date of termination notice
Contact Name	Contact Phone Number	Contact email
Address		

Provider Information

Provider last name	Provider first name	Provide NPI number

Type of Appeal:

☐	**Quality concerns** that could trigger an adverse action under this policy include but are not limited to internal evidence of substandard treatment rendered to Priority Health members, Priority Health member complaints/grievances related to quality concerns, and malpractice judgments/settlements related to a Priority Health member. Prior to taking any formal final action to deny, restrict, reduce, or terminate affiliation based on quality concerns, the practitioner is allowed to pursue the appeal process as described herein.
☐	**Non-quality concerns** that could trigger an adverse action under this policy include, but are not limited to, failure to meet Acceptance/Continued Participation Criteria. Such circumstances are straightforward and do not contain an inherent aspect of judgment on which a substantive Quality appeal could normally be based. Nevertheless, the practitioner is allowed to pursue the appeal process as described herein, for purposes of his or her Medicare contract only, which is limited to review of the merits of the termination process to include the procedural steps associated to the termination, only.

Explanation of appeal:
