Sentara Health Plans

2024 Credentialing Program Description

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Mission

Sentara Health Plans's mission We improve health every day. We do this through innovation, strategic partnerships, and industry-leading health care.

Our History

Founded in 1984, Sentara Health Plans offers a full suite of commercial products including employee-owned and employer-sponsored plans, as well as Individual and Family health plans, employee assistance plans and plans serving Medicare and Medicaid enrollees.. Sentara Health Plans currently serves more than 510,000 members with a network of more than 20,000 providers including specialists, primary care physicians, and hospitals. Our quality provider network features more than 35,000 providers including specialists, primary care physicians and hospitals

Sentara Healthcare, the parent company of Sentara Health Plans is a not-for-profit integrated healthcare system headquartered in Norfolk, Virginia. Through this strategic partnership, we are able to provide services to other integrated delivery systems including: population health management, data analytics, and third-party administrative services for employee benefits. We also work with partners to develop and operate health plans in their market. In 2013, Sentara developed the Sentara Quality Care Network (SQCN); a collaboration among independent/private practice and employed physicians to develop a clinical integration program. There are currently over 2,000 care providers that participate in SQCN

Sentara Health Plans is accredited with the National Committee for Quality Assurance (NCQA). NCQA is an independent not for profit organization that ranks health insurance plans throughout the nation. NCQA evaluates how health plans manage all parts of their delivery systems – physicians, hospitals, and other providers to continuously improve health care for its members. Accreditation surveys include rigorous on-site and off-site evaluation on selected performance measures.

Accreditation is not a one-time event, but an ongoing journey to support quality services for customers, members and practitioners. Sentara Health Plans is committed to excellent services to our customers and have an ongoing plan to monitor the progress towards the goal of excellence.

NCQA's mission provides information that enables purchasers and consumers of managed health care to distinguish among plans based on quality. Sentara Health Plans Stars Rating is (4 Stars). Sentara Health Plans earned a "Accredited" accreditation status from the National Committee on Quality Assurance Accreditation in 2021 for Commercial, Medicaid, and Exchange. Also have LTSS Distinction. This accreditation will expire on March 2024.

Our Business

Sentara Health Plans provides quality health plans that suit a wide range of incomes and health circumstances.

Executive Summary:
2024 Credentialing Program Description
Effective: February 23, 2023

- **Purpose:**

  Sentara Health Plans's Credentialing Program is comprehensive and ensures that its practitioners and providers meet the standards of professional licensure and certification. The process enables Sentara Health Plans to recruit and retain a quality network of practitioners and providers to serve its members and ensure ongoing access to care.

- **Scope:**

  The Credentialing Program is comprehensive and includes credentialing, recredentialing and ongoing monitoring of over 21,000 practitioners and providers. All practitioners/providers with an unrestricted, current and valid license and a National Provider Identification (NPI) Number are eligible to participate.

- **Successes:**
  - Passed Quarterly NCQA Internal Audits
  - Continued electronic approval process by medical directors which decreased approval time for practitioners
- **Challenge(s):**
  - Decrease processing timeframes to 30 days or less
  - Loss of 4 full time employees through attrition
- **Opportunity for Improvement:**
  - Improve processing timeframes
  - Pre-screen applications, upon receipt, for missing and/or expired documents
- **2024 Core Indicators:**

Area of Focus:	Benchmark:
Applications Received to Completion	Departmental Internal: 60 days
Attestation Date to Committee Decision Date	NCQA: 365 days
Providers Initially Credentialed	Departmental Internal: 60 days
Providers Re-credentialed	Departmental Internal: 90 days

I. DEFINITIONS:

The acronyms, phrases, words and terms used in this document shall have these meanings unless the context specifically states otherwise:

1. **Ambulatory Surgical Center (ASC):** Medicare defines ASCs as a distinct entity that operates exclusively to furnish outpatient surgical services to patients. ASCs must be certified as meeting the requirements for an ASC and must enter into a participating provider agreement with the Centers for Medicare & Medicaid Services (CMS)

   An ASC can either be:

   - ❑ Independent (not part of a provider of services or any other facility)
   - ❑ Operated by a hospital (under the common ownership, licensure, or control of a hospital). To be covered as an ASC operated by a hospital, the facility:
     - Elects the coverage and is covered as such unless CMS determines there is good cause to do otherwise
     - Is a separately identifiable entity physically, administratively, and financially independent and distinct from other operations of the hospital, with costs for the ASC treated as a nonreimbursable cost center on the hospital's cost report
     - Meets all requirements regarding health and safety and agrees to the assignment, coverage, and payment rules applied to independent ASCs
     - Is surveyed and approved as complying with the conditions for coverage for ASCs

2. **ARTS:** Addiction Recovery Treatment Services

3. **Atypical Providers:** Atypical providers are those providers not typically credentialed under NCQA, however do provide services to Medicaid beneficiaries. Requirements for atypical providers have been established by the Virginia Administrative Code (VAC) under sections 12 VAC 30-120-940, -950, -960, -970, -980; 12 VAC 40-60-10; and 12 VAC 30-60-300.

4. **Board**: The Board of Directors of Sentara Health Plans. The Board of Directors (the "Board") has ultimate authority, accountability, and responsibility for the Credentialing evaluation process (the "Credentialing Program") and has delegated full oversight of the Credentialing Program to the Credentialing Committee. The Board comprises top executives, including legal counsel, Community practitioner(s), the CEO of Sentara Health Plans, CMO, and other Sentara Health Plans executives attend the Board meetings, as required.

5. **CAQH**: Council for Affordable Quality Healthcare; Manages the Universal Credentialing Initiative by which a practitioner can singly apply to one central database to meet the needs of the health plans and Networks participating in the CAQH effort. Practitioners may easily update their information online or via fax anytime and will confirm once each quarter that the data on file is complete and accurate. CAQH is a coalition of over 20 of America's largest health plans and Networks and three principal health plan associations working together to help improve the healthcare experience for consumers and physicians. There is no cost for CAQH participation for the practitioners. The health plans pay a cost to access the information.

6. **Clean Practitioner or Provider:** A practitioner or provider who meets the standards, guidelines, and/or criteria for network participation.

7. **MHS:** Mental Health Services formerly CMHRS

8. **CMS:** Centers for Medicare and Medicaid Services headquartered in Baltimore, MD; Under the direction and oversight of the U.S. Department of Health and Human Services; Social Security Act, Titles 18, 19 and 21.

9. **Credentialing**: Includes both the credentialing and recredentialing of independently licensed practitioners and/or organizational providers; initial credentialing is conducted before a practitioner or provider being presented to the Credentialing Committee for approval; recredentialing is conducted within three (3) years of the initial credentialing process. is the process used to select and evaluate the practitioners with whom Sentara Health Plans contracts. Credentialing is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability and accessibility, and conformance with Sentara Health Plans standards, as set forth by NCQA and the

   Department of Medical Assistance Service.

10. **Delegated Credentialing**: Occurs when the credentialing functions of a managed care organization or other organization have been outsourced or contracted out to be performed by another capable organization.

11. **DMAS**: The Department of Medical Assistance Services, in the Commonwealth of Virginia; an agency of the Commonwealth of Virginia regulated under the Social Security Act 19.

12. **Dual Credentialing:** A practitioner (typically an internal medicine practitioner) or provider educated and medically trained to provide medical care in two specialties (i.e., internal medicine and gastroenterology, etc.)

13. **Dual Contracting**: A practitioner contracted directly with Sentara Health Plans and also with a contracted delegated entity.

14. **High-Volume:** Fifty (50) or more members on a participating practitioner's or provider's panel.

15. **QIC:** Committee of Sentara Health Plans comprised of the executive leadership from Pharmacy, Quality, Credentials and Utilization

16. **Independent relationship:** Exists when the organization selects and directs its members to see a specific practitioner, provider or group of practitioners or providers, including all practitioners or providers whom members can select as primary care practitioners (PCP).

17. **Licensed independent practitioner or provider** (LIP): A practitioner or provider who does not work under the auspices or authority of another practitioner or provider.

18. **Locum Tenens:** A Latin phrase that means "to hold the place of, to substitute for," In layman's terms, it means a temporary and/or covering practitioner.

19. **MMP Plan:** a health plan that contracts with both Medicare and the Virginia Department of Medical Assistance Services to provide benefits of both programs to enrollees.

20. **Medical Directors:** Sentara Health Plans staff of Medical Director(s); employed Medical Directors include:

    - Chief Medical Officer (CMO): The CMO provides direction for the development and implementation of the Credentialing, Quality Improvement, Utilization Management and New Technology, and other Medical Management programs.

    - Medical Director: The Medical Director is responsible for peer review activities and the collaboration with Practitioners on the development and implementation of the Credentialing Program and is spokesperson at the Credentialing Committee.

    - Administrative Medical Director– Sentara Health Plans's Staff Medical Director who does not have to be credentialed because s/he does not provide direct office based, and/or hospital care to Sentara Health Plans members. The Medical Director's license and malpractice shall be verified and maintained by the Plan's Human Resources personnel to ensure they are unrestricted, current and/or valid, and shall be included in the Human Resources File. Board Certification is not required, although preferred. If the Medical Director participates in a University or other teaching program advising others, the unique teaching program will assume any further credentialing request.

21. **Member:** An individual residing in the Commonwealth of Virginia and eligible for Sentara Health Plans services.

22. **Nationally Recognized Accrediting Entity/Body**: An organization that sets national standards specifically governing healthcare quality assurance processes, utilization review, practitioner credentialing, and other areas covered in this document and accredits managed care health insurance plans under national standards. These entities are examples of nationally recognized accrediting entities/bodies:

    - **JCAHO**: Joint Commission on Accreditation of Healthcare Organizations

    - **NCQA**: National Committee for Quality Assurance; an accrediting body overseeing a variety of health plan functions and ensures quality.

23. **Network Practitione**r: Accredited and/or verified person who has contracted with Sentara Health Plans to provide healthcare services to its members and follow all established plan policies and procedures.

24. **Organizational Providers**: Medical Organizational providers include: hospitals

    home health agencies including infusion services providers, durable medical equipment companies, skilled nursing facilities, free standing surgical centers (of any type – gynecology and/or obstetrics - birthing centers, ophthalmology – laser surgery centers, urological surgery centers, dental surgery centers, cardiac surgery centers, orthopedic surgery centers, free standing hethnic

    ospice centers and rehabilitation facilities. Behavioral health organizational providers include: inpatient, residential, and ambulatory. Please note: By listing all types of organizational providers do not imply that all said providers referenced are covered under Sentara Health Plans benefit structure.

25. **Office of the Inspector General (OIG):** The Health and Human Services Office of Inspector General excludes individuals and maintains a sanctions list that identifies those practitioners and providers who have participated or engaged in certain impermissible, inappropriate, or illegal conduct to include, but not limited to fraudulent billing and misrepresentation of credentials. The OIG's List of Excluded Individuals and Entities (LEIE) provides information on all individuals and entities excluded from participation in Medicare, Medicaid, and all other Federal health care programs.

    If identified billing practices are suspected to be potentially fraudulent or abusive, the **OIG's National Hotline** should be contacted at **1-800-HHS-TIPS (1-800-447-8477)** to report the activity.

    Contacting the HHS OIG Hotline:

    By Phone: 1-800-HHS-TIPS (1-800-447-8477)

    By Fax: 1-800-223-8164

    By E-Mail: HHSTips@oig.hhs.gov

    By TTY: 1-800-377-4950

    By Mail:

Office of Inspector General
Department of Health and Human Services
Attn: HOTLINE
330 Independence Ave., SW
Washington, DC 20201

Centers for Medicare & Medicaid Services (CMS): Suspicions of fraud or abuse may also be reported to Medicare's Customer Service Center at **1-800-MEDICARE (1-800-633-4227)**.

26. **Primary Source Verification**: The original source of a specific credential that can verify the accuracy of a qualification reported by an individual health care practitioner/provider. Examples include medical school, graduate medical education program, and state medical board.

27. **Sentara Health Plans**: Sentara Health Plans; a Virginia nonprofit corporation that is a subsidiary of Sentara Healthcare.

II. AUTHORITY AND RESPONSIBILITY FOR CREDENTIALING

Sentara Health Plans Board of Directors ("Board") has ultimate authority, accountability, and responsibility for the Credentialing evaluation process ("Credentialing Program") and has delegated full oversight of the Credentialing Program to the Credentialing Committee ("Committee"). The Credentialing Committee accepts the responsibility of administering the Credentialing Program and having oversight of operational activities, which include making the final decision, (i.e., approve, table, or deny) for all practitioners and providers regarding network participation. At least annually, the Credentialing Program Description or other comparable report will be presented to the Credentialing Committee, and/or the Quality Improvement Committee (QIC).

(See Credentialing Structure and Governance Organizational Chart - Attachment 1).

III. PURPOSE

Sentara Health Plans has policies and procedures in place for credentialing and recredentialing based on the NCQA, CMS and DMAS requirements. Sentara Health Plans understands that it will develop and implement additional policies and procedures according to the requirements in the three-way contract between Sentara Health Plans, CMS, and DMAS. All Policies and Procedures are updated yearly at a minimum to ensure ongoing compliance, however policies can be reviewed and updated sooner if a change in requirements needs to be reflected in established or new policies.

The Credentialing Program ("Program") of Sentara Health Plans plan is comprehensive and on-going to ensure that its practitioners and providers meet the standards of professional licensure and certification, assuring the competency of practitioners and providers/entities delivering care within the Sentara Health Plans Network. The process enables Sentara Health Plans to recruit and retain a quality network of practitioners and providers to serve its members and ensure ongoing access to care. It consistently and periodically assesses and evaluates a practitioner's or provider's ability to deliver quality care at initial credentialing, re-credentialing and between credentialing and re-credentialing cycles. And the Program emphasizes and supports a practitioner's and provider's ability to manage the health care of network members.

The Credentialing Program of Sentara Health Plans shall be comprehensive to ensure that its practitioners and providers meet the standards of professional licensure and certification. The process enables Sentara Health Plans to recruit and retain a quality network of practitioners and providers to serve its members and ensure ongoing access to care. It consistently and periodically assesses and evaluates a practitioner's or provider's ability to deliver quality care between credentialing and recredentialing cycles, and it emphasizes and supports a practitioner's and provider's ability to manage the health care of network members in a cost-effective manner.

The Credentialing Program enables Sentara Health Plans to ensure that all practitioners and providers continuously comply with the Centers for Medicare and Medicaid Services (CMS) requirements, the Department of Medical Assistance Services (DMAS) or designee requirements, the National Committee for Quality Assurance (NCQA) standards, Commonwealth Coordinated Care by Sentara Health Plans policies and procedures, and any other applicable regulatory or accreditation entity's requirements and/or standards.

The Sentara Health Plans Credentialing and Recredentialing standards shall be reviewed by clinical peers that are members of the Sentara Health Plans Credentialing Committee. All employed and contracted practitioners/providers are subject to peer review.

IV. CREDENTIALING COMMITTEE STRUCTURE & ACTIVITIES

A. Composition:

The Medical Director is responsible for the oversight and operation of the Credentialing Program, or may appoint a Chairperson, with equal qualifications. The Medical Director of Sentara Health Plans must review and approve the Annual Credentialing Program each year.

The Committee is a peer-review body that includes participating practitioners who span a range of specialties, including primary care (i.e., family practice, cardiology, pediatrics, surgery, obstetrics/gynecology, etc.) and specialty care to include, behavioral health (Addiction Medicine Specialists, Professional Counselor, Mental Health Nurse Practitioner, Psychologist, Psychiatrist). Members may be appointed as members, rotated, or removed from the Committee at the sole discretion of the Committee Chairperson.

B. Responsibilities/Duties:

The Committee shall be responsible for the credentialing process of all independently licensed practitioners. Its purpose is to monitor all credentialing activities and delegated credentialing arrangements, to include, but not be limited to:

1) Receive and review the credentials of all practitioners being credentialed or recredentialed who do not meet the organization's established criteria. This includes evaluating practitioner files identified as problematic (e.g., malpractice cases, licensure issues, quality concerns, missing documentation, etc.)
2) Review practitioner credentials and thoughtfully consider the credentialing elements before making recommendations about a practitioner's ability to deliver care.
3) Establish, implement, monitor, and revise policies and procedures for Sentara Health Plans credentialing and recredentialing.
4) Report to the QIC, and any other authorities, as required.

5) Annual Review of the Credentialing Program Description

6) Other related responsibilities

The Medical Director or his/her designee may review and sign off on a list of the names of clean practitioners and providers who meet the established criteria before, between, and after each Committee meeting.

At the next scheduled Committee Meeting, these approved practitioners will be presented to ensure network participation decisions are recorded in the meeting minutes.

C. Quorum:

A quorum (majority of voting members present) shall be satisfactory for the valid transaction of business by the Committee, which meets at least monthly and/or as deemed necessary by the Chairperson. The Committee action may be implemented absent a face-to-face or other type meeting if consent in writing, setting forth the action, is obtained. Voting members include only the Committee members. Non-voting members include the Vice President, Provider Operations, Medical Director, Director, Health Plan Enterprise Credentialing, Chief Medical Officier, Credentials Manager and/or other Plan representatives.

D. Minutes and Reports:

Complete and accurate minutes will be prepared and maintained for each meeting. Minutes will reflect the name of the Committee, the date and

duration of the meeting, the members present and absent, and the names of guests or other representatives. The minutes will reflect decisions and recommendations, the status of activities in progress, and the implementation status of recommendations, when appropriate. Applicable reports and substantiating data will be appended for reporting.

The Committee will review minutes for accuracy. Minutes shall be securely retained electronically and manually.

E. Confidentiality Policy:

It is the policy and procedure of Sentara Health Plans to consider all credentialing documents received from the practitioner, verification sources for credentialing and retained because of the credentialing process as confidential. The mechanisms to ensure the confidentiality of information collected in this process are:

- Access to such documents will be restricted to: (1) The practitioner or provider being credentialed, under the requirements outlined in this document below titled “Erroneous, Incomplete or Illegible Information,” (2) Committee Members, (3) Board Members, (4) Sentara Health Plans Credentialing Staff, and (5) Other specific individuals as designated by the Board and/or Sentara Health Plans’ Quality Improvement Committee (QIC).

- The limited number of staff with access to the credentialing database must have individual user names and passcodes to access credentialing related information.
- Credentialing materials, which are contained within the Medical Management Department, are secured via a passcode protected door in which entry must be gained.

F. Conflict of Interest:

No person may participate in the review and evaluation of any professional practitioner or provider with whom s/he has been in a group practice, professional corporation, partnership, corporation, limited liability company or similar entity whose primary activity is the practice of medicine or where judgment may be compromised. The Chairperson of the Credentialing Committee shall have the authority to excuse a voting member from the Credentialing Committee in the presence of a conflict of interest.

V. THE CREDENTIALING PROGRAM: PRACTITIONERS

Scope of Credentialing:

The Credentialing Program is comprehensive and includes all practitioners with an unrestricted, current and valid license and a National Provider Identification (NPI) number. All licensed practitioners and groups of practitioners who provide care to Sentara Health Plans members are credentialed. Practitioners certified or registered by the state to practice independently and provide care to Sentara Health Plans members are also credentialed.

Nurse practitioners licensed for 5 years or less and physician assistants may participate in the network under the credentials of a supervising, participating physician if she/he has a National Provider Identification (NPI) Number.

Practitioners who will be credentialed and reviewed on an ongoing monitoring basis include:

- Practitioners with an independent relationship with Sentara Health Plans at an outpatient setting. An independent relationship exists when Sentara Health Plans selects and directs its members to see a specific practitioner or group of practitioners. An independent relationship is not synonymous with an independent contract. NCQA does not require the organization to credential practitioners with whom it holds independent contracts.
- Practitioners who see members outside the inpatient hospital setting or outside freestanding, ambulatory facilities.
- Dentists provide care under Sentara Health Plans medical benefits.
- Nonphysician practitioners with an independent relationship with Sentara Health Plans, and who provide care under the organization's medical benefits.

- Hospital based practitioners with an independent relationship with Sentara Health Plans and an outpatient setting:
  - Anesthesiologists with pain-management practices
  - Cardiologists
  - Radiologists
  - University faculty who are hospital based and who also have private practices
- Dentists providing care under medical benefits:
  - Oral surgeons
- Nonphysician practitioners who may have an independent relationship, with Sentara Health Plans and provide care under Sentara Health Plans medical benefits:
  - Behavioral health practitioners
  - Nurse practitioners
  - Nurse midwives
  - Optometrists

Types of practitioner files audited (internally) during the year to ensure ongoing compliance:

Medical practitioners:

- Medical doctors (MD)
- Dentists (DDS/DMD)
- Osteopaths (DO)
- Podiatrists (DPM)
- Chiropractor (DC)
- Nurse Practitioners (NP, PNP, ANP, etc.)
- Speech Language Pathologists, Occupational Therapists, Physical Therapists
- Pharmacists

- Behavioral health practitioners:
  - Psychiatrists and other physicians
  - Addiction medicine specialists
  - Doctoral or master's-level psychologists who are state certified or licensed
  - Master's-level clinical social workers who are state certified or licensed

- Master's-level clinical nurse specialists or psychiatric nurse practitioners nationally or state certified or licensed
- Other behavioral healthcare specialists are licensed, certified, or registered by the state to practice independently.

Additional types of practitioners, not listed above, may also be credentialed and subject to the same policies and procedures, as those listed in this document, to ensure ongoing quality for the Sentara Health Plans members. However, internal files reviews may be restricted to the practitioners listed above.

Practitioners who need not be credentialed:

- Practitioners who practice exclusively within free-standing facilities and who provide care for Sentara Health Plans members only because of members being directed to the facility.
- Covering practitioners (e.g., locum tenens)
- Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants)
- Practitioners who practice exclusively within the inpatient setting and provide care for Sentara Health Plans members only because of members being directed to the hospital or another inpatient setting:
  - Pathologists
  - Radiologists
  - Anesthesiologists
  - Perinatologists
  - Emergency room physicians
  - Hospitalists
  - Telemedicine consultants
- Practitioners who practice exclusively within free-standing facilities in which practitioners may practice exclusively and provide care for Sentara Health Plans Plan (Sentara Health Plans) members only because of members being directed to the facility:
  - Mammography centers
  - Urgent-care centers
  - Surgery centers
  - Ambulatory behavioral healthcare facilities
  - Radiology centers

- Practitioners who practice exclusively within Ambulatory behavioral health care facilities:
  - Psychiatric and addiction disorder clinics

VI. STANDARDS OF PARTICIPATION: PRACTITIONERS

- Professional Criteria:

  Sentara Health Plans accepts professional practitioners into its network at its sole discretion based on the need for professional practitioners in certain specialties, geographic areas, or similar considerations.

  Each professional practitioner must meet minimum standards for participation in Sentara Health Plans Network. These guidelines should comply with Sentara Health Plans, CMS, DMAS, or its designee, NCQA, or any other applicable regulatory and/or accreditation entities where applicable.

- Minimum Standards for Participation include:
  - Unrestricted (no limitations), current and valid professional licensure to practice in Virginia, or other state where Sentara Health Plans membership may receive care, especially in bordering states (TN, WV, NC, KY, MD and DC).
  - Current and valid Federal DEA listed on CAQH for practitioners with the authority to write prescriptions for practice. When a practitioner waives his/her prescriptive authority, or has restricted prescriptive authority, we receive an email from practitioner and Medical Director reviews.
  - Preferred Board certification in a recognized practice specialty. In lieu of Board Certification, the practitioner must have an education (Residency) in his/her practicing specialty. New graduates must become board-certified within six (6) years of completing an approved residency or fellowship-training program in their practice area. In the Hampton Roads area, there are no exceptions or waivers. Board certification requirements may be waived on an exception rule basis by the Medical Director in demographic area of necessity outside of Hampton Roads area a map is requested for surrounding practitioners in the area. Practitioner upon review of the Credentialing Committee if the practitioner has ten (10) years of verified work history and/or has unrestricted, active privileges in the specialty area at a participating hospital in their respective service area they would be deemed acceptable under the exception rule or underserved area for necessity.
  - Current, unrestricted clinical privileges at a participating hospital, if applicable, or evidence of coverage/transfer arrangement with a privileged participating practitioner. Admission arrangements with a hospitalist group within a JCAHO accredited or Critical Access hospital is acceptable.

- Acceptable twenty-four (24) hour coverage system. Coverage system should include twenty-four (24) hour telephone coverage and arrangements for alternate care of patients if absence occurs, through another professional practitioner consistent with Sentara Health Plans and/or payor's policies, procedures, standards and/or criteria.
- Acceptable, must meet Virginia state requirements for MDs, NPs, and Pas which is higher than $1 Million per incident and $3 Million per aggregate per year. For Virginia behavioral health practitioners also current and valid malpractice insurance in the amount $1 Million per incident and $3 Million per aggregate per year. All practitioner types in the other surrounding states MD, DC, WV, TN, NC, KY will follow their state requirements for malpractice requirements or as determined satisfactory by the Credentialing Committee.
- Current professional liability insurance coverage in a minimum amount equal to the amounts under § 8.01-581.15 - Limitation on recovery in certain medical malpractice actions is preferred.
- Absence of a history of denial or cancellation of professional liability insurance, involvement in malpractice suits, arbitration or settlement or evidence that the history does not suggest an ongoing substandard professional competence or conduct.
- Absence of health problems including drug or alcohol abuse, which might hurt judgment or competence, to substantially impede the professional practitioner's ability to perform the essential functions of his/her practice/profession.
- Absence of a history of disciplinary action resulting in suspension, repeal, or limitation by a licensing board, professional society, health care organization, managed care organization, governmental health care program; or evidence this history does not suggest an on-going substandard professional competence or conduct.
- Absence of a history of criminal/felony convictions or indictments or evidence this history does not suggest an effect on professional competence or conduct. A conviction within the meaning of this section includes a plea or verdict of guilt or a conviction following a plea of nolo contendere. Any practitioner that has indicated a felony will not be accepted in Sentara Health Plans.

- <u>Exclusion Criteria:</u>
  - Sentara Health Plans shall, upon obtaining information or receiving information from a verifiable and reliable source, exclude from participation all practitioners that may fall in the following categories (references to the Act in this Section refer to the Social Security Act):
    - Entities, which could be excluded under § 1128(b)(8), as amended of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a

person who has direct or indirect ownership or controlling interest of five (5) percent or more in the entity has been convicted of the following crimes:

1. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, Medicaid, or other State health care program (as provided in § 1128(a)(1) of the Act, as amended).
2. Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient with the delivery of a health care item or service (as provided in § 1128(a)(2) of the Act, as amended)
3. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary.

- Practitioners who appear on the Office of Inspector General exclusions report.
- Practitioners with a suspended or terminated license to practice.

D. Quality of Practice Criteria:

- Professional practitioner(s) must demonstrate acceptable office site survey and medical record keeping practices which meet CMS, DMAS or its designee, NCQA, Sentara Health Plans, or any other standards adopted by Sentara Health Plans.
- Professional practitioner(s) practice patterns must reflect a general adherence to established practice standards and protocols as adopted by Sentara Health Plans.
- Professional practitioner(s) must maintain satisfactory performance in practice quality indicators (i.e., clinical outcomes, performance measure outcomes, member satisfaction, etc.) established by Sentara Health Plans.
- Sentara Health Plans retains the right to approve/deny new practitioners/providers based on quality issues, and to terminate individual practitioners/providers for same. Termination of individual practitioners/providers for quality-of-care considerations shall be supported by documented records of noncompliance with specific expectations and requirements for practitioners/providers. Sentara Health Plans has a prescribed system of appeals available, which must be followed.

E. Business Administrative Criteria:

- Professional practitioner(s) must maintain Sentara Health Plans access standard requirements at the majority of the ambulatory service sites where a member may be seen.
- Professional practitioner(s) area of specialty must fill a network need as determined by Sentara Health Plans. Sentara Health Plans reserves the right to deny participation, case-by-case if need does not exist for a particular

specialty and if such action is deemed in the best interest of the network.

VII. INITIAL CREDENTIALING: PRACTITIONERS

A. Process and Requirements:

Sentara Health Plans credentials all practitioners before being admitted into the Sentara Health Plans network. The intent of the process is to validate and/or confirm credentials related to a prospective or participating practitioner by contacting the primary source of the issuing credential directly. All attestations and verification time limits, applicable in this Credentialing Program and referenced in this document, shall not exceed 180 calendar days of the Committee Meeting and/or Committee Decision.

Each practitioner must submit a legible and completed application, signed and dated consent form, signed and dated confidentiality form, signed and dated Master Agreement, and all other required documentation. The following information is obtained and verified according to the standards and utilizes sources listed under Initial Credentialing:

- Completed Sentara Health Plans or CAQH application, which includes a current and signed attestation and addresses. Application includes the following information:

  1. Reasons for inability to perform the essential functions of the position, with or without accommodation
  2. Lack of present illegal drug use
  3. History of loss of license and/or felony conviction
  4. History of loss or limitation of privileges or disciplinary actions
  5. Malpractice insurance coverage
  6. Attestation as to the correctness and completeness of the application

- Confirmation email sent to practitioner acknowledging receipt of application.
- Copy of the unrestricted (no limitations), current and valid license or license number for the participating practitioner
- Copy of the current and valid DEA/CDS listed in CAQH, if applicable
- Copy of the medical malpractice policy face sheet, or completed liability information section on the application inclusive of policy number, effective dates of coverage, and coverage amounts.
- Copy of the board certificate or highest level of education; proof of education, training and competency in specialty for which practitioner is seeking participation status in the Sentara Health Plans network.

- Copy of the Curriculum Vitae (CV) or detailed work history which must include month/year (Gaps or interruptions in work history 6 months or greater must be explained). CV or work history must cover the previous five years.
- Quality measures
- Primary Source Verification of associated credentialing documentation
- Practitioner explanation of any adverse actions including 1) Any limitation in ability to perform the functions of the position, with or without accommodation; 2) History of loss of license and/or felony convictions; 3) History of loss or limitation of privileges or disciplinary activity; 4) Any malpractice history, either reported or non-reported to the NPDB or other regulatory bodies.
- The Credentialing Committee's final decision (the practitioner shall be notified in writing within 60 calendar days of the Committee's decision)

Practitioners may submit their applications and/or information to the Center for Affordable Quality Healthcare (CAQH). All applications are stored electronically under each practitioner's individual record in the credentialing database.

B. Primary Source Verification:

The Sentara Health Plans credentialing staff will conduct primary source verification as required by the most current and applicable CMS, DMAS or its designee, NCQA, and other Sentara Health Plans adopted guidelines. Sentara Health Plans accepts letters, telephone calls, faxes, computer printouts, and/or online viewing of information as acceptable sources of verification with reference documentation (i.e., the name of the person who provided verification, the date of the call, and the verifier's name). The information must be accurate and current.

Verbal verifications documented in credentialing files are dated and signed by the credentialing staff member who receives the information-noting source and date. Written verifications are received in letters or documented reviews of latest cumulative reports released by primary sources. Internet verifications may be obtained from any CMS, DMAS or its designee, NCQA, and/or Sentara Health Plans Plan-approved web-site source.

To meet verification standards, all credentials must be valid at the time of the Credentialing Committee's decision per Table VII-7(b) below and the specific time limits as set forth by CMS, DMAS or its designee, NCQA, Sentara Health Plans and any other applicable regulatory and/or accreditation entities:

Table VII-A:

Primary Source Information:	Acceptable Sources:
❑ **Credential: License** ❑ **Verification Time Limit: 180 calendar**	❑ State Licensing Agencies

Primary Source Information:	Acceptable Sources:
days* Must confirm that practitioners hold a valid, current state license or certification, which must be in effect at the time of the Committee's decision; must verify licenses or certification in each state where practitioners provide care for plan members; verification must come directly from the state licensing or certification agency; if the plan uses the Internet to verify state licensure or certification, the Web site must be from the appropriate state licensing agency. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	
❑ **Credential: DEA or CDS Certificate** ❑ **Verification Time Limit: 180 calendar days *** Must be effective at the time of the credentialing decision; must be verified in each state in which the practitioner cares for plan members. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	❑ A DEA listed in CAQH ❑ Documented visual inspection of the original certificate ❑ Confirmation with the DEA or CDS Agency ❑ Entry in the National Technical Information Service (NTIS) database ❑ Entry in the American Medical Association (AMA) Physician Master File ❑ Confirmation from the state pharmaceutical licensing agency where applicable
❑ **Credential: Education and Training** ❑ **Verification Time Limit: 180 calendar days*** The organization must verify the highest of the three levels of education and training obtained by the practitioner.	Graduation from medical school (MD, DO): ❑ Medical School ❑ AMA Physician Master File ❑ American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA

Primary Source Information:	Acceptable Sources:
1. Graduation from medical or professional school 2. Residency, if appropriate 3. Board certification, if appropriate Printout from state licensing agency's Web site: The plan may use a dated printout of the licensing agency's Web site in lieu of a letter or other written notice if the site states that the agency verifies education and training with primary sources and indicates this information is current; NCQA does not require the plan to obtain written confirmation from the licensing board if there is a state statute that requires the licensing board to obtain verification of education and training directly from the institution; the plan must include a copy of the state statute as proof Note: If a practitioner's education has not changed during the recredentialing cycle, the previous education verification will stand and not be re-verified. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	❑ Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986. ❑ Association of schools of the health professional, if the association performs primary source verification. At least annually, the organization must obtain written confirmation from the association it performs primary source verification. ❑ State licensing agency, if the state agency performs primary-source verification. At least annually, the organization must obtain written confirmation from the state-licensing agency it performs primary source verification. ❑ Sealed transcripts: If a practitioner submits transcripts to the organization in the institution's sealed envelope with an unbroken institution seal, NCQA accepts this as primary-source verification if the organization provides evidence it inspected the contents of the envelope and confirmed that transcript shows that the practitioner completed (graduated from) the appropriate training program. **Note:** If the practitioner states that education and training were completed through the AMA's Fifth Pathway program, the organization must confirm it

Primary Source Information:	Acceptable Sources:
▪ **Credential: Board Certification** ▪ **Verification Time Limit: 180 calendar days*** Is not required, but must be verified if practitioner lists it on the application. If practitioner is board certified, verifying board certification meets standards for education and training. Verifies if applicable. Must be verified through one of the following sources: AMA, ABMS, ABA, AOA, or AAMC. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	through primary-source verification from the AMA. Please refer to the CMS, DMAS or its designee, and NCQA standards required for non-doctors of medicine and osteopathy. Also, please refer to Sentara Health Plans Credentialing Policies and Procedures. (MD, DO) board certification: ▪ ABMS or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided. ▪ AMA Physician Master File. ▪ AOA Official Osteopathic Physician Profile Report or AOA Physician Master File. ▪ Appropriate Specialty board State licensing agency, if the state agency verifies board status. At least annually, the organization must obtain written confirmation from the state-licensing agency it performs primary-source verification. Please refer to the CMS, DMAS or its designee, NCQA standards for required for non-doctors of medicine and osteopathy. Also, please refer to Sentara Health Plans Credentialing Policies and Procedures.

Primary Source Information:	Acceptable Sources:
❑ **Credential: Hospital Privileges** ❑ **Type of Privileging: Full, Active, Provisional (or equivalent status) and Current at a participating Sentara Health Plans hospital** Verification must be completed before presentation to Sentara Health Plans Credentialing Committee.	❑ Contact the hospital identified on the practitioner's application and use the hospital roster, fax, or other mode to confirm privileges
❑ **Credential: State and Federal (Medicaid and Medicare Sanctions, Restrictions on Licensure or Limitations on scope of practice, Exclusions and limitations related to fraud and abuse and Opt In/Opt Out status** ❑ **Verification Time Limits: 180 calendar days*** The OIG and the Opt In/Opt Out listing must be queried for sanctions and limitations before presenting a practitioner to the Committee for review and a decision Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	**Sources for Licensure Sanctions:** Physicians: ❑ Appropriate state agencies ❑ Medicare Opt/Out ❑ Federation of State Medical Boards (FSMB) ❑ Healthcare Integrity and Protection Databank (HIPDB) ❑ National Practitioner Databank (NPDB) Nonphysician behavioral healthcare professionals: ❑ Appropriate state agency ❑ HIPDB ❑ State licensure or certification board **Sources for Medicare/** **Medicaid Sanctions** ❑ AMA Physician Master File entry ❑ Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General

Primary Source Information:	Acceptable Sources:
	❑ FSMB ❑ HIPDB ❑ List of Excluded Individuals and Entities (maintained by OIG), available over the Internet ❑ Medicare and Medicaid Sanctions and Reinstatement Report, distributed to federally contracting organizations ❑ NPDB ❑ State Medicaid agency or intermediary and the Medicare intermediary ❑ PalmettoGBA.com – Opt In/Opt Out Echo verification through Website ❑ System for Award Management (SAM) ❑ Medicare Exclusions Database (MED) Please refer to the CMS, DMAS or its designee, NCQA, standards required for non-doctors of medicine and osteopathy. Also, please refer to Sentara Health Plans Credentialing Policies and Procedures.
❑ **Credential: Malpractice Insurance** ❑ **Verification Time Limit: 180 calendar days*** The plan must obtain confirmation of the past five years of history of malpractice settlements; the five-year period may include residency or	❑ National Practitioner Data Bank (full report or PDS query) ❑ Malpractice Carrier

Primary Source Information:	Acceptable Sources:
fellowship years, however the plan need not obtain confirmation from the carrier for practitioners with a hospital insurance policy during a residency or fellowship. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	
❑ **Credential: Work History** ❑ **Verification Time Limit: 180 calendar days*** NCQA does not require primary-source verification of work history; the organization must obtain at least five years of work history through the practitioner's application or CV; relevant experience includes work as a health professional; if the practitioner has practiced fewer than five years from verification of work history, it starts at the time of initial licensure; experience practicing as a nonphysician health professional (e.g., registered nurse, nurse practitioner, clinical social worker) within the five years should be included. A gap exceeding six months must be reviewed and clarified either verbally or in writing; a CV or application must include the beginning and ending month and year for each position in the practitioner's employment experience; if a practitioner has had continuous employment for five years or more, then there is no gap and no need to provide the month and year, if the year meets the intent; verbal communication must be appropriately documented in the credentialing file; a gap in work history that exceeds one year must be clarified in writing. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	❑ CV Completed Work History section on application ❑ Documented visual verification

* 180 days calculates on the date of the practitioner's attestation, or the first signed PSV, whichever is first. The end of the calculation period is the date of Sentara Health Plans Credentialing Committee.

C. Practitioner Office Site Quality: Site Visit and Medical Record Keeping/Treatment Practices Assessments/Surveys:

Sentara Health Plans Network Management conducts a site visit, if Appeals Department receives a member grievance/complaint about the quality of a practitioner's office related to but not limited to these criteria:

- Physical Accessibility (handicapped accessible, well-lit exam rooms, posted office hours)
- Physical Appearance
- Adequacy of Waiting- and Examining-Room Space

Member grievances will be monitored for all practitioner sites at least every six months. Follow-up site visits will be conducted at least every six months until the threshold is met.

A random sampling, of all practitioner offices is evaluated against applicable regulatory and accreditation standards, which have been adopted and incorporated into Sentara Health Plans policies and procedures.

The office-site criteria include standards and thresholds for each category.

- Physical Accessibility (handicapped accessible, well-lit exam rooms, posted office hours)
- Physical Appearance
- Adequacy of Waiting- and Examining-Room Space
- Availability of Appointments (timeliness of routine office visits, urgent visits)
- Adequacy of Treatment Record Keeping

Refer to Network Management and Appeals Department Policy, how they handle site visits Sentara Health Plans Staff discuss office documentation practices and medical record keeping/treatment reviews with practitioners or staff during site visits. Quality assurance forms, helpful aids, cultural competency information, advanced directive information, safety brochures, etc. are given to practitioners or their staff during quality site visits.

All site visit documentation is forwarded to the Credentials Department and loaded in provider Credentialed file for recredentials record.

Sentara Health Plans assesses medical/treatment records for orderliness and documentation practices. To ensure member confidentiality, the Quality Nurse and/or designee may review "blinded" medical/treatment records. Actual records

are reviewed during random site visits conducted to ensure Sentara Health Plans Plan office site and MR standards are met. Model records can also be reviewed instead of an actual record. As the review of medical/treatment record keeping practices may include clinical elements, clinical staff conducts these reviews.

The established performance threshold of 90% must be met for site visits and medical record-keeping practices. If the assessment falls below the threshold, the practitioner will have to develop and submit a corrective action plan. The Quality staff person and network educator will work collaboratively with the practitioner's office to institute interventions to correct any quality deficiencies.

If the practitioner does not resolve the initial concern within the identified timeframe, the Quality staff person and network educator will forward the quality issues to the Medical Director, Credentials Manager and/or the Credentialing Committee for further guidance and action. The practitioner's office shall be re-evaluated at least every six months until the deficiency is resolved.

There will be documented follow-up visits for offices that have had deficiencies. If the concern remains unresolved, the Medical Director or his/her designee may recommend to the Credentialing Committee that the practitioner not be credentialed or recredentialed.

VIII. RECREDENTIALING: PRACTITIONERS

A. Sentara Health Plans recredentials all practitioners within three (3) years of their last credentialing or recredentialing date. The intent of the process is to identify any changes that may affect a practitioner's ability to perform the services that s/he is under contract to provide.

All application requirements detailed in Section: VII-A apply to the recredentialing process. All verification time frames detailed in Table: VII-B apply to the recredentialing process.

Each practitioner must complete and sign the Sentara Health Plans or CAQH Recredentialing Application that includes the professional questions and attestation that the information given is correct and gives Sentara Health Plans Plan the right to verify the information. The following information is obtained and verified according to the standards and utilize the sources listed under Initial Credentialing:

- State licenses (unrestricted, current, and valid)
- DEA/CDS certificate (if applicable; if DEA expires, the DEA Form must be completed)
- Additional Education, if applicable
- Board certification
- Hospital affiliations/status of clinical privileges

- Malpractice coverage
- Malpractice claims
- Sanction information
- Proof of completed Model of Care Training (i.e., Access Accommodations & the ADA, Mental Health Awareness, Caring for Members & Patients, and Cultural Sensitivity, Fraud, Waste, and Abuse) or proof it has been taken through another health plan.

B. The recredentialing process shall include performance-monitoring information. Sources of such information may include one or more of:

- Member grievances/complaints
- Member and Practitioner/Provider satisfaction surveys
- Utilization Management
- Risk Management
- Quality improvement activities, performance quality measures, quality deficiencies, and/or trending patterns
- Site Assessment
- Medical Record Keeping Practice/Treatment Assessments

Please Note: A practitioner will receive one of these designations from the Committee:

1	**No concern** with clinical decision making, technique, or administrative processes identified
2	**Questionable concern** with clinical decision making, technique, or administrative process identified.
3	**Clean concern** with clinicial making, technique, or administrative processes identified.

Table VII-B:

Primary Source Information:	Acceptable Sources:
❑ **Credential: License** ❑ **Verification Time Limit: 180 calendar days*** Must confirm that practitioners hold a valid, current state license or certification, which must be in effect at the time of the Committee's decision; must verify licenses or	❑ State Licensing Agencies

Primary Source Information:	Acceptable Sources:
certification in each state where practitioners provide care for plan members; verification must come directly from the state licensing or certification agency; if the plan uses the Internet to verify state licensure or certification, the Web site must be from the appropriate state licensing agency. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	
❑ **Credential: DEA or CDS Certificate** ❑ **Verification Time Limit: 180 calendar days *** Must be effective at the time of the credentialing decision; must be verified in each state in which the practitioner cares for plan members. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	❑ A DEA listed in CAQH ❑ Documented visual inspection of the original certificate. ❑ Confirmation with the DEA or CDS Agency ❑ Entry in the National Technical Information Service (NTIS) database ❑ Entry in the American Medical Association (AMA) Physician Master File ❑ Confirmation from the state pharmaceutical licensing agency where applicable
❑ **Credential: Board Certification** ❑ **Verification Time Limit: 180 calendar days*** Is not required but must be verified if practitioner lists it on the application. If the practitioner is board certified, verifying board certification meets standards for education and training. Verifies if applicable. Must be verified through one of the following sources: AMA, ABMS, ABA, AOA, or AAMC, Nursing Boards and PAs.	Please refer to the CMS, DMAS or its designee, and NCQA standards required for non-doctors of medicine and osteopathy. Also, please refer to Sentara Health Plans Credentialing Policies and Procedures. (MD, DO) board certification: ❑ ABMS or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-

Primary Source Information:	Acceptable Sources:
Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	source authenticity has been provided. ❑ AMA Physician Master File. ❑ AOA Official Osteopathic Physician Profile Report or AOA Physician Master File. ❑ Appropriate Specialty board State licensing agency, if the state agency verifies board status. At least annually, the organization must obtain written confirmation from the state-licensing agency it performs primary-source verification. Please refer to the CMS, DMAS or its designee, NCQA standards for required for non-doctors of medicine and osteopathy. Also, please refer to Sentara Health Plans Credentialing Policies and Procedures.
❑ **Credential: Hospital Privileges** ❑ **Type of Privileging: Full, Active, Provisional (or equivalent status) and Current at a participating Sentara Health Plans Plan hospital** Verification must be completed before presentation to Sentara Health Plans Plan Credentialing Committee.	❑ Contact the hospital identified on the practitioner's application and use the hospital roster, fax, or other mode to confirm privileges. ❑ Family Practice, Internal Medicine and Pediatrics do not need hospital privileges, they follow cross coverage arrangement.
❑ **Credential: State and Federal (Medicaid and Medicare Sanctions, Restrictions on Licensure or Limitations on scope of practice, Exclusions and limitations related to fraud and abuse and Opt In/Opt Out status**	**Sources for Licensure Sanctions:** Physicians: ❑ Appropriate state agencies ❑ Medicare Opt/Out

Primary Source Information:	Acceptable Sources:
❑ **Verification Time Limits: 180 calendar days***	❑ Federation of State Medical Boards (FSMB)
	❑ Healthcare Integrity and Protection Databank (HIPDB)
The OIG and the Opt In/Opt Out listing must be queried for sanctions and limitations before presenting a practitioner to the Committee for review and a decision.	❑ National Practitioner Databank (NPDB)
	Nonphysician behavioral healthcare professionals:
	❑ Appropriate state agency
Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	❑ HIPDB
	❑ State licensure or certification board
	Sources for Medicare/
	Medicaid Sanctions
	❑ AMA Physician Master File entry
	❑ Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General
	❑ FSMB
	❑ HIPDB
	❑ List of Excluded Individuals and Entities (maintained by OIG), available over the Internet
	❑ Medicare and Medicaid Sanctions and Reinstatement Report, distributed to federally contracting organizations
	❑ NPDB
	❑ State Medicaid agency or intermediary and the Medicare intermediary

Primary Source Information:	Acceptable Sources:
	❑ PalmettoGBA.com – Opt In/Opt Out Echo verification through Website ❑ System for Award Management (SAM) ❑ Medicare Exclusions Database (MED) Please refer to the CMS, DMAS or its designee, NCQA, standards for required for non-doctors of medicine and osteopathy. Also, please refer to Sentara Health Plans Credentialing Policies and Procedures.
❑ **Credential: Malpractice Insurance** ❑ **Verification Time Limit: 180 calendar days*** The plan must obtain confirmation of the past five years of history of malpractice settlements; the five-year period may include residency or fellowship years, however the plan need not obtain confirmation from the carrier for practitioners with a hospital insurance policy during a residency or fellowship. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	❑ National Practitioner Data Bank (full report or PDS query) ❑ Malpractice Carrier
❑ **Credential: Work History** ❑ **Verification Time Limit: 180 calendar days*** NCQA does not require primary-source verification of work history; the organization must obtain at least five years of work history through the practitioner's application or CV; relevant experience includes work as a health professional;	❑ CV Completed Work History section on application ❑ Documented visual verification

Primary Source Information:	Acceptable Sources:
if the practitioner has practiced fewer than five years from verification of work history, it starts at the time of initial licensure; experience practicing as a nonphysician health professional (e.g., registered nurse, nurse practitioner, clinical social worker) within the five years should be included. A gap exceeding six months must be reviewed and clarified either verbally or in writing; a CV or application must include the beginning and ending month and year for each position in the practitioner's employment experience; if a practitioner has had continuous employment for five years or more, then there is no gap and no need to provide the month and year, if the year meets the intent; verbal communication must be appropriately documented in the credentialing file; <u>a gap in work history that exceeds one year must be clarified in writing.</u> Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	

After a practitioner has been credentialed, Sentara Health Plans shall not prohibit or otherwise restrict any participating (or nonparticipating) practitioner, acting within the lawful scope of practice, from advising, or advocating on behalf of, a member who is a patient about:

1. The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all treatment options.
2. The risks, benefits, and consequences of treatment or non-treatment.
3. The opportunity for the individual to refuse treatment and/or express preferences about future treatment decisions.

Participating practitioners must provide information regarding treatment options, including the option of no treatment, in a culturally competent manner. They must ensure that enrollees with disabilities have effective communication regarding treatment options and/or decisions with participants throughout the health system.

IX. PRACTITIONER RIGHTS:

A. To Correct Erroneous Information

Sentara Health Plans policies do not preclude practitioners' rights to review and correct erroneous information obtained and used to evaluate their credentialing application from outside primary sources. Such information could include, but is not limited to malpractice insurance carriers, state licensing boards, etc., except for recommendations or other peer-review protected information, if applicable. Sentara Health Plans does not have to reveal the source of information if the information was not obtained to meet organizational credentialing verification requirements or if the law prohibits disclosure.

Sentara Health Plans Plan policies and procedures state the practitioner's right to correct erroneous information submitted by a source. The policy states:

- The time frame for changes
- The format for submitting corrections
- The person to whom corrections must be submitted
- The documentation of receipt of the corrections
- How practitioners are notified of their right to correct erroneous information (avenues identified under Right to review information, above, are appropriate).

Upon acceptance by the Committee, each new practitioner and provider is provided training materials in compliance with Privacy Rule workforce training mandates of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

B. To Review Information

Sentara Health Plans ensures that practitioners can access their own information obtained by Sentara Health Plans during the credentialing process and used to support their credentialing application. Practitioners shall be notified in writing of this right via one or more of these methods:

- Applications
- Contracts
- Practitioner and/or Provider manuals
- Provider Newsletters
- Mail
- Email
- Fax

- Website
- Other Suitable Method

C. To Be Informed of Application Status

Sentara Health Plans policy is to notify a practitioner of his/her application status upon request. The process allows for phone calls, emails, letters, or faxes from practitioners. If either the credentialing staff or another department receives a request, it shall be responded to within 72 hours of receipt. If another department receives a request, it will be routed to the Credentialing Department within one business day for follow-up and resolution by the Credentialing staff within 72 hours of initial receipt.

The Credentialing Department staff can advise the practitioner, once key information is verified, of the following information via phone or in writing, if requested by the practitioner:

- The date the application was received.
- The status of the application – pending for additional information, etc.
- The date the application is tentatively scheduled to be presented to the Committee.
- Answer questions the practitioner may ask.

Before disclosing any confidential practitioner information via phone, the following must be verified by the Credentialing staff and confirmed by the practitioner:

- Practitioner's full name
- Practitioner's primary office location
- Practitioner date of birth
- The name, city and state of the school the practitioner graduated from.
- Year practitioner joined the Sentara Health Plans Plan Network

D. To Be Notified Of His/Her Rights

Each prospective and existing practitioner may be notified of the rights and will be notified via one method listed under "Right to Review Information" described above.

X. FILE RETENTION

Credential files shall be retained for at least seven years. Credential files are protected and confidential. Each practitioner has an electronic file in the credentialing database. Offices containing practitioner files shall be secured, as practical or business appropriate, after normal business hours. Archived files are shipped offsite to a secure file retention company with a file destruction date set to seven years post Committee meeting. A list of these files is maintained for reference and is secured by employee password. Electronic files are backed up every evening.

XI. REINSTATEMENT

If a practitioner is credentialed and leaves the network voluntarily or so Sentara Health Plans has not terminated the practitioner for quality issues or any other adverse or egregious event, she/he may re-enter the network within thirty (30) calendar days.

Sentara Health Plans may make the final determination about which practitioners/providers may participate within its network. If Sentara Health Plans documents unfavorable information (e.g., malpractice claims, deficient site visits and sanctions) about a specific practitioner/provider during the credentialing or recredentialing process, it may credential or recredential the practitioner/provider.

XII. ONGOING MONITORING

Sentara Health Plans monitors practitioner sanctions, grievances/complaints and quality issues between credentialing cycles and takes action(s) against practitioners when it identifies occurrences of poor quality. Sentara Health Plans Plan acts on important quality and safety issues promptly by reporting such occurrences at monthly credentialing meetings. If an occurrence requires urgent attention, the Medical Director and/or designee will address it immediately; engage the Committee and action(s) will be taken to ensure quality. On an ongoing monitoring basis, Sentara Health Plans Plan collects and takes intervention and/or action by:

- **Collecting and reviewing Medicare and Medicaid sanctions**
  Sentara Health Plans will review sanction information within 30 calendar days of being posted on the OIG Report Website, MED database, and/or Preclusion List.

- **Collecting and reviewing sanctions or limitations on licensure:**
  Sentara Health Plans will review sanction information within 30 calendar days of release. In areas where reporting entities do not publish sanction information on a set schedule, Sentara Health Plans will query this information at least every six months.

- **Collecting and reviewing grievances/complaints:**
  Sentara Health Plans may evaluate both the specific grievance/complaint and the practitioner's history of issues. Evaluation of the practitioner's history of grievances/complaints will occur at least every six months; if a trend is identified, a level three (3) rating is assigned, or if a practitioner has a combination thereof, the information will be presented at the next Committee Meeting for discussion.
- **Collecting and reviewing information from identified adverse events:**
  Sentara Health Plans monitors adverse events at least every six months to determine if there is evidence of poor quality that could affect the health and safety of the members. Depending on the adverse event, Sentara Health Plans Plan will implement actions and/or interventions based on its policies and procedures when instances of poor quality is identified.

XIII. NONDISCRIMINATORY PRACTICES

Sentara Health Plans conducts each Committee meeting in a nondiscriminatory manner and does not decide based on practitioner's race, ethnic/national identity, gender, age, sexual orientation, types of procedures, or practice demographics.

A heterogeneous Committee will be maintained and all committee members responsible for credentialing decisions sign a statement affirming non-discrimination for credentialing decisions.

Periodic audits of practitioner grievances/complaints will also be conducted to determine if there are grievances/complaints alleging discrimination.

These procedures will be followed by Sentara Health Plans staff and/or Committee Members to ensure a nondiscriminatory credentialing process:

- Before presenting an issue practitioner at the Credentialing Committee or other committee meeting, identifying information such as the practitioner or provider's name, social security number, address, telephone number, race, gender, etc. are **blinded** on each record by the Credentialing Department staff. Identifying information on reports such as the Office of Inspector General (OIG). National Practitioner Data Bank (NPDB), Department of Health Professions (DHP), and other credentialing bodies are omitted.
- The procedures, member demographics, etc. are never incorporated into the credentialing process.
- If a practitioner or provider's identity is known by a Committee member, the Chairman of the Credentialing Committee supports the abstention of the Committee member from discussion and/or voting on the practitioner.

In credentialing practitioners, Sentara Health Plans shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner, prospective or existing, who is acting within the scope of his or her license or certification under state law solely based on the license or certification.

If a practitioner or group of practitioners is declined network participation, the reason for denial by the Committee shall be communicated in writing within 60 calendar days of the Committee's final decision.

This prohibition does not preclude Sentara Health Plans from refusing to grant participation to a practitioner if there is no network need.

XIV. PROVISIONAL CREDENTIALING

Sentara Health Plans can as needed and when in the interest of members provide practitioners before completion of the entire initial credentialing process. Here, Sentara Health Plans will provisionally credential practitioners applying to the organization for the first time. A practitioner may only be provisionally credentialed once. A practitioner must meet all criteria as a clean practitioner to be eligible for provisional credentialing.

All required Primary Source Verifications (PSV), application, and signature requirements, along with required documentation as outlined in Section VII of this document will be conducted before presentation to the Credentialing Chairperson.

Practitioners provisionally credentialed will be presented to the Credentialing Committee within the 60-calendar day period after the Credentialing Chairperson's approval of the provisional practitioner.

XV. CREDENTIALING APPEAL REVIEW PROCESS

The Committee shall implement a mechanism to resolve disputes with participating practitioners regarding actions by the organization that relate to either: a participating practitioner's status within the network or any action by the organization related to a practitioner's professional competency or conduct. **(See ATTACHMENT 3: APPEALS PROCESS)** with a practitioner where the Committee makes an adverse determination and rejections the application, the Committee shall specify one of the two following reasons for the adverse determination:

- **Business or Administrative**
  - Not related to the practitioner's competence or professional conduct
- **Competence and Professional Conduct – Quality Related**
  - As it affects or may affect the health and welfare of a member
  - Occurrences for physicians and non physicians, may be reported to the National Practitioner's Data Bank, the Department of Health Professions, Licensing and Regulation, American Medical Association, Office of Inspector General, Department of Health and Human Services and/or Department of Medical Assistance Services.
  -

The Committee shall review all information and notify each practitioner via certified mail of the decision to decline, suspend, reduce or terminate network privileges. If an adverse event occurs and before termination, a range of actions to improve performance may be provided to the practitioner (i.e., close panels to all new members, remove all members from a practitioner's panel, restrict a practitioner to perform specific duties, require oversight of surgical procedures by another participating surgeon, periodic reviews of medical records, require continuing medical education course(s), require attendance at in-service(s), etc.). All practitioners hurt shall receive instructions, in writing, on how to appeal a denied request for credentialing.

XVI. ORGANIZATIONAL PROVIDERS

A. Sentara Health Plans conducts initial assessments and re-assessments of organizational providers to evaluate and confirm that the organizational provider has met regulatory and quality requirements as set forth by Sentara Health Plans policies and procedures, CMS, DMAS, NCQA standards, and any other applicable regulatory entities. Organizational providers will be reassessed within at least three (3) years of the last assessment date.

B. Each organizational provider must meet minimum standards for participation with Sentara Health Plans. These guidelines should comply with regulatory and accreditation standards established by CMS, DMAS or its designee, NCQA, Sentara Health Plans, and the laws of the Commonwealth of Virginia. The Sentara Health Plans standards for participation include:

- A valid, unrestricted (no limitations) license to do business and operate in any state where Sentara Health Plans has membership.
- Appropriate, as recognized by industry standard, professional liability insurance and comprehensive general liability insurance. If the organizational provider self-insures for medical malpractice insurance, evidence must be provided of the established policy, adequacy of funding, and any reinsurance provisions.
- Unrestricted, professional, and business licenses, registrations, permits and certifications in good standing on all professional staff members, including certified nurses and aides that may have to deliver services, equipment and supplies.
- The provider is in good standing with State and Federal regulatory bodies and complies with all federal, state, local, city and county laws and regulations in effect or later enacted by these agencies as relates to services rendered to members.
- The provider has been reviewed and approved by an accrediting body (see the accrediting bodies table immediately below); and if not, a site assessment will be conducted initially and within every 3 years thereafter. The survey results will then be communicated to the organizational provider seeking a contractual agreement with Sentara Health Plans Credentialing and Contracting Departments.

- The Provider agrees to report changes in its licensure, certification, accreditation, ownership and location to Sentara Health Plans within five (5) calendar days of the change.

C. Accrediting bodies accepted by Sentara Health Plans are:

Accreditation Association for Ambulatory Health Care	AAAHC
Accreditation Commission for Health Care, Inc.	ACHC
American Association for Accreditation of Ambulatory Surgery Facilities, Inc	AAASF
American Board for Certification in Orthotics and Prosthetics	ABCOP
American College of Radiology	ACR
Commission on Accreditation of Rehabilitation Facilities	CARF
Centers for Medicare and Medicaid Services	CMS
Council on Accreditation for Children and Family Services, Inc	COA
Healthcare Facilities Accreditation Program	HFAP
The Compliance Team, Inc.- Exemplary Provider (DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare, etc)	DMEPOS
National Association of Speech and Hearing Center	NASHC
Rehabilitation Facilities Community	CHAP
The Joint Commission	JCAHO
Det Norske Veritas Healthcare, Inc. (DNV) - Hospitals • Accreditation Program Name: National Integrated Accreditation for Healthcare Organizations (NIAHO) • Approved by CMS: 09-26-08 (per Federal Register)	DNV Healthcare/ NIAHO
Board For Orthotist/Prosthetist Certification	BOC
Continuing Care Accreditation Commission (CARF-CCAC)	CCAC
Healthcare Quality Association on Accreditation	HQAA
Commission for the Accreditation of Birth Centers	CABC
National Children's Alliance	
Behavioral Health Center of Excellence	BHCOE

D. Accreditation Standards include:

- Acute Care Hospital, Rehabilitation Hospitals, Psychiatric Hospitals, Partial Day Facilities: All Hospitals shall within three years of first commencing operations or on the effective date of the participating agreement, whichever is later, be accredited by JCAHO, CAH, or DNV/NIAHO. All Hospitals shall

have Medicare approval unless written documentation of non-applicability is accepted by Sentara Health Plans.

- Skilled Nursing Facility (SNF): This service is covered under the Sentara Health Plans Medicaid/Medicare product line.
- Ambulatory Surgery Centers: All Ambulatory Surgery Centers shall within three years of first commencing operations or on the effective date of the participating agreement, whichever is later, be accredited by JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC). All Ambulatory Surgery Centers shall have Medicare certification unless written documentation of non-applicability is accepted by Sentara Health Plans Plan.
- Home Health (HH) Equipment Suppliers and Durable Medical Equipment (DME) Suppliers: All HH and DME Equipment Suppliers shall meet JCAHO accreditation standards for equipment management services and shall participate with Medicare or Medicaid. CMS or Sentara Health Plans site surveys are also conducted, if the entity is not accredited.
- Home Infusion therapy Suppliers and Home Health Agency Suppliers: All Home Infusion Therapy Suppliers and Home Health Agency Suppliers shall be accredited by JCAHO for home infusion or home care or be accredited by the Community Health Accreditation Program (CHAP) with Medicare or Medicaid certification.

When applicable, the following may be substituted if the stated level of accreditation is absent/pending:

- Site Review– conducted by Sentara Health Plans Quality Staff
- Copy of License
- Written plan for pursuing accreditation

E. Initial Assessment of Organizational Providers:

The organizational provider must submit a legible, complete, and signed Master Agreement and Application. Sentara Health Plans contracting staff shall review the agreement for completeness.

Sentara Health Plans verifies licensure and liability insurance and confirms organizational providers are in good standing with state and federal regulatory bodies and approved by an accrediting body.

Credential to be Verified	Verification Source
License for: Home Health Agencies Hospitals & Ambulatory Care Centers Skill Nursing Facilities	State Medical or Professional Licensing Board (State or other)
Malpractice	Certificate of Insurance (COI) obtained directly from the organizational provider.
Medicare/Medicaid Certification	Certification letter obtained directly from the organizational provider; OIG Exclusions listing
Accreditation	See the grid above.
Medicare/Medicaid Sanctions	Office of the Inspector General Website (OIG), System for Award Management (SAM), Medicare Exclusion Database (MED)

F. Re-Assessment of Organizational Providers:

Sentara Health Plans re-verifies organizational providers within three years of their last assessment date. The intent of the process is to identify any changes that may affect an organizational provider's ability to perform the services they are under contract to provide.

Organizational providers may be asked to complete and sign an "Organizational Provider Re-Assessment" Application or comparable documents. The following information is obtained and verified according to the process for initial credentialing:

- Licensure
- Malpractice coverage Medicare/Medicaid Certification Accreditation

G. Tracking: Initial, ongoing and re-assessment outcomes of contracted organizational providers (medical and behavioral health) will be tracked and documented by a Quality staff person in the following format:

Name of Organization	Type of Organization	Prior Validation Date/License	Current Validation	Prior Accred Validation Date/Body Status	Current Accred Validation Data/Body/Status	Prior Site Visit Date/Body Status	Current Site Visit Date/Body Status
Mega X	Ambulatory	4/1/2004; Active	4/5/2007; Active	4/10/2004; Name; Active	4/15/2007; Name; Active	NA	NA
Getting Better	Residential	3/2/2004; Active	3/17/2007; Active	NA	NA	2/2/2004; CMS Compliant	2/10/2007; CMS Compliant

XVII. ATYPICAL PROVIDERS:

Atypical providers are those providers that do not have credentialing requirements as per NCQA, however do provide services to Medicaid beneficiaries and are regulated under the Virginia Administrative Code. Entities or providers covered under this section are:

- Adult Day Health Care - Regulations: (12 VAC 30-120-940(B)); (12 VAC 30-120-940(C)) and 12 VAC 40-60-10 et seq and EDCD Waiver Manual: Chapter II, Pages 11-17
- Agency Directed Personal Care - Regulation: (12 VAC 30-120-950(D)) and EDCD Waiver Manual: Chapter II, Pages 8-11
- Agency Directed Respite Care – Regulation: (12 VAC 30-120-960(D)) and EDCD Waiver Manual: Chapter II, Pages 8-11
- Personal Emergency Response System (PERS) - Regulations: (12 VAC 30-120-970(D)) and (12 VAC 30-120-970(E)) and EDCD Waiver Manual: Chapter II, Pages 17-19
- Consumer Directed Services (Personal Care Aide) – Regulation: (12 VAC 30-120-980 (D)(10)) and EDCD Waiver Manual: Chapter II, Pages 21-22
- Nursing Facility- Regulation: **(**12 VAC 30-60-300) and EDCD Waiver Manual: Chapter II

1. Organizational Providers who meet these criteria are approved for credentialing and recredentialing by the Credentialing Department if there is:

a) Completed Sentara Health Plans application, which includes a current and signed attestation and addresses
b) Copy of the current and valid medical/business/facility license.
c) Copy of the malpractice policy face sheet or completed liability information section on the application, to include policy number, effective dates of coverage, and coverage amounts where applicable
d) Copy of the accreditation certification, if applicable

e) Quality measures (may include initial credentialing site visit to include an assessment of Americans with Disability Act (ADA) requirements) or some other policy and/or procedure
f) Primary Source Verification of associated credentialing documentation
g) Verification that the provider is in good standing and has met all State and Federal regulatory requirements.
h) Confirmation every three years that the provider continues to be in good standing with State and Federal regulatory bodies

XVIII. DELEGATED CREDENTIALING:

A. Sentara Health Plans enters into delegated agreements with organizations to perform credentialing and recredentialing for prospective and existing Sentara Health Plans practitioners. Through the execution of a pre-site audit of policies, procedures and files (when available), a contractual agreement, annual assessment (after the initial assessment) of policies, procedures and files, and reporting requirements, Sentara Health Plans ensures:

- Each delegate follows CMS, DMAS or its designee, NCQA, Sentara Health Plans and other required regulatory and accreditation requirements, as specified.
- At least semi-annual reporting and the exchange of data is conducted in a timely, efficient, and effective manner.

Sentara Health Plans retains the right of accountability and oversight for credentialing and recredentialing activities of practitioners (to include behavioral health) in all instances and even if Sentara Health Plans delegates all or part of these activities. Sentara Health Plans retains the right to decide to approve, deny, suspend, or terminate a practitioner, provider, vendor, or sites where it has delegated decision-making. Annually, Sentara Health Plans establishes and implements written procedures to ensure effectiveness. Requirements and rights are reflected in the delegation agreements.

These criteria must be met for Sentara Health Plans to enter into a delegated agreement:

- The delegated entity shall provide Sentara Health Plans data and information as requested per the delegated credentialing agreement.
- The delegated entity shall document Sentara Health Plans describing how data collection, information development, and verification processes are performed.
- Sentara Health Plans is provided sufficient and clear information on database functions that include any limitations of information available from the delegated entity (for example, practitioners not included in the database); the time frame for delegated entity responses to requests for

information; and a summary overview of quality control processes relating to data integrity, security, transmission accuracy, and technical specifications.

- Sentara Health Plans and the delegated entity agree upon the format for the transmission of credentialing information for individuals from the delegated entity.
- Sentara Health Plans can easily discern which information transmitted by the delegated entity is from a primary source and which is not.
- For information transmitted by the delegated entity that can expire (for example, licensure, board certification), the date the information was last updated from the primary source will be provided by the delegated entity upon request.
- The delegated entity certifies that the information transmitted to Sentara Health Plans accurately presents the information obtained by the entity.
- Sentara Health Plans can discern whether the information transmitted by the delegated entity from a primary source is the primary source information in the agency's possession pertinent to a item or, if not, where additional information can be obtained.
- Sentara Health Plans can engage the quality control process of the delegated entity when necessary to resolve concerns about transmission errors, inconsistencies, or other data issues that may be identified occasionally.

Sentara Health Plans ensures through an initial onsite pre-delegation audit and annual delegated audits thereafter that these standards are met:

- The credentialing information collected and maintained in the verification process is accurate, up-to-date and supported by documentation.
- The delegated entity utilizes designated equivalent sources.
- The delegated entity queries the NPDB for information on adverse clinical privilege action taken by a health care entity.
- Sentara Health Plans Plan obtains information regarding changes in a practitioner's credentialing status from the accredited hospital or delegated entity to which it delegates credentialing.

All delegated practitioners must be approved by the Chief Medical Officer or designee, Sentara Health Plans Credentialing Committee and/or Committee Chairperson at initial credentialing and recredentialing.

B. if Sentara Health Plans contracts with a delegate and the delegation arrangement includes protected health information (PHI) by the delegate, the delegation agreement will include these provisions to ensure PHI will remain protected:

- A list of the allowed uses of PHI
- A description of delegate safeguards to protect the PHI from inappropriate use or further disclosure.
- A stipulation that the delegate will ensure that subdelegates have similar safeguards.
- A stipulation that the delegate will provide individuals with access to their PHI.
- A stipulation that the delegate will inform the organization if inappropriate uses of PHI occur.
- A stipulation that the delegate will ensure PHI is returned, destroyed, or protected if the delegation agreement ends.

Please note:

- If Sentara Health Plans conducts annual file audits of delegates one year, it does not have to conduct annual file audits the subsequent year if the delegate does not credential or recredential any practitioners before the next file audit is scheduled to occur. Here, the delegate must submit proof it did not credential or recredential any practitioners between audit cycles. Sentara Health Plans shall maintain and meet all delegation oversight.
- A practitioner can participate under a delegated agreement and also be credentialed by Sentara Health Plans as a licensed independent practitioner. Please refer to the section on Dual Credentialing/Contracting. These providers are called "dually contracted" providers.

XIX. DUAL CREDENTIALING and CONTRACTING

A. Dually Credentialed:

i. Sentara Health Plans grants dual credentialing to participating practitioners who can satisfactorily demonstrate the appropriate level of education and training in the specialties s/he wishes to practice. Appropriate education and training must be provided to Sentara Health Plans, and if not, there must be satisfactory evidence, as determined by Sentara Health Plans, of experience and hours of practice in the desired specialties. These practitioners are considered "dually credentialed" practitioners. For example: An internal medicine doctor can act as a primary care physician and a specialist.

B. <u>Dually Contracted:</u>

i. Sentara Health Plans considers those practitioners contracted directly with Sentara Health Plans Plan as a licensed, independent practitioner and with a contracted delegated entity as “dually contracted” practitioners.

2024 Credentialing Program Description Signature Page:

Effective Date: **January 1, 2024**

APPROVED BY:

Sentara Health Plans Plan Chief Executive Officer or designee	Date
Sentara Health Plans Plan Credentialing Committee Chairperson or designee	Date

Original Date: **March 9, 2023**

Reviewed Date(s):

Revised Date(s):

Attachment 2: DEA/CDS Certificate Form

The Optima Health Plan (OHP) Drug Enforcement Agency (DEA)/Controlled Drug Substance (CDS) Form serves as proof that the provider (noted below) does not hold a current and valid Virginia DEA/CDS Certificate and Number, issued by the Drug Enforcement Agency of the U.S.

This form allows providers to be credentialed or recredentialed, avoid suspension and possibly termination from the OHP Network. The form must be completed in its entirety, signed and dated by the provider. By doing so, the provider attests that all information entered on this form is accurate, truthful and will be adhered to.

SECTION 1: To be completed by the provider

By initialing below, the provider agrees to the following:

1. I, _____, do not hold a valid and current Virginia DEA/CDS Number and Certificate.

2. I, _____, shall not write medical or other prescriptions for medications for health plan members until I have duly notified OHP (as referenced in #3).

3. I, _____, shall notify and/or submit a copy of my valid and current Virginia DEA/CDS Certificate and Number to VPEP within five (5) business days of receipt and/or notification.

SECTION 2: Covering Provider Information - To be completed by the provider

During the period in which I agree not to write medical or other prescriptions, the following physician, who is a participating provider, shall write prescriptions on my behalf:

Name of Covering Provider: _____
Address of Covering Provider: _____
_____
_____
Phone Number of Covering Provider: _____

SECTION 3: To be completed by the provider

_____
Printed Name of the Provider

_____ _____
Signature of Provider **Date**

SECTION 4: Office Use Only - To be completed by the Health Plan Representative

Printed Name of Health Plan Representative **Date** **Echo Key# or Medicaid Id#**

Attachment 3:

Sentara Health Plans Plan
Credentialing/Recredentialing Appeals Process

A. <u>Overview</u>:

Sentara Health Plans Credentialing Staff shall verify the information in the application. The Credentialing Committee ("Committee") approves or denies all prospective and existing practitioners/providers based on SENTARA HEALTH PLANS policies and procedures and regulatory and accreditation standards.

SENTARA HEALTH PLANS and/or the Committee does not make credentialing/recredentialing decisions based solely on a practitioner's/provider's race, ethnic/national identify, gender, age, sexual orientation or type of procedure (e.g. abortions) or patient (e.g. Medicaid) in which the practitioner/provider specializes. This does not preclude Sentara Health Plans Plan or the Committee from including in its network practitioners/providers who meet certain demographic or specialty needs (ex. to meet cultural needs of members).

The Committee shall make the final credentialing/recredentialing decision. The Committee shall implement a mechanism to resolve disputes with participating practitioners/providers regarding actions by the organization that relate to either: a participating practitioner's/provider's status within the provider network or any action by the organization related to a practitioner's/provider's professional competency or conduct.

SENTARA HEALTH PLANS reserves the right to overturn all appeal (1st and or 2nd) panel decisions. No further appeal rights shall apply.

With any practitioner/provider for which the Committee makes an adverse decision, the Committee shall distinguish between a recommendation based on the following two *Denial Categories*:

- **<u>Business or Administrative Denials:</u>**

  If the Committee decides not to accept an application of a practitioner/provider for business or administrative concerns (i.e., not related to the practitioner's/provider's competence or professional conduct), the first and second level appeal procedures shall be followed and as established below should the practitioner/provider exercise his/her right to appeal.

- **Competence and Professional Conduct Denials:**

  If the Committee decides not to accept an application of a practitioner/provider based upon a concern related to a practitioner's/provider's competence and /or professional conduct, the first and second level appeal procedures shall be followed and as established below should the practitioner/provider exercise his/her right to appeal.

Competence and Professional Conduct Denials may be reported to the National Practitioner's/Provider's Data Bank, the Department of Health Professions, the American Medical Association, the Department of Medical Assistance Services, the Office of the Inspector General and any other entity as required or deemed appropriate, as this denial may affect the health and welfare of a member.

The Committee shall review all information and notify each practitioner/provider, via certified mail, of its decision to decline, suspend, reduce or terminate network privileges. If an adverse event occurs and before termination, a range of actions to improve performance may be offered to the practitioner/provider (i.e., close panels to all new members, remove all members from a practitioner/provider's panel, restrict a practitioner/provider to perform specific duties, require oversight of surgical procedures by another participating surgeon, periodic reviews of medical records, require continuing medical education course(s), require attendance at in-service(s), etc.). All practitioners/providers hurt shall receive instructions, in writing, on how to appeal a denied request for credentialing/ recredentialing.

Denial Notification Process:

The Credentialing Staff, on behalf of the Committee, shall notify the practitioner/provider by mail of the denial. The Contracting Staff, on behalf of the Committee, shall notify a participating practitioner/provider of suspension, reduction, or termination of privileges in Sentara Health Plans network. The Chairman of the Committee and/or the designated person of the Committee shall sign all credentialing/recredentialing denial letter(s).

Each notice shall:

(1) State the reason for the denial

(2) Notify the practitioner/provider that s/he may declare his/her intention to appeal by completing the Appeal Request Form and forwarding it to SENTARA HEALTH PLANS within thirty- (30) calendar days after receiving the denial notice.

B. Receipt of an Appeal Process – Applicable to 1st and 2nd Level Appeals:

Upon receipt, of an appeal request (regardless of type), Quality Appeal Staff shall:

1) Confirm the appeal request is received within 30 calendar days of the adverse decision

2) Acknowledge receipt of the appeal, in writing, within 5 business days

3) Notify the Chair of the Credentialing Committee and the Vice President of Provider Operations of the appeal request within 48 hours of receipt of the written appeal request

4) Final decisions, at the conclusion of **each** appeal level, shall be communicated to the practitioner/provider, in writing, within 45 calendar days via **certified** mail.

C. Appeal Levels:

1st Level "Standard" Appeal:

- All steps under Section B, **Receipt of an Appeal Process** shall be followed.

- The Medical Director shall appoint an impartial 1st level appeal panel. The panel shall consist of, at least, 3 qualified individuals to include, but not limited to plan representatives, committee members, committee practitioner/providers, and/or network practitioner/providers.

- From the 3 qualified individuals, at least one must be a participating practitioner/provider who:

    1) Holds an active, unrestricted license to practice medicine or a health profession

    2) Is board-certified (if applicable) by a specialty board approved by the American Board of Medical Specialties (doctors of medicine); or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine)

    3) Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate

    4) Are neither the individual who made the original adverse decision, nor the subordinate of such an individual

    5) Is not otherwise involved in network management or in direct economic competition with the appealing practitioner/provider

    6) Is a clinical peer of the appealing practitioner/provider

1st Level "Expanded" Appeal:

- All steps under Section B, **Receipt of an Appeal Process** shall be followed.

- If the appealing practitioner/provider is not satisfied with the 1st Level Appeal Decision and/or the Medical Director includes an expanded review, based on the complexity of the request, the 1st Level Expanded Appeal process will be followed, as described below:

- The Medical Director or designee shall forward the 1st Level Appeal Request, and all associated documents, for an "***expanded***" appeal to be conducted by an impartial, external quality review organization. This organization may uphold the decision, overturn the decision, or make a recommendation.

2nd Level Appeal Hearing:

- If the appealing practitioner/provider is not satisfied with the 1st Level Appeal Decision (standard and/or expanded), s/he can request a 2nd Level Appeal Hearing. The panel shall consist of at least three (3) qualified individuals that were not a member of the 1st Level Appeal Panel, to include, but not limited to plan representatives, committee members, committee practitioner/providers, network practitioner/providers and/or external, quality review organization practitioner/providers. This organization may uphold the decision, overturn the decision, or make a recommendation.

- All steps under Section B, **Receipt of an Appeal Process**, shall be followed, to include informing the practitioner/provider:

  - Of the acceptance, place, time and date of the hearing

  - That the hearing shall be scheduled no less than thirty- (30) calendar days from the request from the practitioner/provider, unless the practitioner/provider voluntarily agrees to an earlier hearing

  - Of the list of witnesses (if any) expected to testify at the hearing on behalf of the Committee

  - That s/he may submit additional written evidence, including statements by any source, to correct the record or erroneous information, as it relates to the reasons for the adverse decision(s), within thirty- (30) calendar days.

- The right to a hearing may be forfeited if the practitioner/provider fails, without good cause, to appear, the practitioner/provider involved has the right: (i) to representation by an attorney or other person of the practitioner's/provider's choice, (ii) to a record of the proceeding, copies of which may be obtained by the practitioner/provider upon payment of reasonable charges associated with preparation of the record, (iii) to call, examine and cross-examine witnesses, (iv) to present evidence determined to be relevant by the hearing chairperson and/or committee designated above, regardless of its admissibility in court, and (v) to submit a written statement at the close of the hearing

- If the practitioner/provider is represented by an attorney or to have an attorney present to advise him or her at the hearing, the practitioner/provider shall notify the Medical Director and/or designee at least five- (5) calendar days before the hearing.

- From the 3 qualified individuals, at least one must be a participating practitioner/provider who:

  1) Holds an active, unrestricted license to practice medicine or a health profession

  2) Is board-certified (if applicable) by a specialty board approved by the American Board of Medical Specialties (doctors of medicine); or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine)

  3) Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate

  4) Are neither the individual who made the original non-certification, nor the subordinate of such an individual

  5) Is not otherwise involved in network management or in direct economic competition with the practitioner/provider

  6) Is a clinical peer of the appealing practitioner/provider

C. **Exclusions**:

- Practitioners/Providers who meet the criteria below are not eligible for the appeals process:
  1) A breach in the practitioner/provider's contract with Sentara Health Plans

  2) Failure to follow and/or adhere to Sentara Health Plans policies and procedures.

  3) A suspended, revoked or terminated license with the Board of Medicine, or other applicable regulatory agencies.

4) Listed on the OIG Exclusions List

5) Medicare Opt In/Opt Out List

PLEASE NOTE:

- At all appeal levels, the practitioner/provider must establish that s/he meets Sentara Health Plans standards for participation.
- At all appeal levels, the practitioner/provider may submit additional written evidence to correct the record of erroneous information within thirty- (30) calendar days of his or her intention to appeal.
- At the Plan's discretion, all appeals filed after the 30-calendar day timeframe are at risk of not being accepted. Appeals received outside of the 30-calendar day timeframe for filing shall be reviewed case-by-case.
- The practitioner/provider will have exhausted all appeal rights at the conclusion of the 2nd Level Appeal Hearing process, if the case progresses to the 2nd Level Appeal Hearing stage.
- The recommendation of the Appeal's Panel and/or SENTARA HEALTH PLANS shall be final.
- The decision reached by the 1st and 2nd Level Appeal panels shall become a part of the record presented to the Chairman of the Committee, the Committee, any other Quality Committee(s) and/or SENTARA HEALTH PLANS.
- SENTARA HEALTH PLANS Appeal process is modeled after the requirements in the Health Care Quality Improvement Committee Act of 1986. The practitioner/provider has no procedural rights, other than those set forth herein or required by law.
- SENTARA HEALTH PLANS reserves the right to make the "final" decision (i.e., uphold or overturn) at all appeal, panel and/or hearing levels (i.e., 1st or 2nd), and no further appeal rights shall apply.

Sentara Health Plans, Inc.
Appeal Request Form

Practitioner's Name:_____

Medicaid Id #:_____

Practitioner's Specialty:_____

Practitioner's Address:_____
_____

Practitioner's Phone #: _____ Fax #:_____

Practitioner's E-Mail:_____

SENTARA HEALTH PLANS Denial
Reason:_____

Practitioner's Rebuttal:_____
_____

(*If additional space is required, please attach using a separate sheet of paper.)*

Additional Comments:_____

_____

I am requesting the appeal review checked below. I do not have to attend document investigations.

Regular Review and Appeal Document Investigation
Expanded Review and Appeal Document Investigation
Expanded Review and Appeal Hearing (only applicable to expanded review and appeal cases)

*All appeals will be governed under the Regular Review or the Expanded Review and Appeal's process unless otherwise noted.

Practitioner's Signature: _____

Date: _____

Please note: *The Appeal Request Form must be completed, signed, and dated by the practitioner filing the appeal to be considered valid. If there is supporting documentation, please attach it to the Appeal Request Form.*

FEEDBACK/COMMENTS:

Feedback related to SENTARA HEALTH PLANS Credentialing Program Description, quality assurance and improvement activities, and clinical or service studies should be mailed to:

Sentara Health Plans

Attn: Medical DIrector

1330 Sentara Park

Virginia Beach VA 23464

Comments and suggestions will be reviewed and assessed for quality improvement opportunities.

APPROVED BY:

2024 Credentialing Program Description Signature Page

_____

Quality Improvement Committee (QIC) Chair Date