Select Health Credentialing
Policy and Procedure Manual

Effective January 2024 – January 2025

Select Health

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ADDENDA

Get Started. Access these quick links to begin the Select Health Credentialing process:

- **Select Health Credentialing Steps**
- **Provider Participation Request Form**

Questions? Contact the appropriate state office for assistance:

- **Colorado: coproviderrelations@selecthealth.org**
- **Idaho: idproviderrelations@selecthealth.org**
- **Nevada: nvproviderrelations@selecthealth.org**
- **Utah: practitionercontracting@selecthealth.org**

Introduction

The *Select Health Credentialing and Recredentialing Policy Manual* includes credentialing, recredentialing, and credentialing committee policies and procedures that may be applicable to physicians, ancillary providers, and contracted facilities/vendors as well as their practice managers and office staff. The intent of this manual is to explain what is required during the credentialing and recredentialing process.

Select Health Credentialing will review this manual annually. Additions, deletions, and changes are approved by the Select Health Credentialing Committee.

Select Health publishes this manual on its provider website (**www.selecthealth.org/providers**) and provides a link to the document in replies to all credentialing inquiries.

If you would like to receive a copy of any Select Health policies/procedures or have questions about the content of this manual, please contact **practitionercontracting@selecthealth.org.**

Definitions

Attestation: A signed statement by a practitioner confirming that a credentialing application is valid, correct, and complete.

CAQH: Council for Affordable Quality Healthcare, a program used to capture accurate, timely, electronic, self-reported provider data used for credentialing.

CCM: Credentialing Committee Meeting, a group of participating providers who use a peer-review process and expertise to advise and make recommendations for credentialing decisions.

Centers for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs as well as the federally facilitated Marketplace.

CertiFACTS: Online resource to verify physician board certification.

Clean File: Practitioner's file is complete, with no concerns identified.

Confidentiality Agreement: Signed standard confidentiality agreement required of all members of Select Health Credentialing Committee (confidentiality agreement available upon request)

Consent Agenda: Any previously approved section of the CCM agenda.

Credentialing: A process of reviewing and evaluating qualifications of licensed independent practitioners.

Credentialing File: Documentation (electronic files) of the credentialing process for a specific provider kept in the custody of Select Health Credentialing in a secure manner. All credential files and their contents shall be considered part of confidential peer review and not subject to discovery, use, or receipt in evidence pursuant to applicable state laws protecting peer review and quality assurance data.

Definitions, continued

Division of Professional Licenses (DOPL): Agency within the Utah Department of Commerce that protects the public and enhances commerce through licensing and regulation.

Drug Enforcement Administration (DEA): A government agency that registers practitioners to dispense controlled substances and assigns practitioners Federal DEA numbers.

Erroneous Information: Evidence that a practitioner provided information on their application that differs from the information received as part of the verification process (e.g., malpractice claims information, state licensing board information, board certification decisions).

Full Termination: Practitioner being completely removed from Select Health Panel.

Locum Tenens: A descriptive term applied to qualified health care practitioners who fill positions on a temporary basis when practitioners are on sabbatical, vacation, or absent for an extended period.

National Committee for Quality Assurance (NCQA): A health plan accreditation body.

National Plan and Provider Enumeration System (NPPES): An online query system that allows users to search for a health care provider's information.

National Practitioner Data Bank (NPDB): A web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers.

Office of the Inspector General (OIG): Government agency with oversight of Medicare and Medicaid.

Opt Out: A process for eligible members to choose not to receive health care services or participate in a health care program (voluntary participation). Members are assumed to be in the program unless they opt out (opt-out enrollment).

Panel Participation: A private, voluntary contractual relationship between a practitioner and Select Health.

Participating Provider Services Agreement (PPSA): Legal agreement between Select Health and a contracted provider.

Peer Review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (e.g., evaluation of a physician's credentials and practice by another physician).

Practitioner: A healthcare provider as indicated in **Figure 1** below.

Primary Source: The entity that originally conferred or issued a credential.

Primary Source Verification: Verification of credentialing information directly from the entity (e.g., state licensing board) that conferred or issued the original credential.

NOTE: The scope of all policies/procedures is defined by the practitioner types shown in Figure 1.[1]

Definitions, continued

Recredentialing: A process of reviewing and re-evaluating qualifications of previously credentialed, licensed independent practitioners every three (3) years.

System for Award Management (SAM): Contains the data for all active exclusions records entered by the federal government, identifying those parties excluded from receiving federal contracts, certain subcontracts, and federal and non-financial assistance and benefits.

Written Plan (Ancillary): A documented plan for appropriate management of patients requiring admission to the hospital.

Figure 1. Healthcare Practitioner Types[1]

Medical Practitioner Types*	Behavioral Health Practitioner Types*	Ancillary Practitioner Types*
• Medical Doctor (MD) • Doctor of Osteopathic Medicine (DO) • Podiatrist (DPM) • Dentist (DDS) • Certified Registered Nurse Anesthetist (CRNA) • Certified Nurse-Midwife (CNM) • Physician Assistant (PA) • Registered Nurse (APRN) • Medical Advanced Practice Registered Nurse (APRN)	• Psychiatrists • Addiction Medicine Specialists • Doctoral or Master's-level Psychologists • Master's-level Clinical Social Workers • Master's-level Clinical Nurse Specialists • Psychiatric Nurse Practitioners	• Audiologist • Clinical Mental Health Counselor • Doctor of Social Work • Doctor of Optometry (OD) • Genetic Counselor • Licensed Clinical Social Worker (LCSW) • Marriage and Family Therapist (MFT) • Occupational Therapist (OT) • Physical Therapist (PT) • Psychologist • Speech-Language Pathologist • Doctor of Chiropractic Medicine (DC)

* Any other medical practitioners, behavioral healthcare specialists, and ancillary practitioners, who may be within the scope of credentialing

Initial Credentialing Policy

Policy Statement

To establish uniform guidelines, requirements and processes associated with practitioner initial credentialing in accordance with the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), state, and federal regulations. This policy applies to all states with which Select Health actively participates and all lines of business.

General Information

Panel participation. This involves a private, voluntary contractual relationship between a practitioner and Select Health. Select Health reserves the right to determine whether a practitioner will be allowed to participate on its panels based on its assessment of specialty- and location-specific needs and other business-related criteria. Select Health reserves the absolute right to determine with whom it will contract.

Credentialing body. Provider credentialing may be performed by Select Health, CAQH, or other delegated organizations. The decision to delegate any portion of the credentialing/recredentialing processes will be determined on a case-by-case basis. Any entity to which delegation is made will be expected to meet NCQA and Select Health credentialing standards.

Credentialing requirements. If applications are being accepted, each practitioner requesting membership on a Select Health practitioner panel will undergo the credentialing process. Submitting a complete application and providing valid practitioner credentials is the sole responsibility of the applicant.

A practitioner must meet certain participation requirements (see **Initial Credentialing Procedure**), unless granted an exception by the Select Health Office of the Medical Director.

Practitioners providing locum tenens coverage for panel practitioners are required to undergo the Select Health credentialing processes and be enrolled as a participating provider for the specified period of time that they will be providing the coverage.

Delegated credentialing/recredentialing. The decision to delegate any portion of the credentialing/recredentialing processes will be determined on a case-by-case basis. Any entity to which delegation is made will be expected to meet NCQA and Select Health credentialing standards.

Specific Requirements

Processing Initial Applications

Select Health will follow all NCQA and Select Health requirements when processing initial credentialing applications and verifying practitioner's credentials. Applications will be submitted to the Select Health Credentialing Committee for review and approval.

Initial Credentialing Policy, Continued

Specific Requirements, Continued

Credentialing Criteria

A practitioner must meet the following requirements to participate, unless granted an exception by the Select Health Office of the Medical Director:[2]

- Hold a current, unrestricted professional license(s) in the State(s) where the practitioner will practice (see **Addendum I - State Licensing and/or DEA Investigation/Action**).
- Hold a current Federal DEA certificate, registered in the State(s) where the practitioner will practice, schedules II-V (see **Addendum I - State Licensing and/or DEA Investigation/Action**).
- If the state requires, hold a current State Controlled Substance license(s) in the State(s) where the practitioner will practice.
- Have and maintain an appropriate covering/call arrangement, including 24-hour accessibility for urgent/emergency member issues (see *Covering Practitioner Select Health Policy*: available upon request).
- Have and maintain professional liability insurance through an admitted carrier in the State as applicable to the practitioner's specialty and location of practice, in an amount of not less than $1,000,000/$3,000,000, with an effective date on or before the approval date (see **"Exceptions" section**).
- Be certified or deemed admissible to take the applicable professional/specialty board examination in the specialty and/or sub-specialty to be practiced
  - For medical and behavioral health practitioners only:
    - Be American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), DPM, DDS, CRNAs or CNMs certified or deemed admissible to take the board examination in the specialty and/or sub-specialty to be practiced.
    - DPMs already on panel need to be American Board of Podiatric Medicine (ABPM) certified or American Board of Foot and Ankle surgery (ABFAS) certified. Any new DPMs need to be ABFAS certified.
  - If board admissible, the applicant must produce evidence of admissibility from the applicable board. Panel participation may be terminated if the practitioner does not become board certified within 3 years of becoming first-time eligible (see **Addendum II - Board Eligibility/Certification/Recertification**).

Additional requirements for MDs, DOs, DPMs, CNMs, and other advanced practice professionals (APPs) with hospital-based practices include:

- Obtain and maintain medical staff membership (in good standing) and clinical privileges appropriate to the practitioner's specialty at a Select Health-contracted hospital(s) within 120 days of being approved as a participation provider. Note that:
  - Practitioners who do not have hospital privileges at the time panel participation is approved must maintain a relationship with a participating practitioner of the same or similar specialty who is willing to provide any necessary inpatient care to the practitioner's Select Health members in the interim while practitioner is waiting for privileges to be granted.

Initial Credentialing Policy, Continued

Specific Requirements, Continued

  - The Credentialing Committee decision will be contingent upon medical staff membership and clinical privileges being granted at a participating hospital appropriate to the practitioner's practice location(s). If privileges are not granted within 120 days of the Credentials Committee decision, panel participation may be terminated, effective immediately, until such time as privileges are granted.
- MDs and DOs must have completed an American Council on Graduate Medical Education (ACGME) or equivalent AOA-accredited residency program and/or fellowship in the specialty and/or sub-specialty(s) to be practiced. DPMs, DDSs, CNMs, and CRNAs must have completed an appropriately accredited education program.
- Physicians participating in a full-time fellowship program will be eligible to participate on Select Health panels as follows:
  - A physician in a full-time fellowship must also have completed a residency in the specialty for which they are requesting panel participation and must be either board certified or board qualified in the specialty to be practiced. A physician will only be credentialed to provide facility-based services not related to his/her fellowship activities.
  - Panel participation for this category of provider will end on the last day of fellowship program participation.

Credentialing Process Notification

Select Health will notify each practitioner applying for panel participation about the credentialing process via the application cover letter including:

- **Their right to request information regarding application status.** The practitioner has the right to review any information obtained from any outside source, with the exception of references, recommendations, or other peer-review protected information.[3]
- **Information about how they will be notified of identified issues during the process.** Select Health Credentialing will provide information about any identified issues (e.g., discrepancies or other issues with the information they provided).

Confidentiality of Data

Select Health and delegates shall maintain a confidential credentialing file on each Select Health panel applicant and participant (see *Credentialing Systems Control Select Health Policy*: available upon request).[4] Credentialing files contain:

- Initial credentialing and recredentialing applications, consent forms, and other documentation submitted by the individual
- Information compiled or obtained in connection with each application process
- Information regarding corrective actions and other disciplinary actions, licensure information, DEA information, board eligibility/certification information, malpractice history, and National Practitioner Data Bank (NPDB) data
- Other relevant information (e.g., membership status, clinical privileges, competence, etc.)

Initial Credentialing Policy, Continued

Specific Requirements, Continued

Except as expressly required by law, no individual shall have the right to examine their own or any other person's credentialing file except in the discharge of a function as an employee of Select Health or as a person directly involved with the credentialing processes/functions. Credentialing files shall be treated as part of the peer-review and quality-assurance records of the hospital/facility, which are protected by state immunity and confidentiality laws.

A practitioner may review any data they have submitted as well as data not protected by state and/or federal peer-review laws as it relates to the credentialing process by calling Select Health Credentialing and arranging a time to meet with the AVP of Select Health Provider Development.

Nondiscrimination Assessment and Monitoring

Select Health does not discriminate based on an applicant's race, ethnic/national identity, gender, age, religion, sexual orientation, or the types of procedures or patients in which the practitioner specializes, except as it relates to the clinical competence of the practitioner. Select Health assesses all Credentialing Committee decisions on an annual basis to ensure nondiscrimination and investigates reports of any discrimination as received.[5]

Exceptions to Participation Requirements

Exceptions may be made only by the Select Health Chief Medical Officer and/or their designee (e.g., the Chair of the Select Health Credentialing Committee) after review by the Select Health Credentialing Committee. Practitioner must have appropriate education, training, and clinical background; however, the Credentialing Committee Chair or their designee may consider the following in making an exception:

- Business needs
- Contract requirements or clinical needs (e.g., specialty of the practitioner and/or the geographical area where the practitioner is to practice)

Leave of Absence

If a practitioner is credentialed as a participating practitioner and experiences a break in panel membership lasting more than 30 days (for any reason), the practitioner must reapply as an initial applicant (see *Leave of Absence Select Health Policy*: available upon request).

Requirements for Out-of-State Telehealth Practitioners

Contracting with out-of-state telehealth practitioners will be at Select Health's discretion in situations where there is a demonstrated need for such practitioners on Select Health networks.

These practitioners will:

- Be required to comply with all applicable licensing laws in the states where care is provided and received
- Potentially need to have relationships with practitioners where the member(s) are located for continuity of care purposes and if the member(s) needs to be seen in person
- Possibly need to have privileges at Select Health-participating facilities

Initial Credentialing Policy, Continued

Specific Requirements, Continued

Exceptions

Exceptions to this policy may only be granted by the Office of the Medical Director in accordance with state and federal requirements.

Ancillary practitioners must meet certain criteria to become credentialed with Select Health. The following requirements only apply to ancillary practitioners as specified:

- **Physicians Assistants (PAs) in Utah must have**:
  - **(For PAs who have less than 4,000 hours of practice)** A collaborating physician who is a Select Health-participating physician practicing in the same or similar practice type. The PA will be approved for the same lines of business as their collaborating physician. Any change in collaborating physician must be reported to Select Health at any time during the recredentialing process. Lines of business will be adjusted to match the new collaborating physician.
  - **(For PAs with more than 4,000 hours and less than 10,000 hours of practice experience in a given practice type)** A collaborating physician or a licensed PA with more than 10,000 hours of practice in the same or similar practice type.
  - **(For PAs changing to another practice type in which the PA has less than 4,000 hours of experience)** A collaborating physician who is a Select Health-participating physician practicing in the same or similar practice type. Any change in practice type must be reported to Select Health at any time during the recredentialing process.

> **Psychiatric Advanced Practice Registered Nurses (APRNs) must:**

- Hold psychiatric advanced practice registered nurse classification of licensure
- Have a written plan in place for appropriately managing required hospital admissions with a participating psychiatrist or group of psychiatrists who are credentialed and hold medical staff membership and clinical privileges at a geographically appropriate hospital
- Report and obtain approval from Select Health of any change in the APRN's collaborating physician(s) and/or group

> **Medical Advanced Practice Registered Nurses (APRNs). These practitioners must:**

- Have a written plan in place for appropriately managing required hospital admissions with a participating physician or group of physicians credentialed and holding medical staff membership and clinical privileges at a geographically appropriate hospital
- Report and obtain approval from Select Health of any change in the APRN's affiliated physician(s) and/or group

- **Doctor of Optometry (OD) must:**
  - Be certified
  - Maintain an optometrist license
  - Hold a DEA license if practitioners prescribe medication. If practitioners hold a DEA license and if the state requires, hold a Controlled Substance license(s)

Initial Credentialing Policy, Continued

Exceptions, Continued

- **Genetic Counselors must:**
  - Be certified by the American Board of Genetic Counseling or the American Board of Medical Genetics
  - Not be listed in the Select Health Provider Directory
- **Doctor of Chiropractic Medicine (DC) must:**
  - Have graduated from an accredited U.S. chiropractic college
  - Hold a chiropractor license
- **Board Certified Behavior Analyst (BCBA).** For Idaho BCBA practitioners, Select Health will accept board certification in lieu of state licensure.

Primary Sources

- **NCQA Standard – HP Standards and Guidelines** – Standards for Credentialing and Recredentialing
- **CMS Standard – Medicare Managed Care Manual** – Chapter 6: Relationships with Providers
- **CMS Standard – Medicare Managed Care Manual** – Chapter 11: Medicare Advantage Application Procedures and Contract Requirements

Secondary Materials

Initial Credentialing Select Health Procedure

Initial Credentialing Procedure

Purpose

To establish uniform processes associated with initial credentialing of practitioners. This procedure applies to all states with which Select Health actively participates and all lines of business.

Provisions

General

Provider credentialing may be performed by Select Health, CAQH, or other delegated organizations.

Practitioner Materials Needed to Process Application

Applicant submits credentialing documents including:

- Complete, signed application form.
- Signed confidential release/consent.
- Select Health Questionnaire.
- Copy of current State professional license(s) showing number and expiration date.
- If practitioners will prescribe medication, a copy of current federal DEA certificate.
- If practitioners hold a DEA license and if the state requires, a copy of State Controlled Substance License(s) showing number and expiration date, as required by state.
- Current malpractice insurance certificate with coverage amounts and effective dates.
- Other documents as required by the Select Health Credentialing Committee.

Review of Application

A credentialing specialist will:

- Review the application for completeness, appropriate signatures, eligibility, etc., and request clarification and additional information from the applicant, as needed.
- Notify the Provider Development Department that a new application has been received from a practitioner and prepare materials for presentation to the Select Health Credentialing Committee.
- Obtain the required primary verification (external verification) of the practitioner's credentials. Note that:
  - In instances where CAQH performs primary source verification, the credentialing specialist will obtain the verification from CAQH.
  - All credentialing verification data presented to the Credentialing Committee will be obtained less than 180 days from the date action is taken by the Credentialing Committee.
- Produce materials for presentation to the Select Health Credentialing Committee.

The application and consent can be signed up to 180 days before the date it is presented to the Credentialing Committee, which will take action on an application within 120 days of the application being deemed complete (all verification received, etc.).

Initial Credentialing Procedure, Continued

Provisions, Continued

Erroneous Information Process

If, during the credentialing verification process, evidence is obtained that the practitioner provided information on their application that differs from the information received as part of the verification process (malpractice claims information, state licensing board information, board certification decisions, etc.), the practitioner will be:[6]

- Contacted by the Select Health Credentialing department either via email, documented phone discussion, or certified letter (depending upon the severity of the erroneous information)[7]
- Asked to provide accurate data[7]
- Asked for an explanation for the discrepancy, in writing, within 15 days from the date of the call or letter by responding directly to the Select Health Credentialing department
- Notified by either email, telephone, or in writing by the Select Health Credentialing department upon receipt of their response

Inquiry of Application Status

At any time during the credentialing process, the practitioner can contact Select Health Credentialing either via phone or email to inquire about the status of their application and will be told verbally or via email what items are still outstanding and/or the anticipated date that their application will be presented to the Select Health Credentialing Committee.[8]

Primary Source Verification

The following credentialing elements require primary source verification directly from the applicable source and/or validation by the credentialing specialist, as appropriate to their profession:[9, 10]

- Current, unrestricted professional license(s) in the State(s) where the practitioner will practice (see **Addendum I - State Licensing and/or DEA Investigation/Action**).[11, 12] Written verification from the appropriate State or verification via the Internet is acceptable.[13]
- Valid DEA certificate.[13] A legible photocopy of an unexpired DEA certificate sent by the practitioner or a copy of the DEA information from the DEA validation site is acceptable (see **Addendum I - State Licensing and/or DEA Investigation/Action**).
- Unrestricted State Controlled Substance License.
- Board eligibility or certification will be obtained:[14, 15]
  - **For MDs and DOs**, Board qualification/eligibility status or certification will be obtained from the appropriate AOA or ABMS Board, or via CertiFACTS. Verification of board certification will fulfill the post-graduate education verification requirement.
  - **For MDs and DOs** who are not Board certified, one of the following will be obtained:
    - Verification of satisfactory completion of an ACGME or AOA-accredited residency program and/or fellowship in the specialty to be practiced from the program. If a physician completed a Fifth Pathway Program, primary source verification of program completion will be obtained.
    - A current AMA Physician Master File Profile

Initial Credentialing Procedure, Continued

Provisions, Continued

  - A current AOA Official Osteopathic Physician Profile Report
  - A current Federal Credentials Verification Service (FCVS) Physician Profile
- — **For DPMs, DDSs, CNMs and CRNAs** they must have completed an appropriately accredited education program and verification must be obtained from the program.
- — **For ancillary practitioners**, verification of board certification will fulfill the post-graduate education verification requirement, as applicable. Note that;
  - If not certified, written verification of satisfactory completion of an appropriate education program will be obtained from the program.
  - Select Health may verify that the education and board certification requirements have been met using the state licensing agency, specialty board or registry, if it performs primary source verification.

- Professional work history for at least the previous five years will be reviewed and any gaps verified.[16]
- Query of the National Practitioners Data Bank (NPDB) will satisfy the following verification requirements (see *Querying and Reporting Requirements Select Health Procedure*: available upon request):
  - — Medicare/Medicaid sanctions
  - — Malpractice settlements/claims payment history look back of at least five years.[17, 18]
- OIG (Office of Inspector General) and the SAM (System for Award Management) will be queried for excluded individuals. This query will satisfy the Medicare/Medicaid sanction verification requirement. If the provider is:
  - — Identified as excluded, an explanation from the practitioner will be obtained.
  - — Excluded but is approved to be participating, they will need to have the excluded contract set up in Facets for all government programs (ACA, Medicare/Medicaid/ Federal Employees Health Benefits [FEHB]).
  - — Approved as a participating provider, Provider Development will be informed and will have accountability to notify the applicable Department of Health within 30 calendar days of the discovery of excluded providers or any notification from providers regarding exclusion information.
- The Medicare Part B Opt Out list and Preclusion List will be queried for all initial applicants. If the practitioner has Opted Out or is on the Preclusion List, it will be noted for Provider Development follow up and appropriate action.[19]
- The National Plan and Provider Enumeration System (NPPES) will be queried for all initial applications to verify the National Provider Identifier (NPI).
- Review of the practitioner certificate of insurance issued directly from the malpractice carrier(s) to ensure the policy is current with appropriate coverage amounts and effective dates.
- By virtue of the consent form signed by the practitioner, if concerns exist, a credentialing specialist may obtain additional verifications as deemed appropriate.

Provisions, Continued

- **Additional Primary Source Verification for Practitioners required to hold hospital privileges**: Documentation of current medical staff membership, in good standing, at a Select Health-contracted hospital, as requested.

Response Requirements

The Select Health initial credentialing application will require response to statements regarding the following matters:

- Current malpractice coverage and present or past malpractice claims, suits, settlements, arbitration proceedings, or notices of intent to commence action.[20]
- Termination of professional liability insurance coverage or exclusion of coverage of any specific procedures.[21]
- Identification as to whether any of the following have been, or are currently in the process of being denied, revoked, suspended, refused, limited, placed on probation or under other disciplinary action, either voluntary or involuntary:[22]
  - Professional license(s) in any state.
  - Other professional registration/license.
  - DEA certification and/or state controlled substance license.
  - Membership and/or employment on any hospital medical staff.
  - Clinical privileges/other rights on any medical staff.
  - Employment or other participation with a group practice.
  - Other institutional affiliation or status.
  - Participation in any private, federal, or state health insurance program (e.g., Medicare, Medicaid).
- Identification as to whether the applicant has ever been:[23]
  - The subject of an investigation/audit by any private, federal, or state health insurance program or assessed a fine or penalty by any of these entities.
  - Convicted (or plead guilty or no contest) of a misdemeanor or felony.
  - Censored by any committees of a state or county medical association with regards to ethics or fees.
  - The subject of a licensing board inquiry.
  - Formally suspended more than twice for delinquent medical records.
- Identification as to whether the applicant has ever:
  - Withdrawn an application for medical staff membership at any facility.
  - Withdrawn a request for any clinical privilege(s) at any facility.
- Identification as to whether the applicant has any physical or mental health condition(s) that would or may affect their ability to fulfill all the functions and obligations of providing services to members as a participating practitioner with or without an accommodation.[25]

Provisions, Continued

- Note that:
  - If the applicant would require an accommodation to fulfill such functions and obligations, an explanation of what accommodations they would require should be documented and submitted with the application.
  - If needed, a query will be sent to the appropriate entity(s), including the practitioner's personal physician if a health issue is noted.
- Identification as to whether the applicant is dependent on alcohol, drugs, or chemical substances.[22]
- Identification as to whether the applicant is taking any medication that may affect either their clinical judgments or motor skills.
- Identification as to whether the applicant is under any limitations, in terms of activity or workload. Clarification and additional information will be requested from the applicant as needed.

If the practitioner responded "Yes" to any of the disclosure questions on the application, the practitioner will be asked to provide a full explanation.

The application will include an attestation statement to be signed by the applicant indicating that the information provided on the application is true and complete, and accurately discloses all matters requested.

If a practitioner desires to appeal the action of the CCM Committee, they must request the appeal, in writing, as instructed, in the *Credentialing Denial, Termination, and Appeal Select Health Policy*: available upon request).[26]

Exceptions

Exceptions may only be granted by the Office of the Medical Director, when in accordance with state and federal requirements.

Any other exceptions to the professional liability insurance requirement can be made by the Select Health Chief Medical Officer or their designee, such as the Chair of the Select Health Credentialing Committee, a representative from the Select Health Provider Development Department, or the Select Health Legal department.

IDAHO ONLY—Providers employed by the state of Idaho and covered by the Retained Risk Account created by the Idaho Tort Claims Act (Idaho Code § 6-901 et seq) may be granted an exception to the requirements relative to professional liability insurance.

PHYSICIANS PRACTICING ADDICTION MEDICINE ONLY—An exception may be granted based on the requirements relative to board certification and holding active medical staff membership, if the following requirements are met:

- Provider is board certified or board eligible in ABMS board of addiction medicine.
- If not board certified but board eligible, they agree in writing to achieve board certification within 3 years of an exception being granted.

Initial Credentialing Procedure, Continued

- Provider's full-time practice is in the area of addiction medicine.
- Provider has a documented arrangement for care of patients requiring hospitalization.

Primary Sources

- **NCQA Standard – HP Standards and Guidelines** – Standards for Credentialing and Recredentialing
- **CMS Standard – Medicare Managed Care Manual** – Chapter 6: Relationships with **Providers**
- **CMS Standard – Medicare Managed Care Manual** – Chapter 11: Medicare Advantage Application Procedures and Contract Requirements

Secondary Materials

Initial Credentialing Select Health Policy

Recredentialing Policy

Policy Statement

To establish uniform guidelines, requirements and processes associated with practitioner recredentialing in accordance with NCQA, CMS, state, and federal regulations. This policy applies to all states with which Select Health actively participates and all lines of business.

Provisions

General Information

Panel participation involves a private, voluntary contractual relationship between a practitioner and Select Health.

Select Health reserves the right to determine whether a practitioner will be allowed to participate on its panels based on its assessment of specialty and location specific needs and other business-related criteria.

Select Health reserves the absolute right to determine with whom it will contract.

Provider credentialing may be performed by Select Health, CAQH, or other delegated organizations.

The decision to delegate any portion of the credentialing/recredentialing processes will be determined on a case-by-case basis. Any entity to which delegation is made will be expected to meet NCQA and Select Health credentialing standards.

Outside of Utah where Intermountain Health does not own hospitals and Select Health offers a network, Select Health will follow NCQA requirements as well as any state and regulatory requirements.

Recredentialing Cycle Length

Select Health Credentialing will maintain a list of recredentialing dates for each practitioner that won't exceed 36 months, or 3 years, or more frequently as determined to be necessary.[27]

Processing Recredentialing Applications

Select Health will follow all requirements and processes regarding recredentialing (see **Recredentialing Select Health Procedure**).

Applications will be submitted to the Select Health Credentialing Committee for review and approval (see **Credentialing Committee Select Health Policy** and **Select Health Credentialing Committee Procedure**).

Recredentialing Criteria

A practitioner must meet the following requirements to participate, unless granted an exception by the Select Health Office of the Medical Director:[2]

- Hold a current, unrestricted professional license(s) in the State(s) where the practitioner will practice (see **Addendum I - State Licensing and/or DEA Investigation/Action**).
- Hold a current Federal DEA certificate, registered in the State(s) where the practitioner will practice, schedules II-V (see **Addendum I - State Licensing and/or DEA Investigation/Action**).
- If the state requires, hold a current State Controlled Substance license(s) in the State(s) where the practitioner will practice.

Recredentialing Policy, Continued

- Have and maintain an appropriate covering/call arrangement, including 24-hour accessibility for urgent/emergency member issues (see *Covering Practitioner Select Health Policy*: available upon request).
- Have and maintain professional liability insurance through an admitted carrier in the State as applicable to the practitioner's specialty and location of practice, in an amount of not less than $1,000,000/$3,000,000, with an effective date on or before the approval date (see **"Exceptions"** section).
- Be certified or deemed admissible to take the applicable professional/specialty board examination in the specialty and/or sub-specialty to be practiced.
  - For medical and behavioral health practitioners only:
    - Be an ABMS, AOA, DPM, DDS, CRNA or CNM certified or deemed admissible to take the board examination in the specialty and/or sub-specialty to be practiced.
    - DPMs already on panel need to be ABPM certified or ABFAS certified. Any new DPMs need to be ABFAS certified.
  - If board admissible, the applicant must produce evidence of admissibility from the applicable board. Panel participation may be terminated if the practitioner does not become board certified within 3 years of becoming first time eligible (see **Addendum II - Board Eligibility/Certification/Recertification**).

Additional Requirements for MDs, DOs, DPMs, CNMs, and other APPs with hospital-based practices include:

- Obtaining and maintaining medical staff membership (in good standing) and clinical privileges appropriate to the practitioner's specialty at a Select Health-contracted hospital(s) within 120 days of being approved as a participation provider.
- Maintaining a relationship with a participating practitioner of the same or similar specialty **for practitioners who do not have hospital privileges at the time panel participation is approved**. The participating practitioner must be willing to provide any necessary inpatient care to the practitioner's Select Health members in the interim while practitioner is waiting for privileges to be granted.

Confidentiality of Data

Select Health and delegates shall maintain a confidential credentialing file on each Select Health panel applicant and participant (see *Credentialing Systems Control Select Health Policy*: available upon request).[4]

Credentialing files contain:

- Applications, initial credentialing and recredentialing, consent forms, and other documentation submitted by the individual.
- Information compiled or obtained in connection with each application process.
- Information regarding corrective actions and other disciplinary actions, licensure information, DEA information, board eligibility/certification information, malpractice history, and NPDB data.
- Other specific information that may be relevant to membership status, clinical privileges, competence, etc.

Recredentialing Policy, Continued

Except as expressly required by law, no individual shall have the right to examine their own or any other person's credentialing file except in the discharge of a function as an employee of Select Health, or a person directly involved with the credentialing processes/functions. Credentialing files shall be treated as part of the peer review and quality assurance records of the hospital/facility, which are protected by state immunity and confidentiality laws.

A practitioner may review any data they have submitted as well as data not protected by State and/or Federal Peer Review Laws as it relates to the credentialing process by calling Select Health Credentialing and arranging a time to meet with the AVP of Select Health Provider Development.

Nondiscrimination Assessment and Monitoring

Select Health does not discriminate based on an applicant's race, ethnic/national identity, gender, age, religion, sexual orientation, or the types of procedure or patient in which the practitioner specializes, except as it relates to the clinical competence of the practitioner. Select Health assesses all Credentialing Committee decisions on an annual basis to ensure nondiscrimination and investigates reports of any discrimination as received.[5]

Exceptions

Exceptions may only be granted by the Office of the Medical Director, when in accordance with state and federal requirements.

Primary Sources

- **NCQA Standard – HP Standards and Guidelines** – Standards for Credentialing and Recredentialing
- **CMS Standard – Medicare Managed Care Manual** – Chapter 6: Relationships with Providers
- **CMS Standard – Medicare Managed Care Manual** – Chapter 11: Medicare Advantage Application Procedures and Contract Requirements

Secondary Materials

- Initial Credentialing Select Health Policy
- Recredentialing Select Health Procedure
- Credentialing Committee Select Health Policy
- Credentialing Committee Select Health Procedure

Recredentialing Procedure

Purpose

To establish uniform processes associated with recredentialing of practitioners. This procedure applies to all states with which Select Health actively participates and all lines of business.

Provisions

General

Provider credentialing may be performed by Select Health, CAQH, or other delegated organizations.

Recredentialing Process

Approximately six months prior to the recredentialing due date, a credentialing specialist will send a recredentialing materials to each practitioner scheduled to be reappointed by Select Health. These materials will include:

- For CAQH or other organization providers:
  - Letter explaining the recredentialing process and the documentation that must be returned with the application
  - Select Health Questionnaire
- For direct credentialing providers:
  - Letter explaining the recredentialing process and the documentation that must be returned with the application
  - Completed and signed application form
  - Signed confidential release/consent
  - Select Health Questionnaire
  - Other documents as required by the Select Health Credentialing Committee

A credentialing specialist will review the application for completeness, appropriate signatures, eligibility, etc., and request clarification and additional information from the applicant, as needed.

Primary Source Verification

The following credentialing elements require primary source verification directly from the applicable source and/or validation by the credentialing specialist, as appropriate to their profession: [9, 10, 28]

- Current, unrestricted professional license(s) in the State(s) where the practitioner will practice (see **Addendum I - State Licensing and/or DEA Investigation/Action**). Written verification from the appropriate State or verification via the Internet is acceptable.
- Valid DEA certificate. A legible photocopy of an unexpired DEA certificate is acceptable sent by the practitioner or a copy of the DEA information from the DEA validation site (see **Addendum I - State Licensing and/or DEA Investigation/Action**).
- Unrestricted State Controlled Substance License

Recredentialing Procedure, Continued

Provisions, Continued

- Review of the practitioner's current active medical staff membership at an Intermountain or Select Health or contracted hospital, or if an exception to active privileges at an Intermountain or Select Health-contracted hospital has been granted, verification of their active affiliation will be obtained. Note that:
  - Select Health does not intend to and will not ask for confidential information contained in the hospital medical staff confidential quality assurance (peer review) files.
  - Select Health will view granting of continuing privileges and recredentialing by the Medical Executive Committee and the Governing Board of the hospital or facility as evidence of favorable peer review at that particular entity.
- Query of the National Practitioners Data Bank (NPDB) will satisfy the following verification requirements (see *Querying and Reporting Requirements Select Health Procedure*: available upon request):
  - Medicare/Medicaid Sanctions
  - Malpractice settlements/claims payment history
- Board certification and/or eligibility via the specialty board itself or CertiFACTS if there has been a change in the status since the last credentialing cycle (see **Addendum II – Board Eligibility/Certification/Recertification**)
- The Office of Inspector Genera (OIG) and the System for Award Management (SAM) will be queried for excluded individuals. This query will satisfy the Medicare/Medicaid sanction verification requirement. Note that:
  - **If the practitioner is identified as excluded**, an explanation from the practitioner will be obtained.
  - **If the provider is excluded but is approved to be participating**, they will need to have the excluded contract set up in Facets for all government programs (ACA, Medicare/Medicaid/FEHB).
  - **If the practitioner is approved as a participating provider**, Provider Development will be informed and will have accountability to notify the applicable Department of Health within 30 calendar days of the discovery of excluded providers or any notification from providers regarding exclusion information.
- The Medicare Part B Opt Out list and Preclusion List will be queried. If the practitioner has opted out or is on the Preclusion List, it will be noted for Provider Development follow-up and appropriate action.
- The National Plan and Provider Enumeration System (NPPES) will be queried for all recredentialing/recredentialing applications to verify the National Provider Identifier (NPI).
- By virtue of the consent form signed by the practitioner, if concerns exist, a credentialing specialist may obtain additional verification as deemed appropriate.

Recredentialing Procedure, Continued

Provisions, Continued

A credentialing specialist will obtain the following information for review by the Select Health Credentialing Committee:

- Available Select Health quality improvement activities, including available performance monitoring data
- Available utilization data
- Available member complaint/grievance data, and results of member satisfaction surveys
- If applicable, review whether the practitioner has maintained an appropriate consultation/referral or supervising arrangement with an appropriate Select Health participating MD, DO, DDS or DPM
- Practitioner office site visit data if necessary (see *Practitioner Office Site Visits Select Health Policy*: available upon request).

Recredentialing may also include a review of any other information deemed important at the discretion of the Medical Director, Select Health Credentialing Committee and/or the Select Health Quality Improvement (QI) Committee.

Erroneous Information Process

If, during the credentialing verification process, evidence is obtained that the practitioner provided information on their application that differs from the information received as part of the verification process (malpractice claims information, state licensing board information, board certification decisions, etc.), the practitioner will be:[6]

- Contacted by the Select Health Credentialing department either via email, documented phone discussion, or certified letter (depending upon the severity of the erroneous information).
- Asked to provide accurate data[7]
- Asked for an explanation for the discrepancy, in writing, within 15 days from the date of the call or letter by responding directly to the Select Health Credentialing department.
- The practitioner shall be notified by either email, telephone, or in writing by the Select Health Credentialing department upon receipt of their response.

Inquiry of Application Status

At any time during the recredentialing process, the practitioner can contact Select Health to inquire about the status of their application. Select Health will inform the practitioner of outstanding items and/or the anticipated date that their application will be presented to the Select Health Credentialing Committee for consideration.

During the month that the practitioner is due for recredentialing, Select Health Credentialing will submit the practitioner's application to the Select Health Credentialing Committee for review and approval.

Recredentialing Procedure, Continued

Provisions, Continued

Response Requirements

The Select Health recredentialing application will require response to statements regarding the following matters:

- Current malpractice coverage and present or past malpractice claims, suits, settlements, arbitration proceedings, or notices of intent to commence action involving the practitioner's medical practice since the last credentialing cycle.[20]
- Termination of professional liability insurance coverage or exclusion of coverage of any specific procedures since the last credentialing cycle.[21]
- Identification as to whether any of the following have been, or are currently in the process of being denied, revoked, suspended, refused, limited, placed on probation or under other disciplinary action, either voluntary or involuntary:[22]
  - Professional license(s) in any state
  - Other professional registration/license
  - DEA certification and/or State Controlled Substance License
  - Membership and/or employment on any hospital medical staff
  - Clinical privileges/other rights on any medical staff
  - Employment or other participation with a group practice or other institutional affiliation or status
  - Participation in any private, federal, or state health insurance program (e.g., Medicare, Medicaid)
- Identification as to whether the applicant has been:[23]
  - The subject of an investigation/audit by any private, federal, or state health insurance program and/or assessed a fine or penalty by any of these entities.
  - Convicted (or plead guilty or no contest) to a misdemeanor or felony.
  - Censored by any committees of a State or County Medical Association with regards to ethics or fees.
  - The subject of a Licensing Board inquiry.
  - Formally suspended more than twice for delinquent medical records.
- Identification as to whether the applicant has withdrawn:
  - An application for Medical Staff Membership at any facility.
  - A request for any clinical privilege(s) at any facility.
- Identification as to whether the applicant has any physical or mental health condition(s) that would or may affect their ability to fulfill all the functions and obligations of providing services to members as a participating practitioner with or without an accommodation.[24]

Recredentialing Procedure, Continued

Provisions, Continued

- Note that:
  - If the applicant would require an accommodation to fulfill such functions and obligations, an explanation of what accommodations they would require should be documented and submitted with the application.
  - If needed, a query will be sent to the appropriate entity(s), including the practitioner's personal physician if a health issue is noted.
- Identification as to whether the applicant is dependent on alcohol, drugs, or chemical substances.[25]
- Identification as to whether the applicant is taking any medication that may affect either their clinical judgment or motor skills.
- Identification as to whether the applicant is under any limitations, in terms of activity or workload. Clarification and additional information will be requested from the applicant as needed.

If the practitioner responded 'Yes' to any of the disclosure questions on the application, the practitioner will be asked to provide a full explanation.

The application will include an attestation statement to be signed by the applicant indicating that the information provided on the application is true and complete, and accurately discloses all matters requested.

If a practitioner desires to appeal the action of the CCM Committee, they must request the appeal, in writing, as instructed, in the *Credentialing Denial, Termination, and Appeal Select Health Policy (available upon request)*. [26]

Exceptions

Exceptions may only be granted by the Office of the Medical Director, when in accordance with state and federal requirements.

Any other exceptions to the professional liability insurance requirement can be made by the Select Health Chief Medical Officer or their designee such as the Chair of the Select Health Credentialing Committee, a representative from the Select Health Provider Development Department, and the Select Health Legal department.

IDAHO ONLY—Providers employed by the state of Idaho and covered by the Retained Risk Account created by the Idaho Tort Claims Act (Idaho Code § 6-901 et seq) may be granted an exception to the requirements relative to professional liability insurance.

Physicians practicing Addiction Medicine only - an exception may be granted based on the requirements relative to board certification and holding active medical staff membership, if the following requirements are met:

- Provider is board certified or board eligible in ABMS board of addiction medicine
- If not board certified but board eligible, they agree in writing to achieve board certification within 3 years of an exception being granted

Recredentialing Procedure, Continued

- Providers full-time practice is in the area of addiction medicine
- Provider has a documented arrangement for care of patients requiring hospitalization

Primary Sources

- **NCQA Standard – HP Standards and Guidelines** – Standards for Credentialing and Recredentialing
- **CMS Standard – Medicare Managed Care Manual** – Chapter 6: Relationships with Providers
- **CMS Standard – Medicare Managed Care Manual** – Chapter 11: Medicare Advantage Application Procedures and Contract Requirements

Secondary Materials

- **Initial Credentialing Select Health Policy**
- **Recredentialing Select Health Policy**

Credentialing Committee Policy

Policy Statement

The Select Health Credentialing Committee uses a peer-review process to make recommendations and determinations regarding credentialing decisions. This policy applies to all states with which Select Health actively participates and all lines of business.

Provisions

All initial credentialing and recredentialing applications will be presented to the Select Health Credentialing Committee for consideration and action. The Select Health Credentialing Committee meetings, in general, are scheduled bimonthly; the Credentialing Committee Chair may send out a request for an email consideration and decision.

Credentialing Committee Composition

The Select Health Credentialing Committee is a peer-review body comprised of different types of practitioners of various specialties who are participating on the Select Health network as follows:[29]

- **Committee Chair.** The Select Health Chief Medical Officer, or their delegate, is the chair of the Select Health Credentialing Committee. The Select Health Credentialing Committee Chair has the responsibility for oversight of the credentialing program and will approve the Committee minutes, indicating their review of the credentialing data and decisions associated with actions taken by the Committee.[30]
- **Designated providers (employed and affiliated) of various specialties.**
- Under certain circumstances, wherein additional specialty specific expertise is required for adequate consideration of an applicant or issue, a specialty specific consultant(s) may be included on the Committee as appointed by the Committee Chair.
- **Representatives from Select Health:**
  - Provider Relations
  - Quality Improvement Committee
  - Provider Development Department
- **One or more Select Health credentialing specialists**

Credentialing Committee Function

The Select Health Credentialing Committee:

- Has the authority to approve provider credentials to be eligible for contracting/panel participation (see **Credentialing Committee Select Health Procedure**)
- Reviews the credentials of practitioners who do not meet the criteria for participation in the network[7]
- Gives thoughtful consideration to credentialing information
- Documents meeting minutes , saving and sending them to the Select Health Medical Director

Credentialing Committee Policy, Continued

Provisions, Continued

- Electronically documents actions and attributes provider approvals to Committee voting members
- Reviews and takes action on credentialing and recredentialing policies and procedures by NCQA, CMS, state, and federal regulations[31]

Confidentiality

All members of the Select Health Credentialing Committee will sign a confidentiality agreement.

Nondiscrimination Assessment and Monitoring

Select Health does not discriminate based on an applicant's race, ethnic/national identity, gender, age, religion, sexual orientation, or the procedures/patients in which the practitioner specializes, except as it relates to the clinical competence of the practitioner. Select Health assesses all Credentialing Committee decisions on an annual basis to ensure nondiscrimination and investigates reports of any discrimination as received.[5]

Exceptions

Exceptions may only be granted by the Office of the Medical Director, when in accordance with state and federal requirements.

Primary Sources

- **NCQA Standard – HP Standards and Guidelines** – Standards for Credentialing and Recredentialing
- **CMS Standard – Medicare Managed Care Manual** – Chapter 6: Relationships with Providers
- **CMS Standard – Medicare Managed Care Manual** – Chapter 11: Medicare Advantage Application Procedures and Contract Requirements

Secondary Materials

Credentialing Committee Select Health Procedure

Credentialing Committee Procedure

Purpose

To establish a uniform process for Credentialing Committee (CCM) operations and application reviews for initial credentialing and recredentialing. This procedure applies to all states in which Select Health actively participates and to all lines of business.

Provisions

General

Select Health Credentialing submits all practitioner files to the Select Health Credentialing Committee for review. The Committee:

- Reviews the applicable credentials, discusses applicants, and takes action, as appropriate.
- Ensures a process for peer review when Select Health considers employing or contracting with a practitioner who does not meet its established credentialing standards.

Application Review

The Select Health Credentialing department identifies whether or not a file is eligible for expedited Credentialing Committee review and approval (see **Addendum I: State Licensing and/or DEA Investigation/Action** and **Addendum II: Board Eligibility/ Certification/Recertification**)

If a file is eligible for expedited approval, it will be reviewed by the Select Health Credentialing Committee Chair, Chief Medical Officer, or other qualified physician, prior to Select Health Credentialing Committee. Note that:

- If a practitioner's file is complete, **with no concerns identified and is deemed a clean file** (see **Addendum III regarding Parameters for Expedited Credentialing Committee Review and Approval**) and the practitioner meets all credentialing criteria, then:
  - The Select Health Credentialing Committee Chair, Chief Medical Officer, or other qualified physician, who may review the practitioner's file, may approve panel membership and sign the letter granting approval.[31]
  - The Credentialing department includes the practitioners under the consent agenda at the next scheduled Select Health Credentialing Committee Meeting.[32]
- If a practitioner's file is complete **with concerns identified as minor issues** (see **Addendum II regarding Parameters for Expedited Credentials Committee Review and Approval – Minor Issues**) and the practitioner meets all credentialing criteria, then:
  - The Select Health Credentialing Committee Chair, Chief Medical Officer, or other qualified physician review the practitioner's file prior to CCM, in collaboration with a Select Health Credentialing designee, to recommend approval for panel membership This recommendation is subject to confirmation by the Select Health Credentialing Committee if the file is found to be complete and the minor issues do not require additional review.

Credentialing Committee Procedure, Continued

Provisions, Continued

  - If it is found to be complete and the minor issues **do require additional review**, the Select Health Credentialing Committee Chair, Chief Medical Officer, or other qualified physician recommend further review by the Select Health Credentialing Committee.
- If a file is not eligible for expedited approval, file will be reviewed by the Select Health Credentialing Committee.[33] The Select Health Credentialing Committee may approve panel participation and sign the letter granting approval.

Application Status

Approved Application Status

A Participating Provider Services Agreement (PPSA) and other plan orientation documents will be sent to the practitioner within 10 business days of the Select Health Credentialing Committee decision.

Once the signed contract is returned to Select Health, the practitioner will be enrolled and sent a welcome letter within 60 calendar days of the date of the Select Health Credentialing Committee decision.[34] For recredentialing, if practitioner is approved, a recredentialing letter is prepared and sent to the practitioner, within 60 calendar days of the date of the Select Health Credentialing Committee decision.

The participating practitioner effective date will not be earlier than the date of the credentialing decision.

The enrollment process will include a review of the practitioner's credentials data, that has been entered into Provider Data Management System, to make certain all data required for accurate enrollment and practitioner listings in Select Health directories and claims systems are verified and accurate.[35]

The practitioner will be submitted to the Practitioner Panel Strategy Committee (PPSC) for consideration of the practitioner's participation on other Select Health plans.

The Provider Development Department submits new enrollment information, as applicable, to local and national network partners.

UTAH ONLY—If the practitioner is approved by the Select Health Credentialing Committee, they are approved to participate on the Select Choice, Select Care, and Select Access provider networks.

Pending Application Status

If a practitioner's application is tabled or pended, a credentialing specialist will document the reasons leading to the decision, assist in obtaining the additional information deemed necessary by the Select Health Credentialing Committee, and put the application on the agenda for a future Select Health Credentialing Committee meeting.

Credentialing Committee Procedure, Continued

Provisions, Continued

Denied Application Status

If the application is denied, within 10 business days of the decision, a credentialing specialist will prepare a letter to the applicant, to be signed by the Medical Director, indicating the denial and the reasons leading to the decision.

If the denial is related to clinical competence, professional conduct, or other issues that may require that a report be submitted to State or National agencies (NPDB, etc.), the Select Health legal department will be contacted for advice and interpretation of the requirements (see *Querying and Reporting Requirements Select Health Policy*: available upon request).

Reporting

A report of the Select Health Credentialing Committee actions will be submitted to the Select Health Quality Improvement (QI) Committee at least quarterly.

Quality of Care

If any issues related to quality of care (see *Appeal of Select Health QIC Action Select Health Procedure*: available upon request), professional conduct, moral turpitude, etc., are deemed reason for termination from the panel (only full terminations), the Select Health Credentialing Committee will make a recommendation to Select Health Quality Improvement Committee (QIC), who will review the issue and take action (see the *Credentialing Denial, Termination, and Appeal Select Health Policy*: available upon request).

Exceptions

Exceptions may only be granted by the Office of the Medical Director, when in accordance with state and federal requirements.

Primary Sources

- **NCQA Standard – HP Standards and Guidelines** – Standards for Credentialing and Recredentialing
- **CMS Standard – Medicare Managed Care Manual** – Chapter 6: Relationships with Providers
- **CMS Standard – Medicare Managed Care Manual** – Chapter 11: Medicare Advantage Application Procedures and Contract Requirements

Secondary Materials

Credentialing Committee Select Health Policy

References

1. NCQA, CR1, Element A, Factor 1
2. NCQA, CR1, Element A, Factor 3
3. NCQA, CR1, Element B, Factor 1
4. NCQA, CR1, Element A, Factor 10
5. NCQA, CR1, Element A, Factor 6
6. NCQA, CR1, Element A, Factor 7
7. NCQA, CR1, Element B, Factor 2
8. NCQA, CR1, Element B, Factor 3
9. NCQA, CR 1, Element A, Factor 2
10. CMS, MMCM, Section 60.3, Primary Source Verification
11. NCQA, CR 3, Element A, Factor 1
12. CMS, MMCM, Ch. 6, Section 60.3, Primary Source Verification, Factor 1
13. NCQA, CR 3, Element A, Factor 2
14. NCQA, CR 3, Element A, Factor 3-4
15. CMS, MMCM, Ch. 6, Section 60.3, Primary Source Verification, Factors 2-3
16. NCQA, CR 3, Element A, Factor 5
17. NCQA, CR 3, Element A, Factor 6
18. NCQA, CR3, Element B, Factor 1
19. CMS, MMCM, Ch. 6, Section 60.2, Opt-Out Providers
20. NCQA, CR 3, Element C, Factor 5
21. NCQA, CR3, Element C, Factor 6
22. NCQA, CR3, Element C, Factor 3
23 NCQA, CR3, Element C, Factor 4
24. NCQA, CR3, Element C, Factor 1
25. NCQA, CR3, Element C, Factor 2
26. MMCM, Ch. 6, Section 60.4
27. NCQA, CR4, Element A
28. NCQA, CR 3, Element A
29. NCQA, CR2, Element A, Factor 1
30. NCQA, CR1, Element A, Factor 9
31. NCQA, CR2, Element A, Factor 3
32. NCQA, CR1, Element A, Factors 4 & 5
33. NCQA, CR 2, Element A, Factor 2
34. NCQA, CR 1, Element A, Factor 8
35. NCQA, CR 1, Element A, Factor 11

Addenda

ADDENDUM I: State Licensing and/or DEA Investigation/Action

A practitioner who has experienced a licensing or DEA investigation and/or action may apply for and be considered for panel participation or continued panel participation under the following circumstances:

- The issue and/or investigation has been fully resolved.
- The practitioner must provide full disclosure and copies of all documentation regarding the issue.
- As applicable, the practitioner must comply with the conditions and/or stipulations as imposed by the applicable state or federal agency (the practitioner must provide a letter from the applicable agency indicating compliance).
- As applicable the practitioner must comply with the conditions and/or stipulations as imposed by any hospital or other entity and must provide the specific details of such conditions and/or stipulations.
- For issues associated with the practitioner's inappropriate drug use, the practitioner may be required to enter into a random substance abuse testing protocol.
- The practitioner may be asked to meet with the Select Health Credentialing Committee, or its designee, before a final decision is rendered.

ADDENDUM II: Board Eligibility/Certification/Recertification

For Board Eligibility/Certification, Select Health requires the following:

- Practitioners must pass the Board examination within three (3) years of becoming (first time) qualified/eligible to take the applicable board examination. Network participation may be terminated if the practitioner does not become board certified within 3 years of becoming first-time eligible.
- Select Health Panel Participation for a credentialed practitioner who is first-time board eligible, but not yet board certified, is conditional upon the individual becoming board certified in the specialty to be practiced. Select Health requires practitioners to pass the Board examination within three (3) years of becoming (first time) qualified/eligible to take the applicable board examination.

When recertification is required by the applicable board:

- It is required for all Select Health participating practitioners at the time of initial application for panel participation status and/or at recredentialing.
- Failure to achieve recertification within one year of the expiration of certification is grounds for denial of a practitioner's application or termination of a practitioner's participation status.

Exceptions to the foregoing requirements may be made only by the Select Health Chief Medical Officer and/or their designee (e.g., the Chair of the Select Health Credentialing Committee) after review by the Committee. In making each exception, practitioner must have appropriate education, training, and clinical background; however, the Committee Chair or their designee may consider:

- Business needs
- Contract requirements or clinical needs (e.g., specialty of the practitioner and/or the geographical area where the practitioner is to practice)

Specialty requirements for board certification or board admissibility/eligibility for Select Health participating:

- MD and/or DO physician practitioners: A board recognized by the ABMS or a comparable AOA in the specialty of practice
- DDS, DMD, MD, and/or DO practicing as oral and maxillofacial surgeons: The American Board of Oral and Maxillofacial Surgery
- Podiatrists: The American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine
- CRNAs: The American Association of Nurse Anesthetists
- CNMs: The American Midwifery Certification Board

Addendum III: Parameters for Expedited Credentialing Committee Review and Approval – Clean Files

When possible, clean files will be reviewed and approved in advance of the Select Health Credentialing Committee Meeting by the Committee Chair and/or the Select Health Chief Medical Officer. An initial file is considered a clean file under the following circumstances:

- The practitioner meets all applicable credentialing criteria.
- The practitioner has not experienced any licensing action(s) in any state.
- There have been no more than 2 malpractice payments and no payment over $250,000 associated with the practitioner during the prior 5 years.
- In states where malpractice claims are reported to DOPL, a practitioner may still be considered to have a clean file if there are 2 or fewer malpractice claims reported to DOPL, and no payments related to malpractice claims were in excess of $250,000 during the prior 5 years.
- The practitioner has no unexplained gaps in professional practice nor any gap in practice equal to or greater than 2 years.
- The practitioner has no reports, other than malpractice settlements, in the NPDB.
- The practitioner has not experienced any professional disciplinary action(s) and has no reported criminal actions.
- There are no health-related issues associated with the practitioner's ability to practice safely.

The Select Health Credentialing Committee Chair and/or Chief Medical Officer reserves the right to request full Committee review of any applicant.

The effective date of applicants approved through the expedited process will be the day the file is reviewed and approved by the Committee Chair and/or Chief Medical Officer. The practitioner will be presented on the Consent Agenda of the next scheduled Select Health Credentialing Committee.

ADDENDUM IV: Parameters for Expedited Credentialing Committee Review and Approval – Minor Issues

When possible, Committee Chair and/or the Select Health Chief Medical Officer will review and approve files with minor issues in advance of the Select Health Credentialing Committee Meeting. On condition that there are no additional "yes" responses to disclosure questions in the practitioner's application unrelated to the minor issue, an initial file is considered a minor issue file under the following circumstances :

- Misdemeanors from more than 5 years ago. Other misdemeanors unrelated to the practice of their licensed specialty and which has no impact in the practitioner's ability to practice safely.
- Employment gaps from more than 5 years ago.
- A license was challenged, but all findings have been resolved and no licensing actions were taken.
- A license was suspended or revoked more than 10 years ago and has been reinstated without restriction.
- Terminations from a managed care organization that occurred more than 10 years ago.

Select Health Credentialing will schedule a meeting prior to the Select Health Credentialing Committee meeting with the Select Health Credentialing Committee Chair and/or Chief Medical Officer to discuss any minor issues found in the applicant's file.

The Select Health Credentialing Committee Chair and/or Chief Medical Officer reserves the right to request full Committee review of any applicant.

Practitioners will still be added to the Select Health Credentialing Committee agenda for tracking purposes. The effective date of applicants will be the day of the Select Health Credentialing Committee meeting.