



Troy Medicare Policy and Procedure

Title: Credentialing Committee		Policy Number: CRED-001	
Primary Department: Network Development	LOB: Medicare Advantage		
Effective Date: 1/1/2023	Original Date: 3/3/2023	Review Date(s):	Archive Date:
Interactive Related Department(s)			
<input type="checkbox"/> All Departments <input type="checkbox"/> Compliance <input type="checkbox"/> Medical Management <input type="checkbox"/> Provider Operations <input type="checkbox"/> Sales and Marketing	<input type="checkbox"/> Appeals and Grievances <input type="checkbox"/> Pharmacy <input type="checkbox"/> Member Services <input type="checkbox"/> Quality Management <input type="checkbox"/> Utilization Management	<input type="checkbox"/> Care Management <input type="checkbox"/> Enrollment <input type="checkbox"/> Plan Administration <input type="checkbox"/> Claims <input type="checkbox"/> Other <u>Network Development</u>	

POLICY PURPOSE

The purpose of this policy is to define the parameters and responsibilities of the Troy Credentialing Committee.

Troy Medicare is committed to complying with federal and state rules and regulations.

SCOPE

This policy applies to the Network Development department.

REFERENCES

- 42 U.S. Code § 1395w-22 - (d)(1)(C)(iii)
- 42 CFR § 422.204
- CMS Managed Care Manual, Chapter 6

RESPONSIBLE PARTIES

- Chief Medical Director
- Chief Development Officer

POLICY

Troy maintains a peer review committee, the Credentialing Committee made up of a range of industry professionals who bring technical knowledge of current medical practice within the communities served. The Credentialing Committee will always include Troy Medicare's Medical Director, a licensed medical doctor. The Credentialing Committee will meet at least 1 (one) time per year.

The Credentialing Committee has authorized the Medical Director (or approved qualified physician designee) authority to evaluate and approve "Level 1" files by remote, independent review. Level 1 files are those that meet verification standards during the credentialing process. Standard levels for Credentialing Committee review are incorporated into this policy as

Attachment A.

Sources considered when verifying credentials include, but are not limited to:

- State License to Practice
- DEA License
- Education and Training
- Board Certification Status
- Work History
- Malpractice Claims History
- State Licensing Board Sanctions
- Medicare/Medicaid Sanctions
- NPI Number

The committee must give thoughtful consideration to the credentialing elements before making recommendations. Committee discussions and recommendations must be documented in meeting minutes.

All approved files must include evidence of evaluation and approval. The medical director's approval date is considered the "credentialing decision date."

PROCEDURE

The Credentialing Committee shall:

1. Collect and verify source verifications (done by the Plan's Credentialing Staff or delegated entity on behalf of, and with oversight from, the Credentialing Committee.)

Verification
needed

What this means

License

A provider is required to have a valid, current license to practice at the time of the credentialing decision. The medical board for the state in which the practitioner practices is the acceptable primary source to validate this element.

DEA permit or CDS certificate	Verification of a current, active DEA or CDS certificate is required to ensure that practitioners can write prescriptions. The organization is required to perform the verification for each state in which the practitioner is writing prescriptions and practicing.
Education	The organization must verify the highest level of education and training. Going from the highest level to the most basic level, board certification, residency, and medical school attendance must be verified. For instance, if a practitioner is board certified, the organization can verify to this level to satisfy NCQA requirements, and no further verification needs to be performed directly with the residency or medical school.
Board certification status	<p>Board certification is not a requirement for a practitioner to be credentialed. However, the organization is required to verify if the practitioner states that he/she is board certified. Acceptable sources include:</p> <ul style="list-style-type: none"> • American Board of Medical Specialties (ABMS) • Equivalent official display agent (e.g., andros, an official display agent of the ABMS) • state licensing agency, provided the state performed the primary source verification originally with the specialty board
Work history	The work history of a provider needs to be verified with a CV or resume provided to the organization. A minimum of five years of work history should be obtained. Employment dates must include month and year. Any gap greater than six months must be explained verbally or in writing. If the gap exceeds one year, the practitioner must provide a written explanation.

Malpractice	Malpractice history up to five years must be obtained, including residency and fellowship. The National Provider Data Bank (NPDB) is the primary source to query to obtain malpractice history.
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Sanctions	State sanctions, Medicare sanctions, Medicaid sanctions, or restrictions on licensure or limitations in scope of practice need to be checked against primary sources. The NPDB is a recommended primary source that is comprehensive and trusted.
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2. Decisions are not based on race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicare) in which the practitioner specializes.
3. Seek additional information and clarification necessary to make an informed recommendation regarding the issue presented, as appropriate and necessary to support decision making.
4. Decide whether the applicant has the requisite credentials and character for appointment and reappointment.
5. Determine if conditions or restrictions are attached to the granting of credentials.
6. Develop, implement, review and revise the credentialing policies
7. Review, revise, and implement the list of specialties that are required to be credentialed by the Plan prior to participation in its network.

Healthcare professional and providers have the right to:

- Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This does not include information collected from references, recommendations and other peer review protected information.
- Be notified if any credential information is received that varies substantially from application information submitted by the health care professional or provider: (actions on license, malpractice claim history, suspension or termination of hospital privileges, or board-certification decisions with the exception of reference, recommendations or other peer-review protected information). The health care professional or provider will have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on his or her application.
- Upon request, be informed of the status of their application – if application is current and complete, the applicant can be informed of the tentative date that his or her application will be presented to the Credentialing Committee for approval

ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES/FORMS

- n/a

APPROVALS



Medical Director

03 / 06 / 2023

Date

Revision History

Revision Date	Revised by Whom	Revisions Made

Attachment A: Credentialing Committee Review Levels and Definitions

All credentialing files presented to Medical Director and/or Credentialing Committee must meet Basic Network Criteria that includes:

- Provider cannot be opted out of Medicare
- MD/DO must have a DEA license (unless specialty is Radiology or Pathology)
 - If the provider has a DEA alert, review to determine if they have any valid DEA, or none. If they possess none, the provider needs outreach to determine if they can prescribe under another physician, or failed to disclose their DEA license info, or if they truly do not possess a DEA License.
- Provider must have a valid license to practice in contracted state(s)
 - If a provider has an expired license in any of these states, additional research is required to determine if the provider is contracted in the state with expired info.

Level Name	Credentialing Authority Requirement	Level Description
Level 1 (clean)	Medical Director granted authority to evaluate and approve clean files as defined by Level 1 (clean)	Credential files with no alerts of any kind
Level 1 (exception)		<p>LEVEL 1 (Exception) = Credential files with (in the last ten years only):</p> <ul style="list-style-type: none"> • Expired/no board certifications and no other alerts, and/or: • Non-MD/DOs without a DEA License and/or: • Expired licenses in non-contracted states and/or: <ul style="list-style-type: none"> • Application disclosure questions related to unmerited/non-formal state board actions and/or: • Less than three (3) malpractice cases with sum settlements less than 1 million dollars (For initial credentials) (Only in review reports with a date of incident in the last ten years) <ul style="list-style-type: none"> ○ For recredentials, same criteria applies, but only looking back since the last credential date (only look at date of

		incidents occurring in the last 3 years)
Level 2	Files requiring Credentialing Committee Level Review	<p>Credential files with:</p> <ul style="list-style-type: none"> • Sanctions from OIG and/or: • Sanctions from SAM and/or: • Sanctions with merit disclosed on credentialing application and/or: • Sanctions Discovered by State License Alert • Sanctions reported to National Provider Databank and/or including (but not limited to: <ul style="list-style-type: none"> ○ Suspensions ○ Revocation of Privileges ○ Termination of Insurance Contracts ○ Exclusions from Federal Healthcare Programs ○ Exclusions from State Healthcare Programs ○ Consent Orders ○ Formal Reprimands • Optional: Files with malpractice settlements more than 1 million and no other alerts (for initials) (Only in review reports with a date of incident in the last ten years)