CREDENTIALING PLAN

Credentialing Plan, Policies and Procedures

INTEGRIS HEALTH PARTNERS, LLC

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Section 1 INTRODUCTION

INTEGRIS Health and several physician leaders in the community developed a new physician network known as INTEGRIS Health Partners. This physician network is governed by a board of directors, led primarily by physicians, and operates for the explicit purpose of implementing a clinical integration program. Its sole focus is controlling costs and improving the quality of health care. INTEGRIS Health Partners pursues pay-for-performance arrangements with those who pay for health care, be it health plans or directly with employers. These pay-for-performance contractual arrangements provide the opportunity to financially recognize the physicians' efforts to improve health care quality and efficiency.

INTEGRIS Health Partners, LLC (IHP) ensures that all Practitioners applying for affiliation meet rigorous credentialing standards prior to approval for participation. IHP will not base credentialing decisions, including granting Initial Credentialing, Recredentialing, and/or Network Participation status on discriminatory reasons, including on the basis of national origin, culture, race, color, gender, sexual orientation, gender identity, age, ethnicity, religion, disability, veteran status, or any other protected class, as defined by applicable state or federal law. IHP will also not discriminate in basing credentialing decisions on the patient population or typical payer source of patients in which the Practitioner specializes. IHP will comply with regulatory and accreditation standards in the development and management of credentialing with the following regulatory provisions.

Section 2 SCOPE

1. The procedures outlined in this IHP Credentialing Plan will be used by INTEGRIS Health Partners (IHP), LLC in conjunction with additional applicable policies and documents, when conducting delegated credentialing for third-party payers.
2. Types of Practitioners to credential and recredential include Practitioners who have an independent relationship in individual or group practices, facilities, and telemedicine.
   - 2.1. Allopaths (MD)
   - 2.2. Osteopaths (DO)
   - 2.3. Oral Surgeons (DDS)
   - 2.4. Podiatrists (DPM)
   - 2.5. Psychologists (PhD/PsyD)
   - 2.6. Advance Practice Registered Nurses (APRN)
   - 2.7. Physician Assistants (PA)
3. Practitioners who **do not** need to be credentialed include:

   Practitioners who practice exclusively in an inpatient setting and provide care for organization members only because members are directed to the hospital or another inpatient setting:

   - 3.1. Hospitalists
   - 3.2. Pathologists
   - 3.3. Radiologists
   - 3.4. Anesthesiologists
   - 3.5. Certified Registered Nurse Anesthetists

3.6. Neonatologists
3.7. Emergency Department Physicians
3.8. Practitioners who practice exclusively in free-standing facilities and provide care for organization members only because members are directed to the facility
3.9. Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates
3.10. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with the organization
3.11. Practitioners who do not provide care for patients/members (e.g., board-certified consultants who may provide a professional opinion to the treating Practitioner)

Section 3 PLAN / POLICY

This Plan defines the credentialing and recredentialing process for selecting and evaluating licensed and independent practitioners. Consistent with INTEGRIS's mission, "partnering with people to live healthier lives", the goal of this Plan is to enable the selection of qualified practitioners.

In some circumstances, IHP is subject to certain credentialing requirements such as state and federal regulations that may exceed current CMS and NCQA requirements.

1. INTEGRIS Health Partners, LLC (IHP) credentialing criteria defines the criteria Practitioners must meet to be considered for inclusion into the IHP participating network.
2. The IHP credentialing policy establishes that IHP will comply with regulatory and accreditation standards in the development and management of Credentialing with the following regulatory provisions:
   2.1. National Committee for Quality Assurance (NCQA) standards – Credentialing
   2.2. Centers for Medicare and Medicaid Services (CMS) guidelines
   2.3. Oklahoma Health Care Authority, SUBCHAPTER 5 Requirements for Managed Care Organizations and Dental Benefits Managers, PART 3, Provider Requirements – 317:55-5-10 Provider Contracts and Credentialing Standards
3. The IHP credentialing process defines the procedure for processing an application, and for conducting verifications to ensure all the credentialing standards are met prior to presentation of the application to the Network Strategy and Credentials Committee (NSCC).
4. For purposes of delegated credentialing and reporting Practitioner effective dates to third-party payers, the Practitioner's effective date will be the first day of the month following approval of the Practitioner's credential file by the NSCC or IHP President or NSCC Chair(s)
5. Credentialing and recredentialing files for all Practitioners, monthly sanction exclusion check (e.g., OIG, SAM, NPDB, state licensing entity, state Medicaid sanction entity) results, and NSCC meeting minutes will be maintained for a period of ten (10) years.

Section 4 DEFINITIONS

Advanced Practice Practitioner means any person holding a license (other than a temporary license) (a) to provide health care services as a physician assistant under Title 59, Oklahoma Statutes, Sections 519.1 *et seq,* as amended

from time to time; or (b) to provide health care services as an advance practice registered nurse under Title 59, Oklahoma Statutes, Sections 567.1 *et seq.,* as amended from time to time.

Adverse Event means an unusual situation that is harmful or may result in harm, to a patient/beneficiary. Examples include suicide, homicide, medicine errors, and criminal action by a staff member to a patient/beneficiary.

Applicant means any Practitioner that submits an applicant to be part of the IHP Network.

Beneficiaries means participants in health, dental, and vision plans.

Board means the Board of Directors for INTEGRIS Health Partners, LLC.

Board-Certified physician means a physician who has successfully completed a medical board's examination and has been certified by the board as a specialist in a particular area of practice. Before sitting for such an examination, the physician must meet the specialty training requirements of the applicable board. Specific health plans may only accept ABMS and AOA boards.

Complaint means an oral or written expression of dissatisfaction by a patient/beneficiary (or provider or representative on behalf of a patient/beneficiary) regarding services performed by participating providers or Practitioners.

Credentialing means the process by which qualifications, certification, and licenses of Practitioners are examined and approved for network participation according to IHP guidelines.

Delegation means a process by which the organization (health plan) gives another entity the authority to perform certain functions on its behalf. Although the organization may delegate the authority to perform a function, it may not delegate the oversight responsibility for ensuring that the function is performed appropriately.

Disaster means an unexpected or sudden event that significantly disrupts the ability of the IHP Network to provide care, treatment, or services; or the environment of care itself; or that results in a sudden, significantly changed, or increased demand for service. Disasters can be pandemic, or either human-made or natural (such as an electrical system failure or a tornado), or a combination of both, and they exist on a continuum of severity.

Employed Medical Staff Practitioners means those Employed Practitioners, regardless of specialty, who are employed by any entity of INTEGRIS Health, Inc., other than IMG, and who are on the medical staff at any hospital or surgery center affiliated with INTEGRIS Health, Inc., without limitation, INTEGRIS Baptist Medical center, INTEGRIS Southwest Medical Center, INTEGRIS Valley Hospital, INTEGRIS Health Edmond, Lakeside Women's Hospital.

Employed Practitioners means those Practitioners, regardless of specialty, who are employed by INTEGRIS Medical Group or any other entity of INTEGRIS Health, Inc.

Facility means the service site for the delivery of various levels of care.

INTEGRIS Health Partners (IHP) is INTEGRIS' network, composed of employed and independent Practitioners, who care for the populations served under Value-Based Care agreements.

IHP Credentialing Office is the office responsible for credentialing Practitioners and ensuring Practitioners are following all appropriate policies and procedures.

IMG means INTEGRIS Ambulatory Care Corporation d/b/a INTEGRIS Medical Group.

Independent Medical Staff Practitioners means those Practitioners, regardless of specialty who are not Employed Practitioners but who are on the medical staff at any hospital or surgery center affiliated with INTEGRIS Health, Inc., including, without limitation, INTEGRIS Baptist Medical Center, INTEGRIS Southwest Medical Center, INTEGRIS Canadian Valley Hospital, INTEGRIS Edmond, Lakeside Women's Hospital or any other affiliated hospital or surgery center within the IHP Network that has been independently accredited by the Joint Commission or other nationally recognized accreditation body.

Independent Practitioners means those Practitioners, regardless of specialty, who are not Employed Practitioners and who are not on the medical staff at any hospital or surgery center affiliated with INTEGRIS Health.

LEIE is the OIG's List of Excluded Individuals and Entities. It is the primary source of information about OIG exclusions and is updated monthly. It provides more details about persons excluded by OIG than GSA's SAM such as the statutory basis for the exclusion action, the person's occupation at the time of exclusion, the person's date of birth, and address information. Also, because it is maintained directly by OIG, OIG's exclusions staff can respond to question and verify information regarding persons identified on LEIE. The effect of OIG exclusion is to preclude payment by federal healthcare programs for items or services furnished, ordered, or prescribed by the excluded party. OIG exclusion does not affect a person's ability to participate in other government procurement or non-procurement transaction.

NCQA shall mean The National Committee for Quality Assurance.

Network refers to INTEGRIS Health Partners (IHP)

Network Strategy and Credentials Committee (NSCC) is INTEGRIS Health Partners' peer review body responsible for administering the credentialing and recredentialing process and takes ownership of ensuring the IHP network is comprised of Practitioners that collectively provide the range of clinically integrated quality and cost-effective services required to meet the needs of the populations served by IHP.

NPDB is the National Practitioner Data Base web-based repository of reports used as a workforce tool to enhance professional review efforts. The information contains medical malpractice payments, adverse actions, and judgment or conviction reports regarding health care practitioners, providers, and suppliers. Subscribing to the NPDB Continuous Query provides more timely information to the organization. The organization is notified within 24 hours of the NPDB's receipt of all licensure actions, Medicare/Medicaid exclusions, medical malpractice payments, clinical privilege actions, and other adjudicated actions or findings concluded against a Practitioner.

OIG means the Office of Inspector General, responsible for the oversight of the Department of Health and Human Services (HHS's) portfolio of programs. The OIG has dual responsibilities to the Secretary of Health and Human Services and to Congress. The OIG requires that healthcare organizations check the OIG List of Excluded Individuals/Entities (LEIE).

Peer is an individual who practices in the same profession or who has expertise in the appropriate subject matter. Peer References are requested at the time of initial and/or recredentialing (Appendix K).

Peer Review is a process that allows IHP to evaluate an individual's professional practice that may affect the quality of care and patient safety.

Physician means (a) any person that holds a license (other than a temporary license) to practice medicine and/or surgery under Title 59, Oklahoma Statutes, Sections 480 *et seq.,* as amended from time to time, or (b) any person

holding a license (other than a temporary license) to practice osteopathic medicine and/or surgery under Title 59, Oklahoma Statutes, Sections 620 *et seq.,* as amended from time to time.

Practitioner A physician, dentist, or other licensed health care practitioner.

Program Manager is a role responsible for IHP Network Operations.

Primary Care Provider (PCP) means a Practitioner who provides all routine and preventive care, such as annual physicals, treatment for flu, well-baby visits, and routine childhood immunizations. If the PCP feels that a particular condition requires specialty care that they cannot perform in their office, they will issue a written referral for the patient to visit an appropriate participating physician or facility.

Provider means a facility that provides health care such as a hospital, free standing emergency department, ambulatory surgery center, urgent care center, home health care center, etc.

Recredentialing means the process by which qualifications, certifications, and licenses of Practitioners are re-examined for re-approval according to IHP guidelines.

SAM is the General Services Administration (GSA) System for Award Management (SAM). It is a comprehensive database that federal agencies can use to determine the eligibility of individuals or entities to participate in federal programs. SAM includes OIG's exclusions but also includes debarment actions taken by federal agencies. The LEIE lists only exclusion actions taken by OIG.

Special Notice means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

Specialist physician means a physician who provides medical care in any generally accepted medical specialty or subspecialty.

Sub-delegation occurs when the organization's delegate gives a third entity the authority to carry out a delegated function.

Section 5 RESPONSIBILITIES AND ACCOUNTABILITY

1. **Board of Directors of IHP.** The IHP Board of Directors (Board) has ultimate responsibility for credentialing and recredentialing Practitioners in the IHP Network
2. **Network Strategy and Credentials Committee.** The Board has delegated responsibility to the Network Strategy and Credentials Committee (NSCC) as a peer review body for administering the credentialing and recredentialing process and has oversight of all credentialing activities. The committee owns and ensures the IHP Network is comprised of Practitioners that collectively provide the range of clinically integrated quality and cost-effective services required to meet the need of the populations served in identified geographic locations (Appendix A)
   2.1. **Credentialing**
      2.1.1. Develops IHP participation criteria.
      2.1.2. Develops the IHP credentialing criteria.
      2.1.3. Reviews and evaluates the qualification of every applicant and the recommendations of the IHP President, Chairperson, or designated Practitioner for initial credentialing, recredentialing, and make written reports of its findings and recommendations.

2.1.4. Review and evaluate the qualification of every Advanced Practice Practitioner applying for network participation and make written reports of its findings and recommendations.

2.1.5. Review as requested, all information regarding the current competence of individuals currently participating in the network.

2.1.6. Oversee and approved the development of professional standards and credentialing criteria and ensure that professional standards and credentialing criteria are uniformly applied.

2.1.7. Develop and review policies related to granting network participation, organizational processes related to credentialing and recredentialing and requisite qualifications of applicants.

2.1.8. Review all associated quality of care issues, member complaints, or off-site quality complaints for all members of the network. Ensure that there are no patterns of adverse behavior of clinical judgment.

2.1.9. Review all applicants that do not meet the standard criteria for participation, or for whom adverse information was discovered during the credentialing verification process, requiring consideration for exception criteria for individual Practitioner participation based on, adverse criminal history, adverse history of professional disciplinary actions, lack of DEA and CDS registration, lack of board certification and any potential risk to the organization.

2.2. **Ongoing Monitoring**

2.2.1. Ensures that IHP members maintain compliance to the network standards as outlined in the Network Participation Agreement and recommends probation or termination of IHP members who fail to adhere to network standards or performance standards sent in partnership with the Performance Improvement Committee.

2.2.2. Monitors physician satisfaction regarding IHP network activities and oversees physician relations activities.

2.2.3. Serves as a forum for education and discussion of IHP partnership concerns.

2.2.4. Maintain collaboration and communication with Physician Leadership Council.

2.2.5. Conduct annual evaluation process to assess participation and engagement. Consider pipeline for new Committee and future Board of Directors members.

2.3. **Network Strategy**

2.3.1. Performs annual market analyses to ensure adequate physician geographic coverage and network composition by physician specialty.

2.3.2. Reviews affiliation strategies for potential geographical and market share expansion of IHP network.

2.3.3. As needed, partners with INTEGRIS Health strategy department on IHP Network Strategy Initiatives.

2.4. **Regulatory Requirements**

2.4.1. Ensures credentialing activity is compliant with all federal and state regulatory requirements.

2.4.2. Ensures credentialing activity is compliant with The Joint Commission, Health Plan(s), NCQA, and other accrediting agency standards that the network may designate.

2.5. **Reporting to the IHP Board of Directors**

2.5.1. An annual report of committee activities for the year, including partnership status updates.

2.5.2. Recommended network expansion strategy when deemed appropriate

2.5.3. Recommended modification(s) of the IHP Credentialing Plan and Policies and Procedures, as appropriate

3. **Practitioners**

3.1. It is the responsibility of the individual Practitioner to provide a complete application for initial credentialing and recredentialing.

3.2. Failure to comply within the timeframe designated in the Practitioner recredentialing notification letter shall invoke the termination process as defined in Section 27. An individual Practitioner, whose participation status has been terminated for any reason, may re-apply to the network as an initial applicant in accordance with the initial credentialing procedures, however, the individual practitioner must wait one (1) year from the termination to reapply to the IHP Network.

4. **IHP President**

4.1. The IHP President will serve as the medical director of the delegated credentialing program.

4.2. The IHP President and the NSCC will be responsible for the program's compliance with relevant laws, regulations, and accreditation standards

4.3. They will oversee the delegated credentialing, recredentialing, and ongoing monitoring process.

5. **IHP Network Program Manager**

5.1. Solicit new applicants for participation based upon individual Practitioner specialty and network need in specific geographic regions; and,

5.2. Review unsolicited individual Practitioner applications to determine if applicant's specialty is currently needed in that area; and,

5.3. When there is no network need, send written notification to the applicant and return the application with the notification/letter.

6. **IHP Credentialing**

6.1. Compile, verify, and report credentialing data.

6.2. Handles time-sensitive information, documenting verification, and releasing the information to the NSCC within the required time period for all initial and recredentialing application(s).

6.3. Populates the credentialing database with the most recent verified data available.

6.4. Ensures that the credentialing process described in this policy is completed in a timely and efficient manner for all Practitioners.

6.5. Notify the IHP President and Program Manager of Operations, promptly, of the adverse actions taken by the NSCC.

6.6. Ensures that all individual Practitioners presented to the NSCC for approval meet the criteria as designated in this Plan.

6.7. Ensure that all reporting agencies are reviewed for adverse information and disciplinary activities against participating Practitioners within the IHP Network.

6.8. Present to NSCC any Practitioner who is deemed to pose a significant risk regarding patient safety or substandard medical care.

6.9. Notify new individual Practitioners of their successful completion of the credentialing process. The notification is provided within ten (10) days of the date of approval by the NSCC or the IHP President or designated Practitioner.

7. **INTEGRIS Central Verification Office (CVO)**

7.1. Compile and verify credentialing data.

7.2. Handles time-sensitive information and documenting verification within the requested time period for all initial and recredentialing application(s) as specified in this Plan.

7.3. Populates the credentialing database with the most recent verified data available.

7.4. Ensures that the credentialing processes described in this Plan are completed in a timely and efficient manner for all Practitioners.
7.5. Notify the IHP Credentialing staff promptly, of any adverse findings found while processing the credentialing application.
7.6. Ensures that all reporting agencies are reviewed for adverse information and disciplinary activities against a participating Practitioner within the IHP Network, as specified by this Plan.

8. **Administrative Oversight**
   8.1. The IHP Program Manager and Credentialing Manager have administrative responsibilities for program implementation as described in the Plan.
   8.2. The IHP Credentialing Manager schedules activities for reporting of Practitioner enrollment and meeting delegated agreement requirements.
9. **Clinical Oversight**
   9.1. The IHP President has overall responsibility for the clinical component of the credentialing program.
   9.2. The NSCC has the responsibility to ensure that all credentialing functions are in alignment with the Plan.

Section 6 NONDISCRIMINATION

1. INTEGRIS Health Partners will not base credentialing decisions, including granting Appointment, Reappointment, and/or Network Participation status on discriminatory reasons, including on the basis of national origin, culture, race, color, gender, sexual orientation, gender identity, age, ethnicity, religion, disability, veteran status, or any other protected class, as defined by applicable state or federal law. INTEGRIS Health Partners will also not discriminate in basing credentialing decisions on the patient population or typical payer source of patients in which the Practitioner specializes.
2. All members of the NSCC sign a statement of confidentiality and nondiscriminatory decision-making (Appendix B) on an annual basis.
3. Monitoring and preventing such discrimination shall be done by completing audits, at least annually of the files of individuals who are denied participation in IHP or have had the participation revoked or suspended.

Section 7 PEER REVIEW PROTECTION

1. All credentialing and peer review activities pursuant to this Policy will be performed by "peer review committees" in accordance with Oklahoma law. These committees include, but are not limited to:
   1.1. all standing and ad hoc committees, including the Network Strategy and Credentials Committee;
   1.2. hearing officers, panels, and appellate bodies;
   1.3. IHP's Board and its Committees; and
   1.4. any individual acting for or on behalf of any such entity, including but not limited to IHP's Program Manager, President, Vice President, Medical Directors, committee chairs and members, all other IHP personnel, and experts or consultants retained to assist in peer review activities.
2. All oral or written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the applicable provisions of Oklahoma law.
3. All peer review committees will also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq.*

Section 8 CONFIDENTIALITY

1. All members of the committee shall, consistent with the IHP, INTEGRIS medical staff, and INTEGRIS hospital confidentiality policies, keep in strict confidence all papers reports, and information obtained by virtue of membership or as a guest on the committee. All proceedings of the committee shall remain confidential and all communications with the committee shall be privileged.
2. The confidentiality of all credentialing information will be maintained as specified, except as otherwise provided by law:
   - 2.1. All members and guests of the Network Strategy and Credentials Committee sign a statement of confidentiality and nondiscriminatory decision-making (Appendix B) on an annual basis.
   - 2.2. Members and guests of the NSCC will not discuss or share information that was obtained at the meeting, or in preparation or follow-up to the meeting. Information is to be utilized only as it is originally intended.
   - 2.3. Information, documents, and/or evidence created, collected, maintained, or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies, will be kept confidential by all participants except as required by law or at the discretion of the NSCC in order to encourage candor and careful assessment necessary to effect peer review and quality assurance.
   - 2.4. Committee members and guests will not discuss, share, or use any peer review information for any purpose other than peer review.
   - 2.5. Access to credentialing documents will be restricted to authorized staff, Committee members, peer reviewers, and reporting bodies as authorized by the NSCC.
   - 2.6. Credentialing files may only be accessed by password in accordance with INTEGRIS Health policies and procedures.
   - 2.7. All credentialing files are electronic and stored in accordance with existing policies.
   - 2.8. Minutes, reports, and files of Credentialing meetings will be maintained in a confidential manner in the IHP Credentialing Microsoft TEAM's private channel. The channel has conditional access, and it is maintained by the IHP Program Manager.
   - 2.9. If paper files for Practitioners exist, the Practitioner file, once it has been imaged:
     - 2.9.1. Files will be transferred offsite in a secure and restricted environment for the duration of five years from the Practitioner's termination date.
     - 2.9.2. At five (5) years from the termination date, the file is shredded or destructed in compliance with the INTEGRIS Health Record Retention and Destruction Policy (SYS-LGL-109).
   - 2.10. Copies of the minutes may not be removed from the site of the NSCC or the IHP office. All paper minutes and documentation will be shredded immediately following the meeting.
   - 2.11. The identity of a person whose condition or treatment has been studied in the NSCC is confidential and the committee shall remove the person's name and address from the record before the committee releases or publishes a record of its proceedings, or its report, findings, and conclusions. Except as otherwise provided, the record of proceedings and the reports, findings, and conclusions, and data collected by or for this committee are confidential, and are not public records, and are not discoverable and shall not be used as evidence in a civil action or administrative proceeding.
   - 2.12. Disclosure of credentialing information is limited to information needed (i.e., name, address, network specialty, education and training, board certification status, hospital affiliation) for the Practitioner directory, Practitioner assignment, or online directory.

2.13. If a user leaves the credentialing department(s) and/or organization, a system administrator will delete that person's user account effective immediately.
2.14. The credentials file (electronic and any associated paper) is the property of IHP/CVO and will be maintained with the strictest confidence and security. The files will be maintained by the designated agent of IHP in locked cabinets or in a secure electronic format. Medical staff and administrative leaders may access credential files for appropriate peer review and institutional reasons.

3. Files may be shown to accreditation, health plan auditors, and licensure agency representatives with permission of the IHP President or designee.

Section 9 PRACTITIONER (APPLICANT) RIGHTS

1. Practitioners who are undergoing the delegated credentialing process have the following rights:
   1.1. To review information obtained to evaluate the Practitioner's credentialing application, attestation, or CV.
   1.2. To review certain information obtained during the verification process.
   1.3. Practitioners do not have the right to review information such as peer-review protected information recommendations or other information that is considered to be peer-review protected.
   1.4. To be informed, upon request, of the status of their application. Requests will be submitted in writing to the IHP Credentialing department, which will respond to such requests in a reasonable amount of time, not to exceed 30 calendar days.
   1.5. To correct or clarify erroneous information from other sources. Refer to Section 13 for procedural steps.
   1.6. To receive the status of their credentialing or recredentialing application, upon request.
      1.6.1. If the Practitioner requests the status of their application, IHP will provide the Practitioner an approximate date the application will be presented to the NSCC and any outstanding primary source verification requests, whether by telephone, email, or written correspondence.
      1.6.2. Practitioners do not have the right to review information such as recommendations, references, or other information that is considered to be peer-review protected.
2. Notification of Practitioner Rights:
   2.1. Practitioners are notified of these rights upon their initial request for participation in IHP, LLC, and on an ongoing basis.
   2.2. This notification is provided on the following form, Consent and Release (Appendix C).

Section 10 CREDENTIALING STANDARDS

Verifications:

Verification of credentialing information should come from one of the following sources:

1. The primary source (or its website), the entity that originally conferred or issued the credential.
2. A contracted agent of the primary source (or its website).
3. Another National Committee for Quality Assurance (NCQA) accepted the source (or the source's website) listed for the credential.

4. The verification sources noted in Appendix D, listing the methods of verification, sources used, requirements for completion at the time of credentialing/recredentialing, and whether primary source verification is required. The sources noted may be used to verify credentialing information for the following:
    4.1. Licensure – current, valid, and unlimited in all states where the Practitioner provides care within the applicant's scope of practice pursuant to the laws of the State of Oklahoma and all other state law where the applicant practices
    4.2. DEA and a controlled dangerous substance (CDS) certificate – current and valid in all states where the Practitioner provides care.
    4.3. Education and Training – verification of the highest of the three levels of education and training
    4.4. Board Certification Status
    4.5. Work History
    4.6. Malpractice/claims history
    4.7. Sanctions and Limitations on Licensure, all states where Practitioner is licensed
    4.8. Medicare and Medicaid sanctions and exclusions
    4.9. Excluded Practitioners - Eligibility for Medicaid for states in which this is applicable.
    4.10. Excluded Practitioners - Eligibility for Medicare
    4.11. Medicare Opt-Out status
    4.12. SAM System Award Management
    4.13. Admitting privileges or described inpatient coverage arrangement
    4.14. NPI number
    4.15. Social Security Administration Death Master File (SSDMF)
    4.16. Professional Liability Insurance
    4.17. Federal, State, and Local Sanction-free Status
    4.18. Prior Actions or Relinquishments
    4.19. Convictions
    4.20. Absence of Physical or Mental Impairment
    4.21. Performance Data Review – recredentialing

Timeframes

1. The application (initial credentialing and recredentialing) is managed through the Credentialing Portal.
2. Once the credentialing and/or recredentialing application is released to the Practitioner via the credentialing portal, the Practitioner has thirty (30) days to submit the application.
    2.1. If the initial credentialing application is not submitted within thirty (30) days, the application will be considered withdrawn.
    2.2. If the recredentialing application is not submitted within thirty (30) days, the recredentialing application will be withdrawn and the Practitioner's network status with IHP will be at risk of termination. This is considered an administrative action and there would be no right to a hearing or appeal.
3. Each application will be processed within one hundred twenty (120) calendar days from the signature date on the credentialing application.
4. Electronic signatures are unique to the applicant and/or administrative staff and may only be entered by the signatory.

5. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for participation, the credentialing process will be terminated, and no further action taken.

Section 11 CRITERIA AND STANDARDS

It is the policy of IHP to ensure that licensed independent practitioners and advanced practice practitioners meet the minimum credentials and performance standards.

1. Prior to enrollment with IHP or any health plans, or listing in the IHP Directory, all individual practitioners must successfully complete the credentialing process as defined in this Plan.
2. The IHP Credentialing program is dedicated to the careful selection and credentialing of individual Practitioners.
3. The following qualifications **must be met** by all applicants for IHP participation for initial credentialing and recredentialing.
    - 3.1. demonstrate that they have successfully graduated from an accredited school of medicine, osteopathy, dentistry, clinical psychology, post-graduate nursing school, Physician Assistant program.
    - 3.2. have a current, valid, unrestricted state or federal license as a practitioner without Material Restrictions, conditions, or other disciplinary action, applicable to their profession and providing permission to practice within the state of Oklahoma; and
    - 3.3. never have had their license to practice medicine or other license to provide healthcare services in any state suspended, revoked, or restricted:
        - 3.3.1. Any finding that results in sanctions or restrictions on the practitioner from any government agency or authority, including but not limited to a state licensing authority may result in denial of credentialing.
        - 3.3.2. The NSCC may recommend accepting the Practitioner if the restriction, previous suspension, or revocation does not limit or impact the Practitioner's practice; and
    - 3.4. have a record that is free from current Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals/Entities (LEIE); and
    - 3.5. Practitioners must not have been convicted of or pled no contest to any felony charges; and
    - 3.6. possess a current, valid, unrestricted Drug Enforcement Administration (DEA) and Controlled Dangerous Substance (CDS) registration, if applicable:
        - 3.6.1. If the DEA is pending, lacking, or expired, and practice requires the ordering of medications, the Practitioner must submit a completed DEA/CDS Prescribing Agreement (Appendix E).
        - 3.6.2. This applies to an expired DEA regardless of whether or not the applicant is in the process of submitting information within the one-month grace period allowed by the DEA; and
    - 3.7. never have been denied membership or reappointment or suspended, terminated, curtailed, or revoked from membership on the medical staff of any hospital or surgical center; and
    - 3.8. possess professional and comprehensive general liability insurance covering Practitioner, its agents, and employees, for any services rendered by; Practitioner, its agents, and employees, in an amount of at least one million dollars ($1,000,000) for each occurrence, with a per annum aggregate limitation of at least three million dollars ($3,000,000.) and no history of denial or cancellation of liability insurance coverage during the past five (5) years; and
    - 3.9. have no record of conviction of plea of guilty or no contest to any felony; and

3.10. have no record of conviction of guilty or no contest to any misdemeanor related to the practice of their profession, or other healthcare-related matters, violence, or controlled substance violations related to the practice of their profession; and
3.11. may not be employed by a health system (or an affiliate thereof) that is in direct competition with the INTEGRIS Health System, unless approved by IHP President to fulfill network adequacy; and
3.12. must be free from any mental or physical impairment, including chemical dependency and substance abuse, that could interfere with the performance of the essential functions or applicant's profession, unless reasonable accommodation can be made for such impairments consistent with the interest of sound patient care; and
3.13. all Practitioners shall strictly adhere to the generally accepted ethical standards applicable to their respective professions, as set forth in the Principles of Medical Ethics of the American Medical Association, the code of Ethics of the American Osteopathic Association, the Guidelines for Ethical conduct for the Physician Assistant profession or the ANA Code of Ethics, whichever is applicable, whether or not they are members of such organization; and
3.14. have appropriate personal qualifications including the applicant's consistent observance of ethical and professional standards. These include, at a minimum:
    3.14.1. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and
    3.14.2. A history of consistently acting in a professional, appropriate, and collegial manner with others in previous clinical and professional settings.

Medical Doctor (MD) / Doctor of Osteopathy (DO) / Podiatrists (DPM) / Oral Surgeons (DDS)

All applicants must meet the minimum credentialing and performance standards as defined in Section 11, 1 – 3, including all subsections, and the following additional criteria:

1. The applicant must have successfully graduated from an accredited school of medicine, osteopathy, or dentistry as determined by their specialty, or successful completion of examination given by the Educational Commission for Foreign Medical Graduates (ECFMG).
2. The applicant must have completed an accredited clinical postgraduate training program/residency (DPM's and DDS excluded).
3. The applicant must be board certified or be an active candidate for the board for the specialty for which the applicant is seeking participation (e.g., American Board of Medical Specialties, National Board of Physicians and Surgeons (NPPAS), the American Osteopathic Association Specialties, the American Board of Foot, and Ankle Surgery (ABFAS), the American Board of Oral and Maxillofacial Surgery (ABMOS). If Practitioner is not board certified, a waiver signed by the IHP President is required (Appendix F).
4. The applicant must have admitting privileges and is in good standing at an IHP in-network participating hospital/facility. The admitting privilege is waived if the physician is practicing under one of the following specialties:
    4.1. Allergy / Immunology; or
    4.2. Dermatology; or
    4.3. Medical Genetics; or

4.4. Occupational Medicine; or
4.5. Ophthalmology; or
4.6. Physical Medicine & Rehabilitation; or
4.7. Rheumatology; or
4.8. Sleep Medicine.

5. Applicants who are required to, but do not meet the criteria above regarding admitting privileges may be accepted for participation if the applicant meets the following additional criteria:
   5.1. The applicant has clinical privileges in good standing at a INTEGRIS hospital; or
   5.2. Provides evidence of how patients are referred to inpatient treatment service at a participating facility (Appendix G); and
   5.3. When risks are identified related to work history are present on the application; the applicant has three letters of reference attesting to the applicant's clinical competence completed by peers of equal or higher level.
   5.4. For recent graduates, letters of reference may be obtained from the residency program director, and any other physician with whom the practitioner worked during their residency.
   5.5. References must be performed by peers with at least one year's knowledge of the applicant's clinical performance.
6. The applicant must possess a current and valid DEA and CDS certificate authorizing a full schedule (2, 2N, 3, 3N, 4, 5) or complete the DEA-CDS Prescribing Agreement (Appendix E).
7. For a physician to be listed as a **Primary Care Provider** (PCP), in the IHP directory, the applicant must hold current medical board certification in one of the following specialties: Family Medicine, Family Practice, Internal Medicine, Gynecology, Geriatrics, or Pediatrics.
8. For a physician to be listed as a **Specialist** in the IHP directory, the applicant must be board certified in a specialty through the American Board of Medical Specialties (ABMS) and its member boards, or the American Osteopathic Association (AOA). Unless otherwise approved by the IHP President.

Psychologists

All applicants must meet the minimum credentialing and performance standards as defined in Section 11, 1 – 3, including all subsections, and the following additional criteria:

1. Psychologist(s) must have earned a doctorate degree in psychology and must be licensed by the Oklahoma State Board of Examiners of Psychologists.

Nurse Specialties (NP-C, APRN, ARNP, ACNPC CNP, CPNP, CRNP)

All applicants must meet the minimum credentialing and performance standards as defined in Section 11, 1 – 3, including all subsections, and the following additional criteria:

1. The applicant must have a master's degree in nursing from an accredited postgraduate school.

2. The applicant must be board certified in the specialty for which the applicant is seeking participation (e.g., American Nurses Credentialing Center, American Academy of Nurse Practitioners, National Certification Corporation).
3. The applicant must possess a current and valid DEA and CDS certificate or provide information on how controlled substances will be handled in their practice.
4. The applicant must demonstrate current experience and documented ability to provide patient care services at the level of quality and efficiency acceptable to IHP Network Strategy and Credentials Committee. This can be done by obtaining peer reviews or by other means deemed acceptable by the IHP Network Strategy and Credentials Committee.
5. Unless approval prior is obtained by the IHP Network Strategy and Credentials Committee (NSCC), the applicant must indicate a supervising physician within the IHP Network. The supervising physician must be an IHP participating physician specializing in the same or related field of practice in which the applicant is certified (Appendix H). If approved by the NSCC to participate without an in-network supervising physician, the application must provide evidence of a supervising physician agreement.
6. If the nurse does not have admitting privileges or is not credentialed at a participating facility, they must provide evidence of how patients are referred to inpatient treatment service at a participating facility (Appendix G).
7. For a nurse Practitioner to be listed as a **Primary Care Provider** (PCP) in the IHP directory, the applicant must have prescriptive authority. (OHCA 317:25-7-5 Primary care providers (PCPs)

Physician Assistants (PA-C)

All applicants must meet the minimum credentialing and performance standards as defined in Section 11, 1 – 3, including all subsections, and the following additional criteria:

1. The applicant must have a baccalaureate or higher degree in a field from an accredited college or university.
2. The applicant must be a graduate of an accredited Physician Assistant program.
3. The applicant must be board certified by the National Commission on Certification of Physician Assistants.
4. The applicant must possess a current and valid DEA and CDS certificate or provide information on how controlled substances will be handled in their practice.
5. The applicant must demonstrate current experience and documented ability to provide patient care services at the level of quality and efficiency acceptable to IHP Network Strategy and Credentials Committee.
6. The applicant must indicate a supervising physician within the IHP Network. The supervising physician must be an IHP participating physician specializing in the same or related field of practice in which the applicant is certified.
7. A physician assistant may be listed as a **Primary Care Practitioner** (PCP) in the IHP directory (OHA 317:25-7-5 Primary care providers (PCPs))

Physician Graduates from a foreign medical school

Must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG).

Telehealth

Physicians and other practitioners providing Telehealth Services must hold appropriate licensure, certifications, and registrations (including DEA and CDS) and comply with applicable professional practice standards and telehealth requirements in the state(s) in which they practice and, in the state(s), in which the beneficiary is receiving Telehealth Services is located at the time of such encounter.

Section 12 **CREDENTIALING APPLICATION AND CRITERIA REVIEW –** Initial and Recredentialing Applicants

Credentialing and Application

1. IHP assures that all Practitioners applying for participation in the IHP Network meet rigorous credentialing standards prior to providing care to members.
2. It is the ultimate responsibility of the Practitioner to ensure complete release of information from any entity queried by IHP. The signature included in the credentialing application cannot be dated more than one hundred twenty (120) days prior to committee review.
3. Practitioner attests by electronic date and signature to the accuracy of all information in the credentialing application. Substantial errors of fact involving documents discovered before or after appointment can be the basis for non-selection or, after appointment, adverse action including termination. Electronic signatures are acceptable and have the same legal effect and enforceability as a handwritten signature.
4. Practitioners consent to the inspection of records and documents pertinent to consideration of their request for appointment.
5. Practitioner specifically authorizes INTEGRIS Health Entities (as described in Section 14, Information Sharing) to share information and documentation with one another.
6. The Practitioner must submit information and documentation of their education qualification(s) and certification which qualifies them to be identified as a specialist in a particular field of medicine.
7. Credentialed specialists are accordingly expected to provide covered services to IHP members that are within the scope of the specialty credentialed by IHP after reviewing the Practitioner's application.
8. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for participation, the credentialing process will be terminated, and no further action taken.
9. Anytime in the credentialing process it becomes apparent that an applicant is not interested in completing an application (i.e., failure to respond to an incomplete application) more than twice in one calendar year, the applicant will not be eligible to apply without a letter of intent to produce a complete application.
    9.1. The Practitioner will be provided one more attempt to produce a complete application.
    9.2. Failure to complete the application a third time, the application will be deemed incomplete a third time and the Practitioner will be deemed not interested and will be restricted from applying for a period of 1 year from the date of the third (3rd) attempt. This is considered an administrative action and there would be no right to a hearing or appeal.
10. Practitioners are notified of the credentialing and recredentialing (for adverse determinations) within thirty (30) days of the credentialing decision.
    10.1. Approval notices are sent by an IHP credentialing team member to the Practitioner notifying the Practitioner of the committee's decision.

10.2. Denial notices with the reason for the denial are sent by a credentialing team member to the Practitioner via certified mail, or a secured carrier that requires acknowledgment or receipt by signature of the Practitioner and can track receipt/delivery of the notification.
10.3. A Practitioner is entitled to request a hearing under the "Fair Hearing/Appeal Policy", Section IV. Hearing Rights, a, 1, whenever one of the following adverse actions are recommended by the NSCC:
10.3.1. Denial of request for initial or renewed participation in the IHP Network as defined in this policy; or
10.3.2. Revocation of Network participation in IHP.
10.4. Suspension of Network partnership for more than thirty (30) days; or
10.5. Any decisions that adversely affect a participating Practitioner's status with the Network for more than thirty (30) days.
10.6. When an adverse action is recommended or taken that entitles a Practitioner to a hearing under the Fair Hearing/Appeal Policy, Section V., a, the affected Practitioner will be informed of such within thirty (30) days by the IHP President and/or Medical Director, in writing, by special notice.

11. Every practitioner will be recredentialed at least every three (3) years. However, the NSCC may require that an individual practitioner be recredentialed more frequently.
12. All credentialing elements that require primary source verification must be collected within one hundred twenty (120) days prior to the NSCC review of the application.
13. IHP monitors participating Practitioner's continued compliance with credentialing criteria between credentialing cycles

Recredentialing

1. Practitioner recredentialing files will be processed within thirty-six (36) months of the previous credentialing decision, aligned to month and year, not to the day.
2. The IHP recredentialing process includes the careful evaluation of the applicable information, as appropriate, to determine if a practitioner should be granted continued participation in the IHP Network.
3. The recredentialing process will include the consideration of Practitioner performance indicators obtained through various forms of data, which may include, but not limited to, results of quality-of-care reviews, quality of service events, the monitoring of Practitioner appeals and grievances, utilization management information, or member satisfaction surveys.

Practitioners on Leave

1. If IHP cannot recredential a Practitioner within the thirty-six (36) month time frame because the Practitioner is on active military assignment, maternity leave, or a sabbatical, but the contract between IHP and the Practitioner remains intact, IHP will recredential the Practitioner upon their return.
2. IHP will document the reason for the delay in the Practitioner's file.
3. It is acceptable to recredential Practitioners on leave. IHP will verify that a Practitioner who returns from military assignment, maternity leave, or a sabbatical has a valid license to practice before they resume seeing patients.
4. Within sixty (60) days of when the Practitioner resumes practice, IHP will complete the recredentialing cycle.

Practitioners on administrative for reasons beyond IHP's control

1. If the Practitioner is reinstated within thirty (30) calendar days from the administrative termination, IHP may recredential the Practitioner if it is documented that the Practitioner was terminated for reasons beyond IHP's control and was recredentialed and reinstated within 30 calendar days of termination.
2. IHP will initial credential Practitioners if reinstatement is more than thirty (30) calendar days.

Section 13 ERRONEOUS INFORMATION / COMPLETED APPLICATION

1. The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the IHP Credentialing Office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of IHP, that the applicant meets the requirement for IHP participation. If information is missing from the application, or new, additional, or clarifying information is required, a notice requesting such information will be sent to the applicant via the email address provided on the application.
2. If the practitioner chooses to exercise his or her right to correct erroneous information:
   2.1. IHP credentialing staff further investigates the primary source information.
   2.2. If the information received varies substantially from the information provided on the application, IHP credentialing staff will request clarification from the Practitioner and provides the Practitioner an opportunity to amend the erroneous information.
   2.3. Notification via email or phone includes what information is missing or what information has been found to be erroneous and the time frames in which all completed information must be received by IHP to continue the application process.
   2.4. If the practitioner does not respond to emails or phone calls, notification of erroneous information is sent to the Practitioner by Special Notice.
   2.5. The Practitioner mails the response to the IHP Manager of Credentialing or the Credentialing Lead.
   2.6. All information collected, along with the Practitioner's response, is presented to the NSCC for review and resolution.
   2.7. The Practitioner is notified via Special Notice within fourteen (14) days of the NSCC decision.
3. If the Practitioner chooses **not** to exercise their right to correct erroneous information, or does not respond within 14 days, the information is presented to the NSCC for review and resolution without input from the Practitioner. The Practitioner is notified of the committee's decision by Special Notice.

Section 14 INFORMATION SHARING

The individual specifically authorizes INTEGRIS Health Entities (as defined below) to share with one another any information maintained in any format (verbal, written, or electronic) that involves (i) the evaluation of the quality, safety, necessity, and compliance with applicable law of services ordered or performed by the individual, or (ii) the individual's professional qualifications, competence, conduct, health/ability to safely practice, experience, or patient care practices. This information and documentation may be shared at any

time, including, but not limited to, any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual.

For purposes of this Section, an INTEGRIS Health Entity means:

1. Any entity that satisfies ***both*** of the following requirements:
   1.1. Has a formal peer review/professional practice evaluation or credentialing process, and an established peer review committee or credentials committee, as evidenced by internal bylaws or policy; and
   1.2. Is directly or indirectly, through one or more intermediaries, controlled by INTEGRIS Health. Entities that are "controlled by INTEGRIS Health" for purposes of this definition include, but are not limited to, the following entities, as well as those individuals, committees, and boards who act on their behalf:
      1.2.1. INTEGRIS Health and its Hospitals;
      1.2.2. INTEGRIS Health urgent care centers cancer care centers, and ambulatory surgery centers;
      1.2.3. INTEGRIS Health Medical Group;
      1.2.4. Any joint ventures in which INTEGRIS Health has an interest of 50 percent or more;
      1.2.5. Any entity that is managed, via a written management services agreement, by one of the entities described in this subsection (1); and
2. Any entity not included in subsection (1) that provides patient care services and that:
   2.1. Has a formal peer review/professional practice evaluation process or credentialing process and an established peer review committee or credentials committee, as evidenced by internal bylaws or policy; and
   2.2. Has appropriate provisions regarding the sharing of Confidential Information consistent with the INTEGRIS Health Information Sharing Policy in a professional services contract or separate agreement with INTEGRIS Health or and INTEGRIS Health Entity identified in subsection (1).

Section 15 APPLICANT ATTESTATION, AUTHORIZATION AND ACKNOWLEDGMENT

The applicant must complete and sign the application form. By signing this application, the applicant:

1. Attests to the accuracy and completeness of all information on the application or accompanying documents and agrees that any substantive inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a hearing or appeal.
2. If the inaccuracy, omission, or misstatement is discovered after an individual has been granted appointment, the individual's appointment may lapse effective immediately upon notification of the individual without the right to a hearing or appeal.
3. Consents to appear for any requested interviews regarding their application.
4. Authorizes representatives of IHP and third parties to solicit, provide and act upon information bearing on their professional abilities and qualifications, character, ethical qualifications, ability to work collaboratively with others, and qualifications for participation.

5. Consents to hospital and IHP medical staff representatives' inspection of all records and documents that may be material to an evaluation of:
    5.1. Professional qualifications and competence,
    5.2. Physical and mental/emotional health status to the extent relevant to safely care for patients,
    5.3. Professional and ethical qualifications,
    5.4. Professional liability actions including currently pending claims involving the applicant; and any other issue relevant to establishing the applicant's suitability for participation in IHP.
6. Agrees to be bound by the provisions of the Plan, and to waive all legal claims against any representatives of IHP and third party who acts in accordance with the provisions of this Plan.
7. Authorizes IHP medical staff and administrative representatives to release any and all credentialing and peer review information to licensing boards, appropriate government bodies, and other healthcare entities or to engage in any valid discussion relating to the past and present evaluation of the applicant's training, experience, character, conduct, judgment or other matters relevant to the determination of the applicant's overall qualifications upon appropriately signed release of information.
8. Agrees to provide accurate answers to the following questions and agrees to immediately notify IHP in writing should any of the information regarding these items change during the processing of this application or the period of the applicant's participation in IHP. If the applicant answers any of the following questions affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation(s) of the circumstances involved.
    8.1. Do you have a current, unrestricted license to practice in Oklahoma that is not subject to any restrictions, conditions, or probation?
    8.2. Is your license to practice currently under investigation by any state licensure agency or has your license to practice ever been denied, revoked, restricted, or suspended by any state licensing agency?
    8.3. Do you have a current, unrestricted DEA controlled substance registration and state-controlled substance license?
    8.4. Has your DEA controlled substance registration or state-controlled substance license ever been denied, revoked, restricted, or suspended?
    8.5. Do you have current, valid, professional liability insurance coverage that will be in effect as of the date that network participation (if granted) will become effective?
    8.6. Have you ever been or are you currently in the process of being denied professional liability insurance coverage?
    8.7. Has your present liability insurance carrier ever excluded, or is it currently in the process of excluding any specific procedures from your coverage?
    8.8. Have any professional liability suits ever been or are there any currently in the process of being filed against you? If yes, you must provide claim information for each case in the "Malpractice Claims" section of the application.
    8.9. Have you ever been convicted of, or entered a plea of guilty or not contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, or have been required to pay civil monetary penalties for the same?
    8.10. Have you ever been or are you currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or any federal or state governmental health care program?
    8.11. Have you ever been terminated from a post-graduate training program for reasons related to clinical competence of professional conduct or resigned from such a program during an investigation or in exchange for the program not conducting an investigation?

8.12. Have you ever been or are you currently in the process of being charged with or convicted of fraud?
8.13. Have you ever had your appointment or clinical privileges denied, suspended, revoked, or terminated by any healthcare facility or health plan for reasons related to clinical competence or professional conduct?
8.14. Have you ever resigned your appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation?
8.15. Are you currently subject to any criminal charges or indictment, and have you ever been convicted of, or entered a plea of guilty or not contest to, any felony; or to any misdemeanor related to controlled substances, illegal drugs, insurance, or health care fraud or abuse, child abuse, elder abuse, violence, or the practitioner-patient relationship?

Section 16 COMPILING AND REPORTING OF CREDENTIALS DATA

Application Evaluation

1. As a preliminary step, the applicant will complete a Participation Request (Appendix I) which is reviewed by the IHP credentialing staff and/or the acting IHP Network Strategy and Credentials Committee Chairperson.,
2. All applications for initial participation are reviewed for network need and contractual relationship between the Practitioner and IHP.
3. All initial individual Practitioner applications are forwarded to the IHP Credentialing staff for processing.

Application Elements

1. An application will be deemed complete if the applicable elements are present and primary source verified. The element's applicability is determined by 1) the applicant's status (i.e., initial or reappointment), 2) the applicant's specialty, and 3) whether the element is deemed essential. An element will be deemed "essential" if is either 1) a required element by an accrediting/regulatory body (i.e., NCQA, TJC, CMS, URAC), or 2) explicitly defined as a requirement by the NSCC committee.
    1.1. IHP Credentialing Application, attestation, authorizations(s), and any applicable supporting documents must be signed and dated. Application must be legible, entire sections completed, and all questions answered with detailed explanations (where deemed appropriate); and
    1.2. Reasons for inability to perform the essential functions attestation signed and is current; and
    1.3. Lack of present illegal drug use attestation signed as is current; and
    1.4. History of loss of license and felony convictions attestation signed and is current; and
    1.5. History of loss or limitation of privileges or disciplinary activity attestation signed and is current
    1.6. Health status that may affect patient care; and
    1.7. Current and valid healthcare professional license to practice issued by the state of Oklahoma and all other states where licensed to practice as a healthcare professional; and
    1.8. Current and valid Drug Enforcement Administration and Controlled Dangerous Substances Registration with applicable schedules as it pertains to practice specialty; and
    1.9. All relevant, US (including US territories and Canada), education and training; and
    1.10. Board certification or admissibility, as directed in this policy; and

1.11. Work History/Curriculum Vitae (CV) in chronological order, accounting for all periods of time from medical/professional education to present with each entry reflecting the start and end dates in month/year format. The applicant will review and provide a written explanation for any time gaps exceeding three (3) months and a detailed explanation if the gap is greater than two (2) years; and
1.12. History of professional liability claims obtained via the National Practitioner Data Bank (NPDB) and self-disclosure; and
1.13. Query of the Medicare and Medicaid Sanctions and/or exclusions; and
1.14. Query of the Licensure Sanctions; and
1.15. Individual National Provider Identifier (NPI) number; and
1.16. All current and prior credentialed affiliations including, but not limited to hospitals, surgery centers, etc.; and
1.17. Current professional and/or medical references from individuals who have worked extensively with the applicant or who have been responsible for professional observation of the applicant's work and current competency; and
1.18. For Advanced Practice Practitioners (APPs), supervising physician form, if not listed on the Oklahoma healthcare professional license. Supervising physician must be in the same area of practice. If not in the IHP network, they will request an exception from the NSCC; and
1.19. A current photo; and
1.20. Material demographic information (e.g., service location, phone numbers, name, mailing address(es), email address(es).

Incomplete Application

1. If the application is incomplete, written notification is sent to the individual practitioner that explains what information is missing or is incomplete from the application, and how the applicant can remedy the situation.
2. The credentialing staff person conducts criteria review to determine if the applicant minimally meets the criteria for acceptance as described in this policy.
3. If the application meets the criteria, the application is accepted, and the credentialing process is initiated.
4. If the application **does not meet** the criteria, the credentialing specialist reviews the applicant's information to determine if either **alternate** or **exception criteria** may be met.
    4.1. If the applicant does not meet the criteria, the credentialing staff reviews the applicant's information to determine if either alternate or exception criteria may be met and provides the applicant the specific forms to complete:
        4.1.1. DEA/CDS Prescribing Agreement (Appendix E) which is used for an individual eligible for an unrestricted DEA license, in which the applicant's DEA license is in the active-pending status. The applicant must have confirmed that a Practitioner with appropriate clinical privileges has a current, unrestricted DEA license, and is willing to write all prescriptions requiring a DEA Number for the individual until their DEA license is granted.
        4.1.2. Hospital Coverage Letter (Appendix G) for those Practitioners that do not have admitting privileges at an in-network IHP participating facility.
        4.1.3. Lack of Board Certification Approval Request (Appendix F)
        4.1.4. Supervising Physician Agreement (Appendix H)

5. If the applicant meets the alternate criteria or exception criteria, then the application is accepted, and the credentialing process is initiated.
6. The Credentialing Manager and/or Credentialing Lead may administratively deny the applicant for participation in the IHP network if any of the following adverse actions are in place at the time of application:
   6.1. The applicant's license to practice has been revoked by the State or federal agency; or,
   6.2. The applicant's license to practice has been restricted (may not be on probation, surrendered, or suspended) by the State or federal agency; or
   6.3. The applicant's DEA or CDS certificate has been revoked or suspended; or,
   6.4. The applicant's Medicare/Medicaid participation has been terminated or limited; or
   6.5. License is not appropriate for independent practice; or
   6.6. Insufficient amounts of professional liability coverage; or
   6.7. No collaborative agreement (for Nurse Practitioners and Physician Assistants) with a participating physician.
7. If the Credentialing Manager and/or Credentialing Lead administratively deny the applicant, notification is sent by Special Notice to the applicant within thirty (30) days of receipt of the completed application.

Section 17 EXPEDITED "CLEAN FILE" CREDENTIALING EVENT

An expedited review and approval process may be used for initial credentialing and recredentialing. All initial applications and reapplications for participation in IHP will be designated as "Clean Files" as follows:

1. A "Clean Application/File" is a completed application that meets all the threshold eligibility criteria and does not raise any concerns as identified in the criteria for a file requiring review by the NSCC.
2. Applicants identified as having a "Clean File" will be granted IHP participation after review and action by the IHP President or NSCC Chair(s).

Criteria for "Clean File"

1. The applicant must currently be engaged in active clinical practice.
2. The applicant must possess a current, valid, unrestricted (may not be on probation, surrendered, or suspended) license to practice independently, in the state in which the service is rendered.
3. The applicant must possess current, adequate professional liability insurance coverage of at least one ($1) million per incident and three ($3) million aggregate; or is covered under the terms of the Federal Tort Claims Act (FTCA).
4. The applicant must attest to the absence of present illegal drug use.
5. The applicant must attest to the absence of adverse professional liability history.
6. The applicant must attest to the absence of adverse criminal history. Minor traffic violations are exempted.
7. The applicant must have valid, current, unrestricted (may not be on probation, surrendered, or suspended, or have opted out) participation in Medicare, and Medicaid programs as verified via the CMS participation agreement, or online verification. The applicant may not have Opted-Out of Medicare in the previous two (2) years.

8. The applicant must attest to the absence of a history of professional disciplinary action, including revocation, suspension, or restriction in any training or residency programs, state licensing board, professional societies, and clinical privileges at a hospital or facility within the IHP network.

Criteria that would determine ineligibility for "Clean File" determination and require full NSCC review

A completed credentialing file that has one or more of the following criteria identified during review and verification will require review and action by the NSCC, with the defined quorum. Criteria that require full committee review include, but at not limited to the following:

1. Recommendations from peers that are adverse or with limitations,
2. The applicant is found to have experienced an involuntary termination of membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration.
3. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions.
4. Applicant has had two (2) or more malpractice cases filed within the past seven (7) years, or one final adverse judgment in a professional liability action in excess of five hundred thousand ($500,000) dollars.
5. Applicant has changed medical schools or residency programs or has gaps in training or practice.
6. Applicant has practiced or has been licensed in four (4) or more states post-residency/fellowship.
7. A discrepancy is found between information received from the applicant and references or verified information
8. Applicant has an adverse National Practitioner Data Bank report
9. Applicant has been removed from a managed care panel for reasons of professional conduct or quality.
10. Applicant has potentially relevant physical, mental, and/or emotional health problems
11. Applicant has gaps in practice or training that raise questions or have a defined gap of greater than two (2) years
12. Applicant has opted-out of the Medicare program within the past two (2) years, or
13. Other reasons as determined by other representatives of the organization which raises questions about the qualifications. Competency, professionalism, or appropriateness of the applicant for participation in IHP.

"Clean File" Process

1. The file and a summary of the supporting materials are presented to the IHP President or one of the NSCC Credentials Chairs for review and recommendation within one hundred twenty (120) days from the date of the applicant's signature on the application.
    1.1. The IHP President or the NSCC Chair, reviews the application to ensure that it fulfills the established standards for IHP participation.
    1.2. The IHP President or the NSCC Chair can determine whether the application is forwarded as a "Clean File" or may change the designation requiring full committee review if there are concerns about the application and/or supporting materials.
    1.3. The IHP President or NSCC Chair articulates those concerns in writing and provides them to the NSCC.
    1.4. If processed as a "Clean File" the IHP President or the NSCC Chair acts on behalf of the NSCC and approves the application. The date the decision is made will be recorded and used in the approval/effective date that is communicated to the applicant and the third-party payer.

1.5. The IHP President or NSCC Chair's decision is provided by wet ink signature/or via DocuSign on a list of clean files presented for decision.

Section 18 CRITERIA FOR RECREDENTIALING EVENT

1. At least three (3) months prior to the expiration of the individual practitioner's current cycle, they will be notified to submit an application and required documentation.
2. The re-credentialing process follows the same as stated above in, Section 12, Credentialing Application and Criteria Review – Initial Applicants.
3. In addition, the individual practitioner must meet acceptable quality assessment and utilization standards:
   3.1. No quality-of-care issues, member complaints, or off-site quality complaints, but may be accepted for ongoing participation if the review of all complaints by the IHP President or designee determines that there is not a pattern of adverse behavior or clinical judgment.
   3.2. These individual practitioners may be presented to NSCC for final determination.
4. Failure to comply with the recredentialing process will result in the termination of IHP Network participation.

Section 19 ALTERNATE CRITERIA FOR INDIVIDUAL PRACTITIONER PARTICIPATION

1. Applicants who do not meet the criteria for the absence of Professional Liability History may be accepted for participation if the review of all liability cases by the IHP President or designee and Legal Counsel determines that there is not a pattern of adverse behavior or clinical judgment.
2. Applicants who do not meet the criteria above for absence of Adverse Criminal History may be accepted for participation if the review of all adverse criminal cases by Legal Counsel and the IHP President or designee determines that:
   2.1. The act was a misdemeanor that does not relate to the delivery of health care nor in which fraud, dishonesty, violence, or moral turpitude was involved; or,
   2.2. The act was a court-martial for actions not related to duties as a medical professional.
3. Applicants who do not meet the criteria above for DEA or CDS registration may be accepted for participation if:
   3.1. Review by the IHP President or designee determines that the applicant's lack of prescriptive authority does not restrict their ability to render appropriate services within the scope of their licensure; or
   3.2. A complete application for an individual eligible for an unrestricted DEA license, in which the applicant's DEA is in active-pending status, may still be presented to the NSCC, provided that the individual has confirmed that a practitioner with appropriate clinical privileges with a current, unrestricted DEA license is willing to write all prescriptions requiring a DEA Number for the individual until their DEA license is granted (Appendix E), DEA/CDS Prescribing Agreement).
4. Applicants who do not meet the criteria above for the absence of Adverse History of Professional Disciplinary Actions may be accepted for participation if the review of all adverse privilege and professional history by Legal Counsel and IHP President or designee determines that:
   4.1. All license and clinical privilege disciplinary action were more than five (5) years ago; or
   4.2. Review of all disciplinary actions does not show patterns of adverse behavior or clinical judgment.

5. Applicants who are required to, but do not meet the criteria above for Board Certification by the appropriate certifying organization (or, with the prior written approval of the IHP Network's President, or their designee):
   5.1. satisfy all requirements needed to take the written board certification examination or otherwise be (qualified on the basis of skills, training, and experience), and
   5.2. never have been reprimanded sanctioned or disciplined by any licensing board or state or local medical society or specialty board.

Section 20 **EXCEPTION CRITERIA FOR INDIVIDUAL PRACTITIONER PARTICIPATION** (Required NSCC Review)

1. Applicants who do not meet the alternate criteria above for absence of Adverse Criminal History and do not meet the alternate criteria may be accepted for participation by exception if the NSCC determines that a review of all criminal history does not show patterns of adverse behavior or clinical judgment.
2. Applicants who do not meet the alternate criteria above for the absence of Adverse History of Professional Disciplinary Actions and do not meet the alternate criteria may be accepted for participation by exception if the NSCC determines that a review of all privileging and disciplinary actions does not show patterns of adverse behavior or clinical judgment.
3. Applicants who do not meet the alternate criteria above for DEA or CDS registration may be accepted for participation if review by the NSCC determines that the applicant's lack of prescriptive authority does not restrict their ability to render appropriate services within the scope of their licensure.
4. Applicants who do not meet the criteria for Board Certification may be accepted for participation on a case-by-case basis by the NSCC. Applicant participation will be granted based on geographic need. Applicant specialty will be granted based upon education/training and admitting privileges in the requested specialty. The NSCC may grant the designation of "General Practice" to practitioners, including but not limited to those requesting PCP specialties of Internal Medicine, Family Medicine, Geriatrics, and Pediatrics.
5. Any other applicants where Legal Counsel and IHP President or designee determines there could be a significant risk. These will be reviewed and discussed by the NSCC on a case-by-case basis.

Section 21 **PROCESS FOR CREDENTIALING AND RECREDENTIALING DECISIONS** (NSCC)

1. Decision-making is governed by a majority vote of the NSCC for Practitioners who were not processed as a "Clean File" and for those practitioners who do not meet minimum IHP standards and is nondiscriminatory.
2. Each decision is based upon information, documents, and/or evidence created, collected, maintained, or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies.
3. Committee decisions will be kept confidential by all participants except as required by law or at the discretion of the NSCC to encourage candor and careful assessment necessary to effect peer review and quality assurance.
4. All credentialing activities follow NCQA, the State of Oklahoma, and all other applicable laws and regulatory bodies.

5. The NSCC considers all applicants, including those who have been granted waivers in the context of all available information. In the case of waivers, the committee must weigh the lack of adherence to standards/IHP requirements with factors such as:
    5.1. Perceived value to INTEGRIS Health Partners, LLC and /or the partnership, which merits approval despite failure to meet the requirements, and/or
    5.2. Perceived professional qualities which may not be appropriately reflected in the IHP requirements requiring board certification and residency training, including:
        5.2.1. Demonstrated motivation to participate in IHP and follow managed care procedures
        5.2.2. Special need for Practitioners in the geographic area/network
        5.2.3. Reputation in the community
        5.2.4. Prominence in the network's managed care organization
        5.2.5. Professional experience/Continuing Medical Education experience
        5.2.6. Partnership with current IHP Practitioners of perceived exceptional quality
    5.3. Board certification waivers (Appendix F) are reviewed for initial and reappointment applications. Board certification waivers will be considered for approval or denial at the discretion of the IHP President.
    5.4. Board certification extensions are granted to recredentialing applicants who provide proof from the board stating they are scheduled to sit for the exam. The NSCC reserves the right for approval or denial of Board certification extensions.
    5.5. Physician's certificates that expired and who fail to become re-certified or those physicians whose board eligibility period expired or lapsed and have no plans of certifying or recertifying must provide a written explanation to the NSCC to continue their participation in the network. The NSCC reserves the right for approval or denial.
6. The NSCC may determine that some applicants who meet minimum IHP standards should not be approved for participation for any of the following reasons, but not limited to:
    6.1. Lack of demonstrated motivation to participate cooperatively as a Practitioner and follow the utilization management and quality management policies and procedures.
    6.2. Lack of perceived need for Practitioners in the geographic area/network.
    6.3. Unfavorable reputation in the community.
    6.4. Lack of good standing at an affiliated hospital.
    6.5. Perceived lack of quality of medical school/residency experience.
    6.6. Failure to comply with the ethics of the profession.
    6.7. Failure to adhere to IHP's policies/procedures/participating agreement.
    6.8. Failure to cooperate with IHP's inquiries or investigations.
7. The NSCC may use the expertise of the IHP President or any member of the IHP Network, an outside consultant, or legal counsel if additional review and recommendation are required regarding the Practitioner's qualification for participation. Such persons shall be considered to be agents of the NSCC for all purposes, including but limited to protection from discovery and immunity for participating in credentialing processes.
8. All NSCC decisions shall be documented in the meeting minutes. Decisions of the NSCC are final, with the exception of those recommendations and actions that are subject to further review under the Fair Hearing/Appeal Policy.

Section 22 OUTCOME DECISIONS OF THE IHP NSCC AND BOARD OF DIRECTORS

NSCC

1. If the application has been designated as a "Clean File" and has been reviewed by the IHP President or designee and approved for network participation, the file is listed as a "consent agenda" item.
2. At any time in the review process, whether by the IHP President or designee, or the NSCC, a file may be determined to not meet the requirements of a "Clean File" and will be processed for full committee review.
3. The NSCC may make the following decisions:
   - 3.1. A recommendation as to whether the application should be acted upon as a Clean File or not.
   - 3.2. **Approve** the applicant's request for participation in the IHP network.
   - 3.3. **Approve the applicant's request with modifications** to the cycle time for recredentialing.
   - 3.4. **Require updates to circumstances that require monitoring** and/or evaluation of performance after the initial grant of participation.
   - 3.5. **Defer** pending the receipt of additional information. Such application will be returned to the credentialing staff, defining specific elements that need additional queries, and defining a time limit within which a subsequent decision must be made.
   - 3.6. **Deny** the applicant for participation in the IHP Network and forward to the Board of Directors.
     - 3.6.1. **Denial** may be based on the applicant's failure to document to the NSCC's satisfaction compliance with the qualifications, or
     - 3.6.2. **Denial** may be based on Network needs. The NSCC may deny an initial or recredentialing application or may refuse to consider an application, for an applicant who does not meet, in NSCC's determination, the IHP network needs, which is an administrative determination.
     - 3.6.3. Revocation of Network participation in IHP;
     - 3.6.4. Suspension of Network participation for more than thirty (30) days; or
     - 3.6.5. Any other decisions that adversely affect a participating Practitioner's status with the Network for more than thirty (30) days.
   - 3.7. Actions that Do Not Provide a Right to a Hearing as defined in Section IV., b., 1-4, of the Fair Hearing/Appeal Policy:
     - 3.7.1. A determination that an applicant fails to meet the threshold eligibility qualifications or criteria during the credentialing process.
     - 3.7.2. The following actions with respect to a Network Practitioner will be considered administrative actions that result in the automatic relinquishment of their status in the Network, with no rights to a hearing or appeal under the Fair Hearing/Appeal Policy:
       - 3.7.2.1. The individual's license to practice has been revoked by the State or federal agency;
       - 3.7.2.2. The individual's license to practice has been restricted (i.e., is on probation, surrendered, or suspended) by the State or federal agency;
       - 3.7.2.3. The individual's DEA or CDS certificate has been revoked or suspended;
       - 3.7.2.4. The individual's Medicare/Medicaid participation has been terminated, sanctioned, or otherwise limited;
       - 3.7.2.5. License is not appropriate for independent practice;
       - 3.7.2.6. Insufficient amounts of professional liability coverage;

3.7.2.7. No collaborative agreement (for Nurse Practitioners and Physician Assistants) with a participating physician;

3.7.3. Failure to submit a complete application or an application in a timely manner, as described, does not provide a right to a hearing.

3.7.4. No other actions beyond those described in Section I, of the Fair Hearing/Appeal Policy will provide a Network Practitioner with a right to a hearing under the Fair Hearing/Appeal Policy.

Board of Directors

1. In the case of an adverse NSCC or a contemplated action of an adverse action by the NSCC, the Board shall take final action in the matter.
2. Such action shall be the final decision of the Board, except that the Board may defer final determination by referring the matter back to the NSCC for further reconsideration. Any referral back shall state the reasons, therefore, shall set a timeframe within which a subsequent recommendation to the Board shall be made.
3. After receipt of subsequent recommendations and new evidence in the matter, if any, the Board shall make a final decision either to approve the applicant for IHP participation or to reject the applicant for IHP participation.

Section 23 MANAGEMENT OF "EXPIRABLES"

1. The credentialing staff goes directly to each source and verifies the information. A data element is considered an "expirable" if it contains an expiration or re-verification date (e.g., license, certifications, malpractice insurance).
2. All expirable elements are monitored in the credentialing database. At least monthly, reports are generated and assessed for upcoming expiration or re-verification dates.
3. Notifications are sent to the Practitioner advising them of the upcoming expiration or re-verification dates, and their need to renew the associated document(s).
4. Expirable items that require verification will be queried through a primary or approved source site. The verification is electronically stamped with both the name of the credentialing staff verifying the information and the date/time of the verification.
5. Expirable items not requiring verification will be renewed upon submission for the Practitioner,
6. Upon receipt, the credentialing database is updated to reflect the most current expiration or re-verification date, and the associated document is uploaded into the credentialing database.

Section 24 MANAGEMENT OF SANCTIONS

Practitioner licenses and Medicare / Medicaid sanctions are continuously monitored between recredentialing cycles by the credentialing staff.

1. All actions regarding a credentialed Practitioner's medical licensure and/or Medicare and Medicaid sanctions are monitored through the NPDB Continuous Query. Actions are recorded in the credentialing database.
2. The credentialing staff receives direct notification from the NPDB and any other contracted agencies. Reports are reviewed by the IHP Credentialing personnel and reported to the NSCC within thirty (30) calendar days of receipt.

3. Upon notification that a malpractice claim has been settled and payment has been made, the IHP credentialing personnel will send a certified letter to the practitioner requesting an explanation within seven (7) calendar days.
    3.1. Upon receipt, practitioner responses are recorded and uploaded into the credentialing database and reported to the NSCC.
    3.2. If a response is not received from the practitioner within the requested timeframe, the NSCC will be notified for further action.

Section 25 ONGOING MONITORING

1. IHP will review the following as part of the ongoing monitoring process:
    1.1. Medicare and Medicaid sanctions
    1.2. Sanctions or limitations on licensure
    1.3. Confirmed and validated grievances or beneficiary/patient complaints.
        1.3.1. Confirmed and validated grievances will be reviewed upon their receipt
        1.3.2. Any history of such complaints and/or grievances will be evaluated at least every six (6) months
    1.4. Information from identified adverse events.
    1.5. Sanction information will also be reviewed within thirty (30) days of its release by the reporting entity.
    1.6. If the reporting entity does not produce sanction information on a set schedule, it will be documented that the reporting entity does not release information on a set schedule, and a query of the reporting entity for the necessary information will occur at least every six (6) months.
    1.7. If there is a subscription to a sanction alert service, the information provided through the services as part of an alert will be reviewed within thirty (30) days of a new alert being issued.
    1.8. Concerns identified through the ongoing monitoring procedures outlined in this section will be addressed through the IHP NSCC process or the IHP Peer Review Policy.
2. Procedures:
    2.1. The IHP credentialing staff maintains a listing of all the reporting entities that are used for monitoring purposes, and on an ongoing basis, updates the listing to ensure that the most recent information regarding the period of reporting (time frames), dates of release, method of reporting, and source of reporting is on file.
    2.2. The credentialing staff queries, retrieves, or receives periodic reports from each of the listed entities and reviews each report within thirty (30) calendar days of the release of the report by the entity.
    2.3. The credentialing staff maintains a log of each report obtained, or the query date if the report is not regularly scheduled. The log includes:
        2.3.1. The name of the report
        2.3.2. The release date of the report, or the query date if the report is not regularly scheduled
        2.3.3. The date of the review
        2.3.4. Any findings related to participating providers
        2.3.5. The name/initials of the individual reviewing the report.
    2.4. If an adverse action is identified through the credentialing ongoing monitoring process, the credentialing staff initiates one of the following:
    2.5. A risk assessment is completed and follows the risk decision process.

2.6. The IHP Credentialing staff will present to the NSCC any Practitioner with professional violations identified between credentialing cycles.

2.7. If the Practitioner is identified as having a Medicare sanction or appears on the Medicare Opt-Out report or a Medicare Preclusion list, is subject to a licensure action by a state agency, or is subject to any other event described in Section IV (b) of the Fair Hearing/Appeals Policy the Practitioner's Network status will be automatically relinquished as outlined in the Fair Hearing/Appeal Policy. Such actions are taken immediately and are not subject to hearing or appeal rights.

2.8. Additional ongoing monitoring activities are performed in conjunction with the Compliance Department and Quality Improvement Department of INTEGRIS Health.

2.8.1. When notified by the Compliance of Quality Improvement Department of a serious quality of care issue, the IHP President and/or Medical Director may precautionarily suspend a Practitioner from participation in the Network if immediate action is necessary to protect the interest of patients, employees, or other persons involved with the Network as outlined in Section IV(a)(2) of the Fair Hearing/Appeal Policy.

2.8.2. Such actions are taken immediately, and special notice will be provided to the Practitioner within 30 days informing them of their right to a hearing under the IHP Fair Hearing/ Appeal Policy.

2.8.3. The requirements pertaining to Medicare participation are applicable to those individuals who apply for initial participation in IHP after the date this Policy is adopted and are not applicable to Network Practitioners who were members of IHP prior to that date. Those Network Practitioners will be grandfathered and governed by any Medicare participation requirements that may have been in effect at the time of their initial partnership. However, any Network Practitioner who was a Medicare participant as of the adoption date of this Policy is expected to maintain Medicare participation, regardless of the Medicare participation requirements that were in effect at the time of their initial participation.

Section 26 PRACTITIONER DIRECTORY

1. All listings in Practitioner directories and other materials for beneficiaries are consistent with credentialing data.
2. The Practitioner directory excludes all Practitioners that are not independently contracted and credentialed and who practice in an inpatient setting. The directory may differ based on beneficiary benefits level.
3. Practitioner-specific information including education and training, board certification status, specialty, hospital affiliation, gender, and language information is derived directly from the IHP Credentialing department's database.
4. All Practitioner specific information (education and training, board certification status, specialty, hospital affiliation, gender, and language information) is verified through the credentialing process and entered in the credentialing database. After the NSCC or IHP President or NSCC Chair(s) in the event of using the "Clean File" process, approval, this information is entered in the Credentialing database where Practitioner directories and all Practitioner-specific information are derived.
5. The IHP Credentialing staff is responsible for entering Practitioner specific information into the credentialing database. Any discrepancies are validated and corrected within thirty (30) calendar days.
6. The IHP public directory must list each Practitioner with whom the network has a direct contractual relationship for covered care. Practitioner information must at least, include the following:

6.1. Name
6.2. Address
6.3. Telephone number
6.4. Digital contact information
6.5. Specialty (required for individual Practitioners, but not for in-network medical groups/clinic/facility)

7. Practitioner directory information is verified and updated, if applicable at least every ninety (90) calendar days.
   7.1. Information regarding a Practitioner that cannot be verified at the ninety (90) calendar day mark, will be subject to removal or suppression.
   7.2. The database is updated within two (2) business days of receiving the required information from Practitioners.
8. If printed directories exist, the printed copy must contain a statement that this printed directory was accurate as of the date of publication and must list the website, plan, or insurer that should be consulted to obtain the most current information.
9. If a request is made by telephone, the IHP Credentialing and/or roster management staff must respond within one (1) business day.
   9.1. The response must include a written response provided in print or electronically.
   9.2. The response must be in the individual Practitioner file for at least two (2) years.
10. Practitioners must support IHP's efforts to improve directories. At a minimum, the Practitioner must submit directory information at the following times:
   10.1. When material changes affect the required Practitioner directory information
   10.2. At any other time determined by IHP, a specific health plan, facility, or secretary of HHS.

Section 27 REPORTING TO AUTHORITIES

1. IHP reports actions against individual practitioners to the National Practitioner Data Bank (NPDB) and state licensing agencies as required by law.
2. Reporting to the National Practitioner Data Bank
   2.1. A report will be submitted to the National Practitioner Data Bank after a physician or dentist has exercised or waived their hearing rights and the Network takes one of the following reportable professional review actions:
      2.1.1. Denial of request for initial or renewed participation in the IHP Network for lack of adherence to the network standards laid out in the IHP Network Participation Agreement and accompanying IHP policies
      2.1.2. Revocation of Network Participation in IHP
      2.1.3. Suspension of Network Participation for more than thirty (30) days
   2.2. A report will also be submitted to the National Practitioner Data Bank if IHP or any of the INTEGRIS Health System member organizations accepts the surrender, restriction, or resignation of a physician's or dentist's Network participation or clinical privileges while under an investigation, or in return for not conducting a professional review action.
   2.3. Under such circumstances the Practitioner will be informed that a report will be made to the National Practitioner Data Bank.
   2.4. Reports to the National Practitioner Data Bank of adverse actions and surrender involving Practitioners other than physicians and dentists are not mandatory under federal law and will not be made.

2.5. Reports to the National Practitioner Data Bank and query results received from the National Practitioner Data Bank are confidential and will not be shared with third-party payers who have delegated credentialing agreements in place with IHP. However, the fact that a query was conducted may be disclosed to third-party payers.
2.6. Copies of all information obtained through queries to the National Practitioner Data Bank shall be maintained as part of the individual's permanent confidential credentials file.

3. State law reporting requirements:
3.1. The state law reporting requirements are not identical to the National Practitioner Data Bank requirements.
3.2. On a case-by-case basis, legal counsel will be consulted to determine if there is an obligation to file a report under the state requirements when a Practitioner has had a request for participation membership, clinical privileges denied or, current participation, membership, or clinical privileges revoked, denied, restricted, or suspended or surrenders or relinquishes participation, membership, or clinical privileges for any period of time.
3.3. Reports will be made consistent with applicable state law.

Section 28 TERMINATION OF NETWORK PARTICIPATION AND REPORTING

1. Credentialing employees will report any questionable documentation to the Credentialing Manager and/or IHP Program Manager along with validation of documentation leading to the concern.
2. Depending on the outcome, the referral will be made to the Corporate Compliance Department for further investigation and action.
3. Terminations for cause are immediate, and not subject to appeal rights as outlined in the IHP Fair Hearing / Appeal policy.
4. Terminations as a result of non-compliance with re-credentialing requirements:
4.1. Notification of termination will be made to the practitioner within one (1) week.
4.2. Second notice of intent to terminate will be made thirty (30) days prior to the set termination date.
4.3. A final termination notification will be made on the date of termination. All termination notifications are made via regular postal service.
5. Termination action taken as a result of non-compliance with recredentialing requirements may be rescinded, if the practitioner successfully submits all necessary documents to perform a re-credentialing cycle, prior to the set date of the final determination.

Procedures

1. Termination for Cause
1.1. The Credentialing Manager may immediately terminate an individual Practitioner for:
1.1.1.1. The individual's license to practice has been revoked by the State or federal agency;
1.1.1.2. The individual's license to practice has been restricted (i.e., is on probation, surrendered, or suspended) by the State or federal agency;
1.1.1.3. The individual's DEA or CDS certificate has been revoked or suspended;

1.1.1.4. The individual's Medicare/Medicaid participation has been terminated, sanctioned, or otherwise limited;
1.1.1.5. License is not appropriate for independent practice;
1.1.1.6. Insufficient amounts of professional liability coverage;
1.1.1.7. No collaborative agreement (for Nurse Practitioners and Physician Assistants) with a participating physician;
1.1.1.8. When a Practitioner appears on the Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE).

1.2. Failure to submit a complete application or an application in a timely manner, as described, does not provide a right to a hearing.
1.3. An individual Practitioner who is terminated for the reasons above may reapply for network participation after the date of agency reinstatement or reinstatement of the lost element.
1.4. Terminations will be reported to the appropriate State and Federal agencies through the IHP after consultation with INTEGRIS Legal Department and/or the INTEGRIS Compliance Department as well as the IHP Program Manager and IHP President.
1.5. The above procedural statement does not preclude IHP from immediately suspending or restricting an individual Practitioner status, subject to subsequent procedures where in the judgment of IHP, failure to take such action may pose a threat or imminent danger to the health of any IHP member.

2. Termination for Administrative Reasons
2.1. Terminations of network participation for administrative reasons may be reportable to outside agencies
2.2. Administrative reasons for termination may include, but are not limited to:
2.2.1. Failure to respond to requests for credentialing information
2.2.2. Failure to report actions by licensing or regulatory agencies
2.2.3. Failure to follow IHP operational policies and procedures
2.2.4. Practitioner terminating from a delegated entity.
2.3. Administrative termination of network participation for business reasons, including but not limited to, the cancellation of a client contract or line of business in the individual practitioner's geographic region will be made at the discretion of IHP and in accordance with the terms of the IHP Participating Agreement.
2.4. Administrative terminations for business reasons are final, not subject to the Fair Hearing / Appeals process, and are not reportable to outside agencies.
2.5. Notice: Individual Practitioners terminated from IHP participation will be notified of the termination via special notice.

3. Voluntary Termination from Participation
3.1. The procedural statements listed below do not apply to situations where the individual Practitioner's participation was involuntarily terminated.
3.2. A participating individual Practitioner who desires, at any time, to voluntarily terminate participation with IHP or any one or more of the lines of business managed by IHP must notify, in writing, the IHP Program Manager or designee, specifying the changes to be made in writing.
3.3. Voluntary termination of participation while under an investigation or in exchange for not conducting an investigation, will not be considered a "voluntary withdrawal" from participation for purposes of reporting to outside agencies.

4. Withdrawal of Request for Participation

4.1. When an applicant for initial credentialing does not provide additional information within specified time frames, this shall be considered a voluntary withdrawal of the request for IHP Network participation.
4.2. Withdrawals of requests for participation are not reportable to outside agencies.

Section 29 REPORTING FRAUD AND ABUSE

1. IHP employees have a responsibility to report any misconduct by employees, members, individual Practitioners, and vendors involving violations of:
   1.1. Federal and state laws and regulations
   1.2. IHP contractual agreements
   1.3. IHP policies
   1.4. Ethical business practices
2. Examples of fraudulent or abusive practices include, but are not limited to:
   2.1. Falsifying information on the credentialing application
   2.2. Failure to disclose information relevant to the credentialing process, such as:
      2.2.1. Prior criminal prosecutions or civil actions
      2.2.2. Non-disclosure of questionable previous employment
      2.2.3. Non-disclosure of any sanctions (e.g., allegation of or investigation into fraud or abuse)
      2.2.4. Requesting credentialing outside of the individual practitioner's scope of practice or expertise.

Section 30 PRACTITIONER TERMINATION AND REINSTATEMENT

1. IHP ensures that individual Practitioners continue to meet minimum credentialing criteria and that mechanisms are available through which IHP will allow individual Practitioners to appeal actions that affect or place conditions upon the Practitioner's health plan or network participation.
2. Terminations from network participation and/or plan enrollment for cause are immediate and not subject to appeal rights. or as noted in Section 28, Procedures, 1.
3. If a Practitioner is denied their request for initial or renewed participation in the network, has network participation revoked or suspended for more than thirty (30) days, or any other decisions that adversely affect a participating Practitioner's status with the Network for more than thirty (30) days as specified in Section IV, Hearing Rights, a., of the Fair Hearing/Appeal Policy, will be provided the right to a hearing.
4. A Practitioner who is terminated for the reasons above, in number two (2), may reapply to IHP after the date of agency reinstatement or reinstatement of the specific element.
5. A Practitioner who has a break in network participation of **less** than thirty (30) calendar days; credentials are re-verified that are no longer within the specified verification time limits. If the break in network participation is **greater** than thirty (30) calendar days; the Practitioner must submit a new application for processing as an "initial applicant".

Section 31 CREDENTIALING SYSTEMS CONTROLS

1. Credentialing applications, supporting documents, and verified information are confidentially and securely received via an electronic application and other electronic means and reviewed by the INTEGRIS CVO or IHP credentialing staff. The receipt of such information is dated, tracked, and stored within the Practitioner's electronic credentialing file. File progress is tracked via internal credentialing checklists.
2. Information collected during the credentialing and recredentialing process is stored securely in the electronic credentialing system used by INTEGRIS Health. Access to Practitioner credentialing files, including initially verified information, is limited to users within the IHP and INTEGRIS Health CVO, and by database administrators using security groups, configured within the credentialing software.
3. Modification or deletion of specific fields in electronic credentialing files is managed through the database administrator granting security permissions to specific user groups, including the IHP staff and INTEGRIS CVO staff involved in credentialing. Modifications to credentialing records are tracked through the credentialing software, which has an audit log showing the date/time of change, what was modified, and the user who made the modification(s).
4. Information that is inaccurate (e.g., incorrect insurance carrier/broker) or duplicative, may be modified or deleted, as applicable.
5. If credentialing information changes, new verifications will be obtained, initialed, and dated by credentialing staff, and updated in the electronic system.
6. If a modification is made to change the verification date/user/source, and a note will be made to reflect the reason for the change.
7. The accuracy of credentialing and re-credentialing information is maintained using secure electronic storage, which limits access to those who have a business need to access such information, as described in this section. Credentialing information is only released to authorized individuals consistent with the purposes described in this policy, such as for legal support and to facilitate the delegated credentialing program (e.g., to their-party payors during audits or regulatory and accreditation entities, if requested).
8. Authorized individuals who are given access to confidential credentialing information and credentialing platforms create a username and password.
9. The INTEGRIS CVO/MSO Manager, IHP Credentialing Manager, or IHP Program Manager is alerted when an employee with access to the credentialing database leaves the organization and automatically expires the former employee's access to the credentialing database and when there is a potential breach of security (e.g., through a virus or unsolicited access), so that the appropriate staff may be instructed on the need to change their password or take other remedial steps.

Authorization to Modify Information

1. IHP monitors its compliance with the controls described in this section at least annually and takes appropriate action when needed.
2. Examples of ***appropriate*** modification to credentialing information include, but are not limited to:
    2.1. Updates to expired licensure or other documents
    2.2. Changes/updates to education or training
    2.3. Correction of data entry errors
    2.4. Information that is inaccurate or duplicative
    2.5. Duplicate profiles
    2.6. Documents appended to incorrect provider profile

3. Examples of ***inappropriate*** modification to credentialing information includes, but is not limited to:
   3.1. Altering credentialing approval dates
   3.2. Altering dates on verification(s)
   3.3. "Whited out" dates or signatures on hard copy documents
   3.4. Unauthorized deletion of provider files or documentation
4. Modifications to credentialing records are tracked through the credentialing software and will be reviewed by the IHP Credentialing Manager or designee to ensure accuracy, appropriate access, and compliance with the policy statements in this section.
5. Modifications that do not meet the requirements listed will be identified and documented by the IHP Credentialing Manager or designee, who will analyze the improper modification and implement a corrective action plan appropriate to the circumstances. Any such corrective action plan will be monitored for effectiveness on a quarterly basis until improvement is demonstrated over at least three consecutive quarters.
6. The analysis of improper modifications will include both a qualitative (e.g., an examination of the underlying reasons giving rise to the modification at issue) and quantitative (e.g., a comparison of the number of improper modifications against a standard or benchmark, trended over time) aspect and shared with the NSCC at least annually.

Limiting Physical Access/Securing Information

1. Hard copy data (any printed confidential/sensitive documents) must be stored out of sight and not accessible to anyone who does not have a business need to view the contents.
2. Credentialing staff shall secure all Practitioner hard copy files and information when not in process and during non-work hours in locked cabinets in a restricted area that is only accessible to authorized staff.
3. Workstations are in physically secure areas.
4. Computer screens in public areas should be positioned to prevent viewing by unauthorized individuals.
5. All password-based systems on workstations must mask, suppress, or otherwise obscure the passwords so that unauthorized persons are not able to observe them.
6. Authorized users are prohibited from allowing others to access computer systems or restricted areas without their account, password, badge, or unique ID information.

Release of Credentialing Information

Releases include the following:

1. Requests from Risk Management, corporate attorney, NSCC, Chair(s), IHP President. Reasonable efforts will be made to notify the impacted provider(s) prior to disclosure of information to an attorney(s).
2. Requests from regulatory or accreditation agencies. Access will require direct supervision by a credentialing team lead or credentialing manager to ensure no data is accessed without authorization.
3. Third parties or organizations (health plans, MCOs, etc.) with whom the delegate is contracted. Each practitioner must have an appropriate signed authorization and release form on file.

Frequency and Methods of Monitoring Activities

1. The monitoring process must occur at least annually, but IHP may use a frequency and/or method other than a single annual process to review credentialing modifications. These may include but are not limited to the following:
   1.1. A description of the system functionality that prevents or disallows modifications of credentialing information.
   1.2. If the credentialing system allows modifications, only under specific circumstances, an annual process for identifying changes to established policies within the past twelve (12) months and then updating the system controls accordingly.
   1.3. A review of automatic system alerts or flags for modification or events in real-time and a separate process for annually testing the performance of the system's automatic alerts or flags.
2. Annual Review of job roles and current user access to ensure system access is still appropriate for the role requirements. May be done in conjunction with IT Services.
3. Monthly quarterly, semiannual, or annual review of all modifications to credentialing data to confirm accuracy and appropriateness using the electronic systems audit trail function to change tracking reporting capability.
4. For paper documents/files, conduct a periodic walk-through of the department to ensure confidential/sensitive documents are being handled and stored properly during and after business hours (i.e., locked drawers/filing cabinets, not left on fax or copy machines, etc.)
5. Incorporate review of data modification/changes/updates to credentialing data into the file review process. Assess accuracy, appropriateness, compliance with policies, and document findings.
6. Require all credentialing staff and anyone who has access to credentialing information to sign confidentiality forms annually.

Section 32 CREDENTIALING AUDITS

1. The IHP credentialing staff monitors its performance for improvement opportunities through credentialing file audits.
   1.1. Each IHP Credentialing staff will perform a "Self-Audit" prior to releasing the credentialing file to the NSCC.
   1.2. If deficiencies are found, the specialist will correct the error and produce a final credentialing file/summary to the NSCC.
   1.3. Prior to the NSCC meeting the IHP Credentialing Lead or Manager will review any applications (initial and recredentialing) that are not considered clean to ensure the file is processed in accordance with policy statements within this policy.
   1.4. For any files that were not approved by the NSCC, the file is reviewed by the IHP Credentialing Lead and/or Credentialing Manager to ensure credentialing decisions were made in accordance with existing policies and procedures.
2. Audits are completed to ensure the integrity and security of the practitioner data contained in the credentialing database.
3. Auditing is used to identify opportunities for improvement and is communicated within the IHP Credentialing and INTEGRIS CVO staff and leadership.
4. The objective of this auditing process is to assess the performance for accuracy, completeness of credentialing data, as well as to enhance the efficiency and quality of service.
   4.1. In the event of a discrepancy, appropriate steps shall be taken by the credentialing Manager.

Section 33 DOCUMENTATION OF INFORMATION AND ACTIVITIES IN CREDENTIAL FILES

1. All primary or approved source(s) of verification are electronically stamped with a unique staff electronic identifier to document verification.
   1.1. The electronic stamp contains both the name of the credentialing staff verifying the information and the date/time of the verification.
   1.2. The stamp can only be accessed by the signatory by user ID and password.
2. All source documents not requiring verification will be reviewed for appropriateness and will be accepted if directly submitted by the applicant or collected from an approved third party.
3. The IHP and CVO staff will use an electronic checklist to document verification(s) of information for Practitioner credential files.
   3.1. The electronic checklist includes, among other items, the date that the verification was received, the electronic signature and/or the electronic initials that are issued to the individual credentialing staff, or the individual conducting the verification, and where applicable the report date.
4. IHP uses the National Practitioner Data Bank (NPDB) Continuous Query Monitoring Service as part of its credentialing practices.
   4.1. The Continuous Query Monitoring Service provides an NPDB report for all Practitioners registered by IHP at the time of initial credentialing and annually when the service is renewed.
   4.2. NPDB reports are not otherwise issued by the Continuous Query Monitoring Service unless there is an update to a Practitioner's NPDB status (e.g., report of an adverse clinical privilege action).
   4.3. The NPDB Continuous Query report is considered accurate and valid at the time of reappointment
   4.4. Any updated reports are considered and updated in the Practitioner's credentialing file.

Section 34 OFFICE SITE QUALITY

1. IHP conducts ongoing monitoring and investigation of member complaints related to the quality of all credentialed Practitioner office sites, considering the severity of an issue based on a reasonable threshold for the number of reported complaints. If the complaint threshold is, related to quality and safety, physical accessibility, physical appearance, and/or adequacy of waiting and examining room space, IHP conducts an office site visit.
2. IHP considers a reasonable complaint threshold to be **three (3) complaints per rolling six (6) month period.** However, IHP at its discretion and can consider one (1) complaint to be a potential threat to beneficiary care and/or safety sufficient to trigger a site visit.

Practitioner Responsibility

1. Provide IHP, if applicable, with a current copy of accreditation by a recognized accrediting body or a copy of the Centers for Medicare & Medicaid Services (CMS) or state review, including the status and time frame for which accreditation is valid.
2. In lieu of a site visit by IHP, a CMS or State quality review may be used if it is not more than three (3) years old. IHP, by virtue of approval of this policy, has certified that CMS requirements for facilities meet IHP's facility site requirements. A copy of the CMS or State agency report must be provided to IHP.

3. Acceptable accreditation agencies include:

AABB	American Association of Blood Banks/Immigration DNA Diagnostic Center
A2LA	American Association for Laboratory Accreditation
AAAASF	American Association for Accreditation of Ambulatory Surgery Facilities
AAAHC	American Association for Ambulatory Health Care
ACHC	Accreditation Commission for Health Care, Inc.
ACR	American College of Radiology
AOA	American Osteopathic Association
ASHI	American Society for Histocompatibility and Immunogenetics
CAP	College of American Pathologists
CARF	Commission on Accreditation of Rehabilitation Facilities
CHAP	Community Health Accreditation Program
CIHQ	Center for Improvement in Healthcare Quality
COLA	Commission in Office Laboratory Accreditation
DNV NIAHO	Det Norske Veritas National Integrated Accreditation for Healthcare Organizations
HFAP	Healthcare Facilities Accreditation Program
IMQ	Institute for Medical Quality
JC	Joint Commission
OFMQ	Oklahoma Foundation for Medical Quality

IHP Responsibility

1. Site assessments (Appendix L) may be conducted to ensure that the offices of all Primary Care and OB-GYN Practitioners meet office site standards. If the site assessments are conducted as part of the delegated credentialing process, the provisions in this section will apply.
2. The quality safety and accessibility of Practitioners' offices will be assessed based on the following factors:
   2.1. Physical accessibility (80% performance threshold)
   2.2. Physical appearance (80% performance threshold)
   2.3. Adequacy of waiting and examination room space (80% performance threshold)
   2.4. Availability of appointments and,
   2.5. Adequacy of medical/treatment record keeping. (80% performance threshold)
3. Upon receipt of complaints sufficient in number, severity, or type, IHP will conduct office site visits to ensure the site meets established performance thresholds
   3.1. Conduct site visits for primary care provider offices including family practice, pediatric, internal medicine, obstetrics/gynecology (OB/GYN), General Practitioner, Advanced Practice Practitioners, and mental health care provider sites about which member complaints have been received.
   3.2. Conduct site visits for specialty care provider offices about which member complaints have been received.
4. When complaints related to the quality of Practitioner/provider office sites are received, the need for a site visit is determined by the number and severity or type of issues reported (site visits are not required for complaints about the availability of an appointment or adequacy of medical record keeping) and reviewed by IHP President, NSCC, and/or IHP staff.

5. Site visits are completed within sixty (60) days of reaching the threshold of three (3) valid complaints within a rolling six (6) month period and as determined by the IHP President.
6. The results of the assessments will be scored on a zero (0) to one hundred (100) percent compliance scale
   6.1. For sites demonstrating eighty (80) percent or greater compliance, no follow-up is required.
   6.2. For sites demonstrating less than eighty (80) percent compliance, a corrective action plan will occur at least every six (6) months until the deficiency is resolved.
7. If a complaint is verified or deficiencies are identified during the on-site visit, the site will develop and submit a corrective action plan (CAP) to IHP President for approval within thirty (30) calendar days of IHP notification.
   7.1. IHP provides the site with a specified time frame for completion and an expected date for follow-up.
   7.2. All Corrective Action Plans are reported to the NSCC and IHP President
   7.3. Effectiveness of the CAP is monitored for a minimum of six (6) months or until such time that the correction is completed, and monitoring for an additional six months occur

Section 35 SUB-DELEGATION

1. Sub-delegation to an entity outside of IHP or INTEGRIS Health of the functions described in this policy will not occur.
2. If a need arises for IHP to sub-delegate any of the functions described in this policy, the sub-delegation will include the following:
   2.1. A delegation agreement that:
      2.1.1. Is mutually agreed upon; and
      2.1.2. Describes the delegated activities and the responsibilities of IHP and the sub-delegated entity; and
      2.1.3. Requires at least semi-annual reporting by the sub-delegated entity to IHP; and
      2.1.4. Describes the process by which IHP evaluates the sub-delegated entity's performance; and
      2.1.5. Specifies that IHP retains the right to approve, suspend, and terminate individual Practitioners; and
      2.1.6. Describes the remedies available to IHP if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement; and
      2.1.7. A pre-delegation evaluation that evaluates the capacity of the sub-delegated entity to meet regulatory and accreditation requirements; and
      2.1.8. An annual review of the sub-delegate's activities; and
      2.1.9. For arrangements in effect for more than twelve (12) months, identification of and follow-up on opportunities for improvement at least once every two (2) years.

Section 36 OVERSIGHT OF THE IHP CREDENTIALING PROGRAM

1. The President of IHP will serve as the medical director of the delegated credentialing program.
2. The President will also oversee the delegated credentialing, recredentialing, and ongoing monitoring processes and is accountable to the IHP Board of Directors.
3. The President ensures that IHP carries out its credentialing activities in the most efficient, effective way possible and that all credentialing activities are in compliance with the Credentialing policies, NCQA standards, relevant laws of the State of Oklahoma, and all other applicable laws, accreditation standards, and regulations.

4. The President may approve initial and recredentialing files that meet all credentialing criteria or may determine that additional review is necessary by the NSCC.

Section 37 TIME LIMITED IN-NETWORK STATUS IN THE EVENT OF A DISASTER PLAN

1. This Disaster Plan will be initiated whenever the usual credentialing process cannot be reasonably completed in time to safely meet patient care needs.
2. Time-limited in-network status may be granted in the event of a Disaster to the following while the Disaster plan is in effect, and locations are unable to handle the immediate patient needs as determined under the Incident Command System and authorized by the Incident Command Officer. Whether it is local, state, or national, the IHP President, the NSCC Chairperson(s), or his/her designee may grant time-limited in-network status, and such decision(s) to grant in-network status shall be made on a case-by-case basis and shall depend on the specific needs of the Disaster.
3. Application process for time-limited in-network status:
    3.1. The Applicant Information Form (Appendix J) is completed by the applicant and submitted to the IHP Credentialing staff.
    3.2. Once received, the application will be completed within seventy-two (72) hours of receipt.
    3.3. The application will require the Practitioner to present a valid government-issued photo identification (driver's license, passport) and at least one of the following:
        3.3.1. Current photo identification card from a health care organization that clearly identifies professional designation (including badge from another health care facility where the Practitioner currently holds privileges/scope of practice; or
        3.3.2. Current professional license to practice in the State of Oklahoma. Out-of-state medical licensure may be accepted if so, declared by the State of Oklahoma.
        3.3.3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or another recognized state or federal Response organization or group; or
        3.3.4. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
        3.3.5. Presentation by a current member of hospital staff or medical staff with personal knowledge regarding the individual's identity and competence to practice.
    3.4. If the Practitioner already has an application submitted and is in the credentialing process and if the Practitioner is determined as meeting the Disaster needs, the Practitioner's application will be processed using the Disaster guidelines set forth in this Plan.
    3.5. IHP Credentialing shall begin the primary source verification(s) of the Practitioner's licensure as soon as feasible, but no later than seventy-two (72) hours after the time that the Practitioner presents the requested information.
    3.6. IHP Credentialing shall obtain approval of in-network status from the IHP President, NSCC Chairperson(s), or designee.

3.7. Once the Disaster Plan has been inactivated, the time-limited disaster in-network status granted to Practitioners will be relinquished unless the Practitioner is then fully credentialed with the guidelines set forth in the IHP Credentialing Plan and can be presented to the NSCC.

4. If it becomes reasonably foreseeable that the Disaster will extend for a period of more than seven (7) days after the initial granting of time-limited in-network status, then the IHP Credentialing staff will verify the remaining credentials.
5. As soon as the immediate situation is under control, time permits, and access to required resources is available, the verification of the remainder of the Practitioner's credentials shall be given high priority.

Section 38 POLICY MONITORING / REVIEW

1. This policy is reviewed at least on an annual basis.
2. During the review process, the policy will be assessed for regulatory compliance and ongoing best practices.
3. The approval process includes the IHP Credentialing Office leadership, Network Strategy and Credentials Committee, and executive IHP Leadership.
4. All policies are reviewed more frequently as new guidance becomes available.

Section 39 SUPPORTING DOCUMENTS

1. IHP Applications:
   1.1. Initial Credentialing Application
   1.2. Recredentialing Application
2. Notice of ineligibility
3. Modification report

Section 40 ENFORCEMENT AND SANCTIONS

Violations of this policy may lead to revocation of network participation and/or disciplinary action including termination. Anyone willfully violating this policy will be subject to disciplinary action up to and including termination.

Section 41 REFERENCES

1. National Committee for Quality Assurance (NCQA) standards – Credentialing
2. Centers for Medicare and Medicaid Services (CMS) guidelines
3. Oklahoma Health Care Authority, SUBCHAPTER 5 Requirements for Managed Care Organizations and Dental Benefits Managers, PART 3, Provider Requirements – 317:55-5-10 Provider Contracts and Credentialing Standards
4. ERISA section 720; Internal Revenue Code section 9820; Public Health Service Act, section 2799A-5
5. Oklahoma Administrative CODE Section 310-657-17-3 – Provider Directory, Current through Vol. 40, No. 18, February 15, 2023
6. https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf

7. 29 USC § 1185i Protecting patients and improving the accuracy of provider directory information (ERISA § 720)
8. https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title29-section1185i&num=0&edition=prelim
9. Pub.L. No. 116-260 Consolidated Appropriations Act, 2021 (Dec. 27, 2020)
10. https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf

Section 42 APPENDICES

A. NSCC Charter
B. IHP Confidentiality Agreement
C. Consent and Release
D. Verification Sources
E. DEA-CDS Prescribing Agreement
F. Lack of Board Certification or Eligibility Waiver
G. Hospital Coverage Letter
H. Supervising Physician Agreement
I. IHP Participation Request
J. Initial Application Requirements
K. Peer Reference Requirements
L. Site Assessment Tool

Appendix A: NSCC Charter

INTEGRIS Health Partners, LLC
Network Strategy and Credentials Committee Charter

I. Purpose

Peer review body responsible for administering the credentialing and recredentialing process and has oversight of all credentialing activities. This committee takes ownership of ensuring the IHP network is comprised of providers that collectively provide the range of clinically integrated quality and cost-effective services required to meet the needs of the populations served by INTEGRIS Health Partners (IHP).

II. Membership

1. Composition
    a. Nine (9) members or additional members added at discretion of IHP Board of Directors
    b. Target 33% primary care
    c. Maximum of 50% INTEGRIS employed physicians
    d. Ad hoc subject matter experts (Contracting, Legal, etc.)
    e. IHP and PHSO administrative support
2. Selection
    a. Selection: Chair and Vice-Chair appointed by IHP President and approved by vote of the IHP Board of Directors
    b. Term: Two (2) year term with a maximum of three (3) consecutive terms or at discretion of IHP President and/or IHP Board of Directors
3. Member Appointments
    a. Selection: Members appointed by IHP President and approved by vote of the IHP Board of Directors
    b. Term: Two (2) year term with a maximum of three (3) consecutive terms or at discretion of IHP President and/or IHP Board of Directors
        i. Appointments take effect in January of each year or at discretion of Board of Directors
4. Voting
    a. Physician Chairman/Vice Chairman
    b. IHP Medical Director
    c. IHP Physician Members
    d. IHP President
    e. IHP Vice President
5. Non-Voting
    a. Ad hoc subject matter experts
    b. IHP and PHSO administrative support
6. Membership Expectations and Accountability
    a. Actively participate in Network Strategy initiatives
    b. Review network appointment packet monthly prior to committee meetings

III. Actions

1. Credentialing

a. Develops IHP membership criteria, with the process to be overseen by IHP administration
b. Develops IHP credentialing criteria, with the process to be overseen by IHP administration
c. Review and evaluate the qualifications of every applicant and the recommendations of the IHP President, Chairperson, or designated practitioner for initial credentialing, recredentialing, and make written reports of its findings and recommendations.
d. Review and evaluate the qualifications of every advanced practice practitioner applying for network participation and make written reports of its findings and recommendations
e. Review, as requested, all information regarding the current lineal competence of individuals currently participating in the network
f. Oversee and approve the development of professional standards and credentialing criteria and ensure that professional standards and credentialing criteria are uniformly applied
g. Develop and review policies related to granting network participation, organizational processes related to credentialing and recredentialing and requisite qualifications of applicants
h. Review all associated quality of care issues, member complaints, or off-site quality complaints for all members of the network. Ensure that there are no patterns of adverse behavior or clinical judgment.
i. Review all applicants that do not meet the standard criteria for participation, or for whom adverse information was discovered during the credentialing verification process, requiring consideration for exception criteria for individual practitioner participation based on, adverse criminal history, adverse history of professional disciplinary actions, lack of DEA and CDS registration, lack of board certification and any potential risk to the organization.

2. Network Strategy

a. Performs annual market analyses to ensure adequate physician geographic coverage and network composition by physician specialty
b. Reviews affiliation strategies for potential geographical and market share expansion of IHP network
c. As needed, partners with INTEGRIS Health strategy department on IHP Network Strategy initiatives

3. Ongoing Monitoring

a. Ensures that IHP members maintain compliance to the network standards as outlined in the Network Participation Agreement and recommends probation or termination of IHP members who fail to adhere to network standards or performance standards set in partnership with the Performance Improvement Committee
b. Monitors physician satisfaction with regards to IHP network activities and oversees physician relations activities
c. Serves as a forum for education and discussion of IHP membership concerns
d. Maintain collaboration and communication with Physician Leadership Council
e. Conduct annual evaluation process to assess participation and engagement. Consider pipeline for new Committee and future Board of Directors members.

IV. Regulatory Requirements

1. Ensures credentialing activity is compliant with all federal and state regulatory requirements
2. Ensures credentialing activity is compliant with Joint Commission, Health Plan, NCQA, and other accrediting agency standards that the network may designate

V. Reporting

The following material will be forwarded to the committee:

1. All initial credentialing and recredentialing applicants
2. Applicants requiring consideration of exception criteria

3. Reports of ongoing monitoring of all practitioners in the network. Agencies monitored for adverse actions include:
    a. State Licensing Board
    b. Office of Inspector General (OIG)
    c. NPDB
    d. Medicare Opt-Out List of practitioners
    e. Medicare Preclusion List of practitioners
4. Reports of other issues involving quality of care, deficiencies in services rendered, or professional reprimands
5. Credentialing System Controls Oversight Report
6. Monitoring and Reporting of Inappropriate Modification Report
7. Reports of Pre-Application Notice/Ineligibility
8. Reports of all waivers granted outside of the full committee
9. Annual quality review of the overall performance of the credentialing functions of the network, addressing effectiveness, opportunities, and barriers to improvement
10. Annual review of IHP, LLC Credentialing Plan
11. Monthly summary of disseminated communication from health plan(s) directly to individual practitioners
12. Annual audits of practitioner complaints for evidence of alleged discrimination

Committee to provide the IHP Board of Directors with:

1. An annual report of committee activities for the year including membership status updates
2. Recommended network expansion strategy when deemed appropriate

Appendix B: IHP Confidentiality Agreement

CONFIDENTIALITY AGREEMENT – INTEGRIS Health Partner (IHP) Physician Leader

As an INTEGRIS Health Partner Physician Leader, I recognize that I will have access to very sensitive and confidential credentialing and peer review information regarding other Practitioners in the INTEGRIS Health Partner Network.

I understand that all such information and any discussions regarding it are strictly confidential. I will not discuss this confidential information outside of appropriate committee meetings unless (i) I am legitimately working on an issue with another IHP Physician Leader or IHP Network colleague who assists us and (ii) the discussions take place in a private, protected manner.

I understand that breaches of confidentiality reflect a lack of professionalism and respect for others and have multiple, serious consequences not only for me but also my colleagues, including:

- loss of the legal protections afforded to us by our state peer review law;
- damage to the reputation of our colleague who is the subject of the breach;
- damage to the integrity and credibility of our IHP Credentialing processes from everyone's perspective (other IHP Physician Leaders and IHP Network staff)
- promoting the perception of a punitive and harsh peer review culture rather than the educational and constructive one that is intended; and
- adversely affecting the willingness of our colleagues to trust us and to work with us on improvement efforts.

Therefore, if I breach confidentiality, I understand that my actions may result in:

(1) dismissal from a committee assignment, loss of my IHP Physician Leader position, and/or removal from participation in IHP Network Strategy and Credentials Committee;

(2) loss of available legal protections (including loss of insurance coverage and indemnification for any litigation costs and expenses);

(3) disciplinary action as deemed appropriate under applicable IHP Network policies; and/or

(4) other appropriate action that may be necessary to protect the IHP Network and IHP Network staff.

Signature_____ Date_____

Appendix C: IHP Consent and Release

APPLICANT CONSENT AND RELEASE

As part of my application for initial appointment or re-appointment to INTEGRIS Health Partners, LLC ("IHP"), I hereby warrant and represent that I:

- Authorize IHP to investigate all statements contained in this application and in support of this application; and
- Authorize IHP to obtain information and review documents from third parties and further authorize such third parties to provide information and documents to IHP, to assist IHP in evaluating my professional competence and qualifications, including my character and ethical standards, my ability to work cooperatively with others, and my physical and mental health and emotional stability; and
- Understand that I have the burden of producing adequate information for proper evaluation of my application and further understand that failure to produce this information and any additional information as may be requested to consider my application may prevent my application from being evaluated and / or acted upon; and
- Agree to appear for interviews (if applicable); and
- Understand and agree that as part of the credentialing process, a medical records audit and site review may be necessary to satisfy National Committee for Quality Assurance (NCQA) requirements for primary care physicians and OB/GYN specialists and high-volume behavioral health care practitioners; and
- Will not rebate a portion of a fee or accept other inducements in exchange for a patient referral; and will not deceive a patient as to the identity of an operating surgeon, or any other medical practitioner providing treatment or services; and
- Agree to uphold the professional ethics of my profession, provide for continuous care of my patients and refrain from delegating the responsibility of my patients' care to any practitioner not qualified or competent to provide such care; and
- Acknowledge that I have received, or had made available to me, and read the IHP Network Participation Agreement to which this application applies; and
- Am not, nor have I ever been, excluded from Medicaid and/or Medicare participation under Section 1128 or 1128(a) of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services; and agree to promptly notify IHP in writing if at any time I am excluded from Medicaid and/or Medicare participation during any term of my service as an IHP provider and understand and agree that such exclusion may result in immediate termination of network agreement; and
- Understand that limitation, suspension, or termination of medical staff membership or privileges based on professional competence or professional conduct which affects or could affect the health and welfare of patients is subject to the provisions of the Health Care Quality Improvement Act, and may result in reporting of such action to the National Practitioner Data Bank; and
- Understand if my application is denied it may be necessary for IHP to report the denial to the National Practitioner Data Bank; and
- Understand that as a condition to making this application, any misrepresentation or misstatements in or omission from this application whether intentional or not, shall constitute cause for automatic and immediate rejection of this application resulting in denial; and in the event that approval has been granted prior to discovery of such misrepresentation, misstatement, or omission, such discovery may result in immediate termination of network agreement; and
- Certify that all information contained in my application is true, correct, and complete in all respects and shall promptly inform IHP if there are any changes in the information provided; and
- Understand that I have the right to review all information submitted by a third party in support of this application if disclosure of the information is not prohibited by law and to correct erroneous information submitted by a third party or to correct any erroneous information inadvertently submitted by me; and
- In consideration of IHP's acceptance and review of the application and with intent to be legally bound I hereby release IHP, its officers, employees, and agents from and against any and all liability arising out of the investigation, review and determination with respect to this application, and further release any and all individuals, corporations and organizations who or which provide information including otherwise privileged or confidential information, relating to this application from any and all liability.

- The individual specifically authorizes INTEGRIS Health Entities (as defined below) to share with one another any information maintained in any format (verbal, written, or electronic) that involves (i) the evaluation of the quality, safety, necessity, and compliance with applicable law of services ordered or performed by the individual, or (ii) the individual's professional qualifications, competence, conduct, health/ability to safely practice, experience, or patient care practices. This information and documentation may be shared at any time, including, but not limited to, any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual.
- For purposes of this Section, an INTEGRIS Health Entity means:
    - any entity that satisfies ***both*** of the following requirements:
    - has a formal peer review/professional practice evaluation or credentialing process, and an established peer review committee or credentials committee, as evidenced by internal bylaws or policy; and
    - is directly or indirectly, through one or more intermediaries, controlled by INTEGRIS Health. Entities that are "controlled by INTEGRIS Health" for purposes of this definition include, but are not limited to, the following entities, as well as those individuals, committees, and boards who act on their behalf:
    - INTEGRIS Health and its Hospitals;
    - INTEGRIS Health urgent care centers, cancer care centers, and ambulatory surgery centers;
    - INTEGRIS Health Medical Group;
    - any joint ventures in which INTEGRIS Health has an interest of 50 percent or more;
    - any entity that is managed, via a written management services agreement, by one of the entities described in this subsection (a); and
    - any entity not included in subsection (a) that provides patient care services and that:
    - has a formal peer review/professional practice evaluation process or credentialing process and an established peer review committee or credentials committee, as evidenced by internal bylaws or policy; and
    - has appropriate provisions regarding the sharing of Confidential Information consistent with the INTEGRIS Health Information Sharing Policy in a professional services contract or separate agreement with INTEGRIS Health or an INTEGRIS Health Entity identified in subsection (a).

All applicants have the right, and are subject to the following:

- Review any information submitted in support of their application, except such information specifically excluded by law from disclosure.
- Request status of their application at any time during the credentialing process.
- Respond to any information received during the credentialing process that varies substantially from information supplied to Integris Health Partners, LLC and/or INTEGRIS Health, Inc., and such response will be conveyed in writing to IHP Credentialing staff within a reasonable period of time, not to exceed thirty (30) calendar days. All discrepancies are documented until an appropriate response is received.
- When appropriate, explanations or corrections can be provided in person, via telephone or electronic mail. Explanations will be maintained as part of the permanent credentials file.

Applicant's Name: _____

(Please print name legibly)

Applicant's Signature: _____

Date: _____

Appendix D: Verification Sources

Verification Table: Credentialing Source and Timeframe Requirements (NCQA and health plan credentialing)

Based on NCQA July 2023 Standards (Health Plan), CMS CoPs & Interpretive Guidelines for Hospitals (SOM 2-21-20)

Element	Verification Requirements	Completion Requirements		Primary or Secondary Source Validation?	Time Frame	Source(s)
		Initial	Recred			
Application	The application must include a signed, current attestation confirming that the application is accurate and complete within the specified time frame.	Yes	Yes	Primary	180 days prior to the credentialing decision	If attestation exceeds 180 days, the practitioner must re-attest that the information on the application is current and complete.
Licensure and/or sanctions against licensure **Current valid, unrestricted license**	Current and valid at the time of decision Verify all states in which the practitioner will provide care Verification of the status of all licenses provided on the application Continuous monitoring to demonstrate that all licenses where patient care is provided remain current	Yes	Yes	Primary	HP/CR Within 180 days of credentialing decision CVO within 120 days Current at the time of action by the credentialing committee Ongoing monitoring to ensure maintenance of current licensure	**Physicians MD** • OK State Board of Medical Licensure and Supervision **Physicians DO** • OK State Board of Osteopathic Examiners **Physicians – Psychiatrist** • OK Board of Behavioral Health **Oral Surgeons** • State Board of Dental Examiners OK Board of Dentistry **Podiatrists** • OK State Board of Medical Licensure and Supervision **Other nonphysician health care professional(s)** **APRN** • OK Board of Nursing **PA** • OK State Board of Medical Licensure and Supervision
License – Special Considerations Nurse Practitioners and Physician Assistants	Evidence of a current collaborative or supervisory agreement.	Yes	Yes			Verify that supervisory agreement is noted on license.

Element	Verification Requirements	Completion Requirements		Primary or Secondary Source Validation?	Time Frame	Source(s)
		Initial	Recred			
	Supervising Physician is an IHP participant and has the same privileges as those requested by NP/PA					Supervisory agreement renews concurrently with license.
Federal Drug Enforcement Agency (DEA) certificate and/or State Controlled Dangerous Substances (CDS) certificate or Controlled Substance Registration (CSR)	Verify in each state where the practitioner is authorized to prescribe medications and provide care A separate DEA number is needed for each state in which the applicant practices Must have OK DEA prior to going to the credentials committee In the absence of a DEA/BNDD prior to credentialing committee decision: • Applicants with a pending DEA/BNDD may submit a complete DEA/CDS Prescribing Agreement to allow another practitioner to write prescriptions on their behalf	Yes	Yes	Primary	NCQA: Current at the time of decision CMS: Current and verified within 180 days of the committee decision The DEA and/or CDS must be current at the time of action by the credentialing committee, or an alternate arrangement must be in place.	• Confirmation through DEA or CDS agency • OK Bureau of Narcotics and Dangerous Drugs Control • APRN and PA – under the direct supervision of a physician. ○ Application through the state of OK ○ Schedule III, IV, and V
Education and Training*Annual written confirmation required:*** Directories/marketing must be consistent with credentialing data obtained	Highest level of certification or training: • Board certification (if applicable) • Residency	Yes	No	Primary	Prior to credentialing committee's decision	<u>Residency</u> • AMA Physician Masterfile • AOiA American Osteopathic Information Association - Official Osteopathic Physician Profile Report or AOA Physician Masterfile (DO only) • Residency Program

Element	Verification Requirements	Completion Requirements		Primary or Secondary Source Validation?	Time Frame	Source(s)
		Initial	Recred			
(i.e., education training, certification, and specialty)	• Graduation from medical or professional school **NCQA only recognizes programs accredited by:** • Accreditation Council for Graduate Medical Education (ACGME) • American Osteopathic Association (in the United States) • College of Family Physicians of Canada (CFPC) • Royal College of Physicians and Surgeons of Canada					<u>Medical/Professional school</u> • AMA Physician Masterfile • AOiA American Osteopathic Information Association-Physician Profile Report or AOiA Physician Master File • Education Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986 • Sealed transcripts <u>For other health care professionals:</u> • Registry that performs PSV of board status if the organization obtains annual written confirmation that the registry performs PSV of board status. • School • National Student Clearing House (NSC) [*although not an approved source for PSV, NCQA allows verification of credentials through the NSC if you have obtained documentation of a contractual relationship between the educational institution(s) that work with the NSC that entitles the NSC to provide verification of credentials on behalf of the educational institution]*
Board Certification (if reported by the practitioner) ****Annual written confirmation is required for Boards in the United States that are not members of the ABMS, AOA, or NBPAS** ****Annual written confirmation from the ANCC,**	Verify board certification expiration date or lifetime certification If a practitioner has a certification that does not expire (e.g., lifetime certification status), the organization verifies that board certification is current and documents the date of verification	Yes	Yes	Primary	Within 180 days of credentialing decision CVO 120 days	For physicians (MD, DO) • The primary source (appropriate specialty board) • The state licensing agency if it completes primary source verification of board certification • ABMS or its member boards, or an official Display Agent, where a dated certificate of primary-source authenticity has been provided. Note: The ABMS "Is your Doctor Board Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification. • AMA Physician Masterfile

Element	Verification Requirements	Completion Requirements		Primary or Secondary Source Validation?	Time Frame	Source(s)
		Initial	Recred			

AANP, or NCCPA for NP, PA, and CRNA practitioners						• AOiA Physician Profile Report (DO only)
						• If the specialty board does not provide an expiration date, verification that the board certification is current is required.
						• NBPAS National Board of Physicians and Surgeons
						
						<u>For Nurse Practitioners:</u>
						• The primary source (appropriate specialty board)
						  ○ PNCB (Pediatric Nursing Certification Board
						  ○ CRNA (National Board of Certification & Recertification for Nurse Anesthetists)
						  ○ American Association of Critical Care Nurse Certification
						• Registry that performs primary source verification of board status if the organization obtains annual written confirmation that the registry performs primary source verification of board certification status.
						• NCC (National Certification Corporation)
						• ANCC (American Nurses Credentialing Center)
						• AANP (American Academy of Nurse Practitioners)
						<u>For Physician Assistants:</u>
						• NCCPA (National Commission on Certification of Physician Assistants)

Work History	Review most recent 5-year work history **as a health professional** If training has recently been completed; the time frame	Yes	Yes	Secondary – typically from the application or CV with current attestation	Within 365 days of credentialing decision	Application or curriculum vitae with current attestation

Element	Verification Requirements	Completion Requirements		Primary or Secondary Source Validation?	Time Frame	Source(s)
		Initial	Recred			
	begins at the time of initial licensure If less than 5 years are available, the time frame starts at the initial licensure date Month/year must be provided (unless continuous employment for 5 years or more) Documentation includes the signature or initial of staff and the date of review: • Gaps greater than 30 days are clarified in writing • Gaps greater than 2 years must have a detailed explanation accounting for the time away from practice. ***Work History is defined as relevant work experience, including as a health professional, experience as a non-physician health professional within the 5 years should be included (e.g., RN, NP, PA, CSW, MD). Hospital memberships/affiliations are not acceptable as work*				HP/Medicare Advantage remains 180 days	

Element	Verification Requirements	Completion Requirements		Primary or Secondary Source Validation?	Time Frame	Source(s)
		Initial	Recred			
	history unless the provider is employed by the hospital.					
Malpractice/ Claims History	Verify past 5 years of malpractice history resulting in settlement or judgment paid on behalf of the practitioner Verification of coverage may come directly from the carrier or in the form of a copy of the applicant's policy binder that shows the dates and amounts of coverage. Seek information on inclusions, exclusions, and/or limitations to professional liability coverage – whether requested by the practitioner or imposed upon the practitioner ("endorsement" or "waiver"). If not available note the attempt was made.	Yes	Yes	Primary	Within 180 days of credentialing decision	• Application statement and correspondence with the malpractice carrier • Query the carrier regarding not only final judgments or settlements but also open claims • NPDB *NPDB Continuous Query- INTEGRIS Health Partners, LLC is notified by NPDB within 24 hours of the NPDB's receipt of all licensure actions, Medicare/Medicaid exclusions, medical malpractice payment, clinical privilege actions, and other adjudicated actions or findings concluded against a practitioner*
Malpractice/Liability Insurance Coverage	Copy of the insurance face sheet from the malpractice carrier or collect the information in the application. Must include the amounts and the date of expiration.	Yes	Yes	Primary	NCQA: Current and verified within 365 days of the committee decision	• Documentation of coverage may also be a face sheet, a federal tort letter, or an employer professional liability policy as an addendum to the application • The document must include the insurance effective and expiration dates (the future effective date is acceptable)

Element	Verification Requirements	Completion Requirements		Primary or Secondary Source Validation?	Time Frame	Source(s)
		Initial	Recred			
	• If the practitioner does not have current malpractice coverage, it is acceptable to include future coverage with the effective and expiration dates				CMS: Current and verified within 180 days of the committee decision	• The face sheet must reflect the verification and/or reverification date and name of the reviewer prior to committee's decision
Medicare/Medicaid Sanctions	Most recent five (5) year period **Complete both OIG and SAM**	Yes	Yes	Primary	Within 180 days of the committee's decision CVO: 120 days	• NPDB – enrollment in NPDB Continuous Query • List of Excluded Individuals and Entities (LEIE) maintained by the Office of Inspector General (OIG) • General Services Administration (GSA) System for Award Management (SAM) • Medicare Exclusion Database • State Medicaid agency or intermediary • Medicare intermediary ***Note: Most Health Plans will state that regardless of the contracted line of business, (Medicare, Medicaid, Commercial), the applicant must not be ineligible, excluded, debarred, or precluded from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or Children's Health Insurance Program (CHIP) program and must be without any sanctions levied by the OIG, the CMS Preclusion List or other disciplinary action by any federal or state entities identified by CMS. At a minimum, the credentialing entity verifies reported information from the OIG, Medicare Opt-Out, and the CMS Preclusion List.

Element	Verification Requirements	Completion Requirements		Primary or Secondary Source Validation?	Time Frame	Source(s)
		Initial	Recred			
Ongoing Monitoring of Sanctions, Complaints, and Quality Issues	Ongoing monitoring, defined by policies and procedures, of Medicare and Medicaid sanctions, and sanctions or limitations on licensure or limitations on scope of practice including complaints, any adverse events or quality concerns, and action taken. Documentation is regularly obtained and reviewed The organization must review the information within 30 days of publication. Must show evidence of review of information obtained in monitoring efforts within 30 days. Must routinely monitor (at least every 6 months) and evaluates: • Practitioner complaints from members • Information from identified adverse events (i.e., patient harm/injury)	Ongoing		Primary	Minimum Every six (6) months for practitioner performance and member complaints Must reflect review by committee in each practitioner file at the time of committee decision Sanction reviews are ongoing through the continuous query of NPDB enrollment	• Sources for monitoring Medicare and Medicaid sanctions are noted above. • National Practitioner Data Base Continuous Query • Complaints received through [organization's] established systems of reporting (grievances, incidence reports, patient satisfaction survey responses), and communication through staff • Additional sources include medical staff established quality committees, OPPE/FPPE reports • Internal and external reporting structures for practitioner-specific complaints from members and adverse events • Notification of a publicly verifiable report that a government agency has initiated an investigation related to the LIP, which raises concerns regarding the potential for imminent harm to the beneficiary

Element	Verification Requirements	Completion Requirements		Primary or Secondary Source Validation?	Time Frame	Source(s)
		Initial	Recred			
	A review of QI practitioner performance and member complaints is documented at the time of Credentialing Committee decision. Must reflect committee review.					
Attestation	Current, signed attestation statement. The practitioner must attest that the application is true and complete. The practitioner must address: • Inability to perform essential functions • Illegal drug use • History of loss of license • History of felony convictions • Limitation of privileges or disciplinary actions • Current malpractice coverage • Correctness and completeness of the application	Yes	Yes		Valid, current, and no more than 365 calendar days old at the time of the credentialing committee's decision Medicare Advantage is 180 days	Documented confirmation of the applicant's statement Signed attestation
Medicare Opt-Out	The screen capture should indicate the date that the Opt-Out was verified/checked, and the	Yes	Yes	Primary	Within 180 days of the committee's decision	• Documented review of Opt-Out lists or printed Opt-Out report • Checklist should indicate the date that the Opt-Out was checked, and the initials of the staff who reviewed the Opt-Out

Element	Verification Requirements	Completion Requirements		Primary or Secondary Source Validation?	Time Frame	Source(s)
		Initial	Recred			
	initials of the staff person who reviewed the Opt-out **Cannot contract with a Practitioner that has opted out of Medicare within the preceding 24 months. If found after initial credentialing, notify the health plan immediately					
Social Security Administration Death Master File	Provided by the Social Security Administration. It is the official site to search the Death Master File to verify identity, verify death and prevent identity fraud.	Yes	Yes	Primary	Current at the time of credentialing committee decision (180 days)	Social Security Limited Access Death Master File completed through background check vendor.
NPPES (National Plan and Provider Enumeration System/ NPI (National Provider Identifier)	**NPI** is a unique 10-digit identification number issued to healthcare providers in the United States by the Centers for Medicare and Medicaid Services (CMS).	Yes	Yes	Primary	Within 180 days of the committee's decision	NPI Lookup https://npiregistry.cms.hhs.gov/
Office Site Quality Visit	Refer to the Site Visit Form	Yes	Yes			Assessment form used per policy
No prior denials or terminations	At the discretion of the health plan, the applicant must not have been denied initial participation or had participation terminated (for reasons other than network need) by the credentialing entity within the preceding 24 months.					Refer to plan agreements
Hospital Staff Privileges	Applicant must have full hospital admitting privileges, without Material	Yes	Yes		Prior to credentialing committee	Use Hospital Coverage Letter if no admitting privileges have been provided.

Element	Verification Requirements	Completion Requirements		Primary or Secondary Source Validation?	Time Frame	Source(s)
		Initial	Recred			
	Restrictions, conditions, or other disciplinary actions, **or**, arrangements with a plan participating LIP to admit and provide hospital coverage to beneficiaries. All privileges must be reviewed and noted with the name of the person completing the review and the date of the review				decision – within 180 days	
CMS Preclusion List						

***All credentialing documents are reviewed and noted with the initials of the person completing the review and the date of the review. The document includes the following:**

- **Source used**
- **The date of verification**
- **The initials or full name of the person who verified the information**
- **Report date**

**** Obtains <u>annual</u> written confirmation of primary source verification from the primary source or,**

- **provides a printed, dated screenshot of the state licensing agency, specialty board, or registry website that it performs primary source verification of practitioner education and training, or**
- **provides evidence of a state statute requiring licensing agency, specialty board, or registry to obtain written verification of education and training directly from the institution.**

INTEGRIS HEALTH Partners

Appendix E: DEA/CDS Prescribing Agreement

DEA/CDS Prescribing Agreement

As specified in the INTEGRIS Health Partners, LLC Credentialing Plan, and the Network Participation Agreement, for all qualified practitioners who write prescriptions for controlled substances, you must:

- maintain an unrestricted federal and state drug enforcement and controlled substances registration number and certificate
- have never been reprimanded, sanctioned, or disciplined by a federal or state drug enforcement or controlled substances agency or commission.
- you may not have been denied a federal or state drug enforcement or controlled substances registration number or certificate
- may not have had a federal or state drug enforcement or controlled substances registration number or certificate restricted.

In the absence of a valid Drug Enforcement Administration (DEA) and Controlled Dangerous Substances (CDS) certificate that is valid and current in each state where you provide care to patients, please complete the following information:

☐ **I do not prescribe controlled substances** and patients in my care do not require controlled substances. If this statement is checked, you must describe your process for handling instances when a patient requires a controlled substance:

_____

_____

☐ **My DEA/CDS Certificate is pending**. The following practitioner has agreed to write prescriptions on my behalf. Once my DEA/CDS is received by IHP this agreement will be null and void.

Name (Individual, Practice, Facility)	Type (MD, APRN, Hospital, etc.)	DEA Number	CDS Number

☐ **My DEA/CDS Certificate is pending**, my current employment does not start until _____. I intend to have my DEA/CDS in place prior to this date. If my DEA/CDS is not active and following the above guideline, prior to this date, the following practitioner has agreed to write prescriptions on my behalf. Once my DEA/CDS is received by IHP this agreement will be null and void.

Name (Individual, Practice, Facility)	Type (MD, APRN, Hospital, etc.)	DEA Number	CDS Number

Applicant's Name: _____

(Please print name legibly)

Applicant's Signature: _____

The Network Strategy/Credentialing Committee will review your submission as part of the credentialing and recredentialing/reappointment process. The absence of a DEA/CDS coverage plan may be the basis for denial or termination from our network.

Appendix F: Lack of Board Certification Waiver

Lack of Certification Approval

Lack of Certification or Eligibility in a Board Specialty

Date: _____

The following applicant is not board certified or board eligible and requires approval from the INTEGRIS Health Partners president before credentialing can proceed.

Applicant Name: _____

Practicing Specialty: _____

Residency Specialty: _____

Residency Institution: _____

Dates of Residency: _____ to _____

Number of years practicing specialty in a clinic, hospital, or surgery center: _____

Was provider previously board certified? _____ Yes _____ No

Is provider currently in the IHP network? _____ Yes _____ No

Additional Information:

This applicant's experience and skills have been reviewed.
_____ Approved, in lieu of certification
_____ Denied
_____ Additional information requested

Comments:
_____

_____ _____
Carl Raczkowski, M.D. Date
President
INTEGRIS Health Partners, LLC.

Appendix G: Hospital Coverage Letter

Hospital Coverage Letter

To: INTEGRIS Health Partners **Date: _____**

Please accept this correspondence as confirmation that since I do not have active admitting privileges at an INTEGRIS Health Partners participating network hospital, with the exception of medical emergencies, my practice will be confined to outpatient.

I hereby agree and attest, if non-emergency hospitalization is necessary, I will refer care to an INTEGRIS Health Partners participating network physician or hospitalist that has active admitting privileges at a participating network hospital.

Practitioner's Name: _____
(Please print name legibly)

Practitioner's Signature: _____

Please Note:

If you are unsure of the participation status for INTEGRIS Health Partners, for yourself, another physician, hospitalist, or hospital, please visit https://integrisok.com/doctors/search in-network providers are indicated with **IHP**. You may also contact INTEGRIS Health Partners Credentialing at IHPCredentialing@integrisok.com

Appendix H: Supervising Physician Agreement

Advanced Practice Providers

Advance Practice Nurses
Supervising Physician
Protocols/Duties/Scope of Practice

This form applies to Advance Practice Nurses currently contracted and credentialed by INTEGRIS Health Partners (IHP). Advance Practice Nurses are required to be supervised/monitored by a physician with the INTEGRIS Health Partners Network in accordance with the INTEGRIS Health Partners Credentialing Plan unless prior approval is granted by the IHP Network Strategy Committee.

Section 1: Collaborating/Supervising/Monitoring Physician

Applicant's Name: _____ Degree: _____ Specialty: _____

Collaborating/Supervising/Monitoring Physician

Name: _____ Degree: _____
This physician must be in network with INTEGRIS Health Partners.

Alternate Collaborating/Supervising/Monitoring Physician

Name: _____ Degree: _____
This physician must be in network with INTEGRIS Health Partners.

Section 2: Protocols/Duties/Scope of Practice

In my current position with _____, Collaborating/Supervising/Monitoring
(Supervising Physician Name)
Physician, I have reviewed, understood, agreed upon and signed along with my Supervising Physician, protocols or other written authorization which defines my duties and role as an Advanced Practice Nurse in a manner that promotes professional judgment commensurate with my education and experience. A copy of the protocols/duties/scope of practice is maintained onsite (at my primary office location).

Attestation:
I certify the information provided by me on this document is true, correct, and complete to the best of my knowledge and belief. I understand and agree that any misstatement or omission of information concerning my collaborating/supervising physician and the established protocols/duties/scope of practice may constitute grounds for withdrawal of the application for consideration.

Applicant's Signature: _____ Date: _____

INTEGRIS HEALTH Partners

Appendix I: IHP Participation Request

Participation Request Form

- Please complete the form in its entirety. This form will be used to determine your eligibility to join INTEGRIS Health Partners (IHP).
- If you have or will be applying for privileges at an INTEGRIS Health facility, you will not need to complete the IHP Credentialing. application. Please visit https://integrisok.com/ihp/prospective-providers for additional forms to complete this process.
- Please return this form & a W9 to INTEGRIS Credentialing Office at IHPCredentialing@integrishealth.org. You will receive an e-mail with further instructions.

Please see attached for documents that will be required for the full initial application.

Last Name	First Name
Birth Date	Primary Degree (APRN, MD, etc.)
NPI Number	
Provider E-mail (must be unique to this provider)	

If you have an admin that will be completing this application for you, please complete the Credentialing Contact section below.

Credentialing Contact Name	Credentialing Contact Phone Number
Credentialing Contact E-Mail (cannot be the same as the provider)	

Primary Office Location	
Practice Name (as listed on the W9)	**City and State of Practice**

For Advance Practice Providers:				
Is your supervising physician in network with INTEGRIS Health Partners?	**Yes**		**No**	
Please list your supervising physician(s):				

Specialty Information				
Are you board certified?	**Yes**		**No**	
If not certified, are you board eligible?	**Yes**		**No**	
If not board certified or eligible, please explain your board status or lack of certification.				

License Specialty	
Education Specialty	
Primary Specialty	
Practicing Specialty	

Hospital Affiliation Information				
Do you perform procedures?	**Yes**		**No**	
Do you have hospital privileges to perform those procedures?	**Yes**		**No**	
Where do you have privileges?				
Admitting Privileges				
Do you possess admitting privileges at an in-network facility?	**Yes**		**No**	

To see a list of IHP in-network facilities, visit http://www.hchlogix.com/ProviderSearch or request a copy of the list from our office.

Medicare Opt-Out				
Are you currently opted-out of Medicare through CMS.gov?	**Yes**		**No**	
DEA/OBNDD				
Do you possess and plan to maintain a DEA and OBNDD?	**Yes**		**No**	

I expressly agree that, in consideration for the Network's willingness to review and consider the information provided herein, I waive and release any claims, including but not limited to any claim of entitlement to a hearing or appellate review, against the Network, its participants, officers, directors and agents, arising from a decision to not provide me an application for membership in the Network. I expressly agree that such a decision is an administrative and business decision which may be made by the Network independent of any professional review and that such a decision will not result in any report to the National Practitioner Data Bank or any other agency. I also agree that if I am offered an application and granted participation and fail to fulfill the conditions to which I have agreed, my network eligibility may be administratively terminated without giving rise to any claim of any nature against INTEGRIS Health Partners, its participants, officers, directors, and agents. I hereby attest that the information provided above is true and correct. I fully understand that any significant misstatements in or omissions from this document constitute cause for denial of my request for an application, denial of appointment to the network, or termination from the network. I will immediately notify INTEGRIS Health Partners if any information provided on this document changes or is no longer true and correct.

Provider Name: _____

Signature: _____ Date: _____

Appendix J: Initial Application Requirements

Initial Application Requirements

The following items will be needed for the IHP (INTEGRIS Health Partners) online application. Please prepare these documents prior to receiving the application. This will ensure the application is completed promptly and will prevent any delays in credentialing.
Please do not send these documents with the Participation Request Form, they will be discarded.

	Claims Information All claims information must be entered into the online application under **Malpractice Claims**.
	ECFMG Certificate Required if the practitioner is a foreign graduate.
	Disclosure Questions Explanation must be provided for any questions in which the practitioner answered 'yes'.
	Education/Training: APPs must provide the highest level of education in the medical field. Physicians must provide Medical School, Residency and Fellowship.
	Board Certification or Board Eligibility Proof of board certification/board eligibility or an IHP Lack of Board Certification approved waiver.
	State License Must have an Oklahoma License that is unlimited and within the applicant's scope of practice.
	Other State License Must provide information any active and inactive state license
	Photo The photo must be current and in a .jpg or. tif file. All other formats will be rejected.
	DEA/CDS Practitioner must maintain a DEA/CDD. If the practitioner does not maintain a DEA/CDS they must provide the DEA/CDS Prescribing Agreement.
	Current Malpractice Please provide all current insurance certificates. Coverage for IHP must be at least $1Mil/$3Mil.
	Previous Malpractice Certificates Certificates for the last five (5) years or from the highest level of education. If the Practitioner has/had Tort Coverage, we require you upload the letter for certification.
	Peers 3 peer references that meet guidelines listed (see next page). Please ensure you provide accurate e-mails that are unique to the reference, so confidentiality is maintained.
	Sponsoring Physician (APPs only) Must be in network or go through credentialing simultaneously.
	Hospital Privileges: Specialists who perform hospital procedures must hold membership and clinical privileges at an IHP in-network facility. Any provider without admitting privileges must provide the Hospital Coverage Letter.
	Work History A complete list of work history as a medical professional including any gaps greater than 30 days. **If you graduated less than 5 years ago, you would need to provide** any experience as a healthcare professional (such as a moonlighting physician, RN, lab tech, etc.)
	Curriculum Vitae (CV) Please provide an up-to-date CV.

	Signed Document Any documents attached to the application must be signed by the Practitioner.

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Appendix K: Peer Reference Requirements

Peer Reference Requirements

Please list at least three (3) references that meet the following guidelines:

- Current professional reference who is familiar with your work and same discipline (physicians for physicians, podiatrists for podiatrists, etc.)
- The reference must be familiar with your work in the past six (6) months to twenty-four (24) months.
- Reference cannot be someone of relation (previous, current, or future) to the applicant.
- If you are applying directly from a training program (residency, fellowship, preceptorship, etc.), and have not practiced at your current location for at least six (6) months, please list your program director and/or preceptor.

For Advanced Practice Professionals:

- You must meet the above criteria.
- **And** list your current supervising physician, if you have worked with them for at least 6 months. Otherwise, please list your previous supervising physician.

Other criteria can be deemed acceptable by the Network Strategy and Credentials Committee upon further review.

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Appendix L: Site Assessment Tool

When conducting a site visit, written verification of criteria is not required unless specifically stated. Reviewers deviating from the criteria should indicate rationale in comments section. The initial reviewer is responsible for conducting corrective action plan (CAP) follow-up if indicated. This form may be used for all CAP follow-up activities. Please note deficiency-specific comments on CAP section of tool and indicate follow-up dates (on last page of form).

Practitioner Information:		**Total Number of On-Site Staff:**				**Reviewer Information:**
PCP or Specialty:						Name
Name		Physician		NP		Organization
Address		RN		PA		
		LPN		MOA		
		Clerical		CNM		
Phone	Fax	Other				Date of Site Visit
Names of additional practitioners (of attach roster)		**Visit Purpose**				**Corrective Action Plan**
		Complaint Regarding: ___Physical Accessibility ___Physical Appearance ___Adequacy of Waiting/Exam Room space ___Adequacy of Equipment ___CAP Follow-up ___Other_____				Scores below____% require a CAP **CAP INFORMATION** *CAP follow-up visits must occur within six months of deficiency* Next Follow-up Date:_____ Next Follow-up Date:_____ Next Follow-up Date:_____
Name of office contact						

Site Point Summary Enter total earned (yes) points and total available (yes + no) points for each section.				**Site Score Summary** Calculate the percentage score for each section (earned/available). Calculate site score (total earned/total available).			**Medical Recordkeeping Score** Scores below _____% require a CAP	
		Earned	Available	Section Score		Site Score	Earned	Available
A	Physical Accessibility				%	Earned		
B	Physical Appearance				%	Available		
C	Adequacy of Room Space				%		Medical Record-Keeping Score	
D	Adequacy of Equipment				%			
E	Availability of Appointments				%	Total Score _____%	_____%	

A	**Physical Accessibility and Appearance**	**Yes**	**No**	**N/A**	**Comments**

1	Access to the building is adequate, evidenced by reasonable parking and/or feasible transportation within walking distance				
2	Accommodations for persons with disabilities are available, evidenced by designated parking, loading zone and/or public transportation within proximity to the building. This includes the following:				
	a. External ramp (if applicable)				
	b. Automatic entry option of alternative access method				
	c. Elevator for public use (if applicable)				
	d. Restroom equipped with large stall and safety bars of other reasonable accommodation				
	Inside Office and Reception area				
1	Well-lit waiting rooms				
2	Exam rooms are neat, clean and contain adequate space				
3	Exam rooms are constructed and maintained in a manner that ensures patient privacy during interviews, examinations, treatment, and consultation				
4	The OK Patient Bill of Rights is posted, or brochures are readily available and easily accessed				
B	**Physical Appearance/Safety**	**Yes**	**No**	**N/A**	**Comments**
1	Inside exit signs are clearly visible				
2	Evacuation plan is posted, inside building, in a visible location				
C	**Adequacy of Waiting and Examining Room Space**	**Yes**	**No**	**N/A**	**Comments**
1	Waiting room seating capacity is adequate				
2	The number of exam rooms per practitioner is adequate				
D	**Electronic Communication & Connectivity**	**Yes**	**No**	**N/A**	**Comments**
1	Scheduling facilitates meeting patient needs for same day appointment, if appropriate				
2	Scheduling facilitates urgent appointments within one day, if appropriate				
3	Scheduling facilitates routine sick care visits within one week				
4	Scheduling well visits for preventive care including immunizations, within one month of request				
5	No show appointments are documented				
E	**Medical Record Keeping** *(this is not a chart audit. There is no minimum requirement for number of charts. A model chart or blinded chart may be used)*	**Yes**	**No**	**N/A**	**Comments**
1	Patient medical records have a secure/confidential filing system				
2	Patient medical records have legible file markers				
3	Forms and methodology for filing within a chart are consistent (if paper or electronic record)				
4	Patient medical records can be easily located				

5	Refusal of interpretation services is documented in the record, if applicable				
6	Medical record documentation is signed with practitioner credentials (both paper and electronic)				