Policy: To maintain a quality provider network, Colorado Access will establish credentialing and recredentialing criteria and process to evaluate and determine participation status for providers who are either applying for network participation (credentialing) or continued network participation (recredentialing). The Colorado Access credentialing program will satisfy the most recent applicable regulations/standards/instructions as required by National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS), Division of Insurance (DOI), Health Care Policy and Financing (HCPF), Colorado Access, and/or any other applicable federal or state regulatory authority.

Applicability:
Credentialing
Provider Contracting
Provider Configuration
All products that utilize a credentialed provider network

Definitions:
Clinical Privileges: Authorization from an appropriate authority for a provider to provide defined patient care services in an organization. Authorization is based on the provider’s license, education, training, experience, competence, ability to perform requested privileges and judgment.

DEA (Drug Enforcement Agency): The federal agency that issues licenses to prescribe and dispense scheduled drugs.

Provider: A state-licensed, state-certified, or state-authorized facility or a practitioner or physician delivering healthcare services to individuals.

Primary source verification: The process by which an organization validates credentialing information from the organization that originally conferred or issued the credentialing element to the provider.

Credentials Committee- peer or professional review committee: For purposes of this policy, the Credentials Committee performs peer review and serves the function of a "Professional review committee" as defined by statute that means any committee authorized under the provisions of this article to review and evaluate the professional conduct of and the quality and appropriateness of patient care provided by any provider licensed under Title12, Colorado Revised Statutes.

Procedures:
1. Credentialing and Recredentialing Scope

A. Colorado Access conducts credentialing and recredentialing for all participating Providers who are contracted to provide health care services. Credentialing requirements apply to:
   • Providers who are licensed or certified by the state to practice independently.
   • Providers who have an independent relationship with Colorado Access. (Note - An independent relationship exists when Colorado Access directs its members
to see a specific provider or group of providers, including all providers whom members can select as a primary care practitioner.)

- The following is a list of providers in the scope of credentialing:
  a. Medical providers
     i. Medical doctors
     ii. Oral surgeons
     iii. Osteopaths
     iv. Podiatrists
     v. Advanced Practice Nurses (NP, CNM, CNS)
     vi. Physician assistants
     vii. Therapists (physical, speech, occupational)
     viii. Audiologist
     ix. Optometrist
  b. Behavioral healthcare providers
     i. Psychiatrists
     ii. Licensed addiction counselors
     iii. Licensed psychologists
     iv. Licensed clinical social workers
     v. Licensed marriage family therapists
     vi. Licensed professional counselors
- The criteria listed above apply to providers in the following settings:
  a. Individual or group outpatient practices
  b. Individuals practicing at Federally Qualified Healthcare Centers and Rural Health Clinics

B. Providers that are exempt from the credentialing process are listed below. However, Colorado Access does credential and recredential hospital-based providers who provide care in an outpatient setting (such as an anesthesiologist offering pain management or university faculty who have private practices that will be contracted or are contracted with Colorado Access to provide healthcare services):

- Covering Providers;
- Locum tenens;
- Providers who practice exclusively within the inpatient setting or are hospital-based and who provide care to Colorado Access members only as a result of the member being directed to the hospital or another inpatient setting (e.g. anesthesiologists, pathologists, radiologists, emergency medicine providers, neonatologists, and hospitalists);
- Providers who practice exclusively within free-standing facilities and who provide care to Colorado Access members only as result of members being directed to the facility (e.g. mammography centers, urgent care centers, surgery centers, and ambulatory behavioral health facilities);
- Dentists who provide primary dental care only under a dental plan;
- Pharmacists; and
- Unlicensed Doctoral or Master’s Level Providers only when necessary to meet member linguistic/cultural needs, or for service provision in a rural under-served area.

Providers subject to this policy shall not be considered participants of the network until they have completed the credentialing process. Retro payment of claims is outside the scope of NQCA’s credentialing requirement.
2. **Non-Discrimination**

A. Colorado Access and its Credentials Committee will make credentialing and recredentialing decisions based on multiple criteria related to professional competency, quality of care and the appropriateness of health services provided. This does not preclude Colorado Access from including Providers in its network who may meet certain demographic, cultural, or special needs. Colorado Access maintains a heterogeneous Credentialing Committee, which requires those responsible for credentialing decisions to sign an acknowledgement form stating they do not discriminate based on an individual’s gender, sexual orientation, gender identity, age, race, religion, disability, ethnic origin, national origin, and any other such prejudicial policies when making credentialing and recredentialing decisions. In addition, Colorado Access and its Credentials Committee will not discriminate against Providers seeking qualification who serve high-risk populations or who specialize in the treatment of costly conditions.

B. Colorado Access will not discriminate in terms of participation, reimbursement, or indemnification against any healthcare professional that is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification. The Credentialing Coordinator and the Senior Medical Director apply the criteria as set forth in the credentialing policies to each case prepared and reviewed for credentialing and recredentialing.

C. If Colorado Access declines to include a Provider or group of Providers in its network, notification will be provided to the affected Provider(s) of the reason for the decision.

D. This discrimination prohibition does not preclude Colorado Access from refusal to grant participation to healthcare professionals in excess of the number necessary to meet the needs of its members.

3. **Program Resources**

The Senior Medical Director is the Chairman of the Credentials Committee and is responsible for the clinical aspects of the credentialing department. In addition to the Senior Medical Director, resources for the credentialing program include:

- Manager, Credentialing Program – is responsible for the oversight of the credentialing program;
- Credentialing Coordinators – process credentialing applications for weekly and monthly reviews;
- Director of Configuration, Credentialing, and Enrollment; and
- Quality Management Program.

4. **Provider Rights**

Providers have the right to review the information submitted in support of the credentialing application unless law prohibits disclosure. Providers will be notified during the credentialing process if information obtained varies substantially from Provider’s information. Providers have the right to correct any erroneous information submitted as a part of the credentialing process, provide missing information during the verification process, and be informed, upon request, of the status of their credentialing or recredentialing application. Process will be conducted according to department procedures.

5. **Delegation**
A. Colorado Access may elect to delegate the functions associated with credentialing and recredentialing to a contracted entity after satisfactory completion of a pre-delegation audit and the Credentials Committee and the Compliance Department’s approval of the entity’s delegation status. Delegated entities shall adhere to the requirements set forth in the delegation agreement, and comply with delegation oversight activities conducted by Colorado Access. Colorado Access retains responsibility for ensuring that each function is performed in accordance with Colorado Access policies and those of regulatory and accreditation bodies.

B. Colorado Access retains the right, to terminate Providers in situations where it has delegated credentialing and re-credentialing activities (see policy and procedure ADM223 Delegation). Colorado Access retains authority to make the final credentialing determination regarding any Provider, including Providers credentialed through delegated entities.

C. Delegation status and oversight of the entities are the Credentials Committee responsibility. A list of providers approved by the delegate is presented during the committee meetings for review and acceptance.

6. File Maintenance and Confidentiality

A. Information obtained during the credentialing/recredentialing process and Credentials Committee meeting minutes are treated confidentially. Colorado law protects quality issues addressed under peer review. Files are maintained on a secured server.

B. Annually, participants of the Credentials Committee sign a confidentiality agreement that addresses the confidential nature of the information reviewed, subsequent decisions, and conflict of interest.
## 7. Credentialing/Recredentialing Criteria and Verification Time Limits

Criteria and verification time limits utilized to evaluate Providers under the scope of this policy include the following:

<table>
<thead>
<tr>
<th>Verification</th>
<th>Required at Credentialing (C) or Recredentialing (R)</th>
<th>Verification Time Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed application, including signed and dated attestation and authorization</td>
<td>C R</td>
<td>Within 180 calendar days of Committee decision</td>
</tr>
<tr>
<td>Enrolled and validated for Medicaid</td>
<td>C R</td>
<td>Must be enrolled and validated by Health First Colorado prior to credentialing and recredentialing</td>
</tr>
<tr>
<td>Licensure – current and unrestricted license to practice in the state at which they are practicing</td>
<td>C R</td>
<td>Within 180 calendar days of Committee decision; license must be valid at time of credentialing decision</td>
</tr>
<tr>
<td>Clinical Privileges (if applicable) – current, unrestricted Clinical Privileges at a hospital designated by the provider as the primary admitting facility or a documented coverage arrangement through an affiliated provider or hospitalist</td>
<td>C R</td>
<td>Within 180 calendar days of Committee decision</td>
</tr>
<tr>
<td>DEA or CDS certificates (if applicable) – current and unrestricted in state at which they are practicing</td>
<td>C R</td>
<td>None. Certificate must be effective at time of Committee decision</td>
</tr>
<tr>
<td>Education and Training – satisfactory completion of residency or graduate program, or medical school</td>
<td>C</td>
<td>Within 180 calendar days of Committee decision</td>
</tr>
<tr>
<td>Board Certification – if provider states they are board certified and certification is in field of practice</td>
<td>C R</td>
<td>Within 180 calendar days of Committee decision</td>
</tr>
<tr>
<td>Work History – a minimum of the most recent five years, or since their license was issued</td>
<td>C</td>
<td>Within 180 calendar days of Committee decision</td>
</tr>
<tr>
<td>Malpractice Coverage – current with minimum limits of liability of $1 million and $3 million</td>
<td>C R</td>
<td>Effective at time of Committee decision</td>
</tr>
<tr>
<td>Malpractice History/Medicare and Medicaid Sanctions</td>
<td>C R</td>
<td>Within 180 calendar days of Committee decision</td>
</tr>
<tr>
<td>Collecting and reviewing complaints and information from identified adverse events – for all providers that fall under the scope of credentialing, and have a complaint filed</td>
<td>R</td>
<td>Upon notification of a complaint meeting the thresholds</td>
</tr>
</tbody>
</table>
8. Credentials Committee

A. Voting membership shall include Behavioral Health Specialist, Pediatric Provider, Primary Care Physician, Advanced Practice Nurse, and a Specialist. Ex officio non-voting membership shall include the Sr. VP of Medical Services or designee and Credentialing Program Manager/Coordinators. A Colorado Access Senior Medical Director serves as chair of the Committee.

B. The Credentials Committee is designated as a peer review body. At a minimum, one (1) of the Credentials Committee members will be a participating provider in the Colorado Access provider network who does not participate in the administrative aspects of the organization.

C. The Credentials Committee participants consider the applications of Providers for initial and ongoing participation in the Colorado Access provider network.

D. The Credentials Committee will have a specialist available to weigh in on a case if the Credentials Committee is unable to come to a decision. The Senior Medical Director (chair) or designee will seek the expert’s input to present to the Credentials Committee.

E. Responsibilities of the Credentials Committee include:
   • Annually reviewing and approving the credentialing and recredentialing criteria, policy, procedures, and the process used to make credentialing and recredentialing decisions:
   • Review results of ongoing monitoring of sanctions and grievances:
   • Review and determine participation status of Providers who, at a minimum, do not meet the established credentialing criteria. However, the Committee may review a list of Providers who “meet criteria” if the Senior Medical Director or designee is not available to review and approve these Providers;
   • Review and accept a list of delegated approved Providers;
   • Approval of new Credentials Committee members.

F. The Credentials Committee meetings are scheduled monthly and may take place in person or via virtual meetings. In the event that there are no files to review or other business to discuss, the Credentials Committee meeting may be canceled. At minimum, the Credentials Committee will meet on a quarterly basis.

9. Credentialing and Recredentialing Application

A. Colorado Access requires all Providers to complete the Colorado Health Care Professional Credentials Application to obtain and validate information attested to by the Provider that allows thorough evaluation for participation or continued participation. Colorado Access utilizes the Council for Affordable Quality Healthcare (CAQH) to obtain applications for credentialing and recredentialing.

B. The Provider credentialing and recredentialing processes begin with the completion of an application, signed and dated attestation and submission of requested documentation to either CAQH or Colorado Access. The applications include an attestation by the applicant regarding:
   • Reasons for any inability to perform the essential functions of the position;
   • Lack of present illegal drug use;
   • History of loss of license and felony convictions;
   • History of loss or limitation of privileges or disciplinary actions;
• Current malpractice insurance coverage that includes the dates and amount of the coverage;
• Clinical Privileges in good standing at the Provider’s primary admitting facility; and
• Current and signed attestation confirming the correctness and completeness of the application.

10. Ongoing Monitoring of Sanctions

A. Colorado Access conducts ongoing monitoring of contracted Providers that fall within the scope of credentialing. The ongoing monitoring activities conducted between recredentialing cycles will include Medicare and Medicaid sanctions or exclusions, Colorado State licensing sanctions or limitations on licensure, and Provider- specific member grievances, and occurrences of adverse events.

B. If a Provider receives an adverse action, Colorado Access will retrieve documentation from the applicable issuing agency. Failure by the Provider to comply with the corrective action plan as set forth by the issuing agency will be evidenced through ongoing monitoring activities as outlined in this policy. When instances of poor quality are identified, Colorado Access takes appropriate action according to department procedures.

11. Participating Provider Quality Monitoring

A. The Quality Management Department will notify the Credentialing department regarding any quality of care concerns.

B. As part of the recredentialing process, the credentialing coordinator will verify by looking on the Quality Management QOC Worksheet to verify if the provider has had any quality issues in the past three (3) years. If the Provider has had quality issues in the past three (3) years, the Provider will be forwarded to the Credentials Committee meeting for review.

12. Provider Hearing and Reporting to the Board of Medical Examiners

During the recredentialing process, the Credentials Committee may recommend actions be taken for quality reasons that alter the Provider’s relationship with Colorado Access. Colorado Access offers the Provider a formal hearing process, and when appropriate or indicated, reports the action to the appropriate authorities (see policy and procedure ADM301 Adverse Actions Hearing and Appeal Process for Providers).

13. Verification Process

A. Verification can be obtained verbally, in writing, or electronically. The following must be included as part of the verification: the source used, the date of the verification, the signature or initials of the person who verified the information.

B. Validation

• Search the enrollment website to verify provider is approved (https://colorado-hcp-portal.xco.dcs-usps.com/hcp/provider/Home/ProviderEnrollment/ProviderEnrollmentStatus/tabid/453/Default.aspx)

C. Licensure
• Current valid license and investigation of restrictions, limitations or sanctions are reviewed.
• The Provider must have a valid license to practice.
• Sanction activity, which may have occurred in other states, is obtained through a query of the National Practitioner Data Bank (NPDB).

D. DEA, CDS (Controlled Dangerous Substances) and Prescriptive Authority Certificates are verified for Providers who indicate they prescribe controlled substances.
• Primary source verification from the DEA website (www.deadiversion.usdoj.gov) and verification from the American Medical Association (AMA) Physician profile are acceptable sources. A copy of the certificate is acceptable.
• Primary source verification for Prescriptive Authority (RXN or RXN-P) is obtained from the Department of Regulatory Agencies (DORA) is acceptable source.

E. Clinical Privileges
• Physicians must have Clinical Privileges in good standing at a hospital designated by the Provider as the primary admitting facility or a documented coverage arrangement through an affiliated Provider or hospitalist. If an allied practitioner indicates privileges on their application, the verification is obtained.
• Confirmation of Clinical Privileges is obtained via the signed attestation on the application or through verification with the hospital via a roster, phone verification, or internet verification.

F. Education and Training
• This verification is not necessary for MDs and DOs who, through primary source verification, are confirmed to be board certified. If the Provider is not board certified, only the highest level of education/training is verified, i.e., residency, graduation from medical school. Verification of fellowship is not required or accepted as verification of education and training.
• Verification of residency training or graduation from a medical school or graduate school is obtained through verification of licensure with the applicable State board (written confirmation of primary source verification from each of the applicable State licensing boards is obtained annually). Other acceptable sources of verification may include written verification from the institution awarding the degree (graduate school, medical school or residency program), verification received from the AMA, or American Osteopathic Association (AOA) Master File (Physician Profile).
• For international medical graduates licensed after 1986 that are not board certified or have not completed a residency in the United States, verification of foreign medical school graduation is obtained through written confirmation received from the Educational Commission for Foreign Medical Graduates (ECFMG).

G. Board Certification
• Board certification is verified for MDs, DOs, DDSs, and DPMs only if the Provider has indicated they are board certified.
• Board certification for MD and DO providers is verified in each clinical specialty for which the Provider is being credentialed is verified using an electronic source (Internet) that utilizes current information from the American Board of Medical Specialties (ABMS), the AMA or AOA Physician Profile.
• DPM, DMD and DDS board certification is verified with the appropriate specialty board.
• SLP and AUD board certification is verified with the American Speech Language Hearing Association website (http://www.asha.org/Certification/cert-verify).
• CNM board certification is verified with the ACNM Certification Council, Inc. website (https://ams.amcbmidwife.org/amcbssa).

H. Work History
• Work history is not primary source verified; however, the Provider is required to either submit a curriculum vitae (CV) or resume, or document a minimum of the past five (5) years of work history, on the credentialing application. If the Provider has less than five (5) years of work history from the verification date of work history, it starts from the time of the initial licensure.
• The Credentialing Coordinator clarifies either verbally or in writing with the Provider of any gaps in work history that exceed six (6) months and document the file. The Provider must clarify in writing any gap in work history that exceeds one (1) year.

I. Malpractice Insurance Coverage
• Colorado Access requires Providers to carry minimum malpractice coverage amounts of $1 million per incident and $3 million aggregate.
• A copy of the insurance face sheet that includes the Provider’s name, effective and expiration dates and amounts of coverage must be provided at initial credentialing. If the cover sheet does not include the name of the Provider, then a photocopy of those covered under the plan must be submitted on the sheet that includes the insurer’s letterhead. A letter from the group the Provider is joining; including the company’s letterhead identifying the Provider is covered under the group policy is acceptable. An email from the providers’ office indicating the provider is covered under the policy number on the facesheet is acceptable. The policy number must also be included in the email. Providers may attest to having coverage at the time of recredentialing. The application must include the insurance company name, the coverage amounts, and effective dates.
• Providers who have coverage through the Self-Insurance Trust, the Federal Tort Claims Act (FTCA) or have governmental immunity are exempt from carrying the minimum amounts of malpractice insurance of $1 million and $3 million. A copy of the current FTCA certificate including a letter from the group the Provider is joining or/with will be sufficient.

J. Malpractice History, Medicare/Medicaid Sanctions and Licensure Sanctions
1. All Providers complete attestation questions on the credentialing and recredentialing application regarding their claims history. The Provider is requested to supply additional information by way of a narrative to explain the circumstances surrounding any incident(s) identified. The Credentialing Coordinator retrieves any additional information as appropriate from the issuing entity that indicates a corrective action for instances when disciplinary action is taken.

2. Verification of licensure sanctions:
• For Physicians, verification is performed via the National Practitioner Databank-Healthcare Integrity and Protection Databank (NPDB-HIPDB), Federation of State Medical Boards (FSMB) or the appropriate state licensing agency.
• For dentists, the State Board of Dental Examiners or the NPDB-HIPDB.
• For podiatrists, the State Board of Podiatric Examiners or Federation of Podiatric Medical Boards.
• For all other Providers, the appropriate state licensing agency.

3. Verification of Medicare/Medicaid sanctions:
• NPDB-HIPDB, FSMB, Office of Inspector General database, System for Award Management (SAM), or the American Medical Association (AMA) Physician Master File for physicians.

4. Verification of malpractice history:
• NPDB-HIPDB or written confirmation of the past ten (10) years of history of malpractice settlements from the Provider’s malpractice carrier.

K. Collecting and reviewing complaints and information from identified adverse events:

1. At the time of recredentialing, the Quality of Care Report collected from the Quality Management Program for all providers that fall under the scope of credentialing is reviewed to see if there have been any complaints or adverse events reported.

14. File Criteria Process
To maintain a quality provider network, the Credentials Committee will establish file review criteria and a classification system for credentialing/recredentialing files that have issues requiring further review and discussion. NOTE: Settlement/payment date of a claim and the date of the Credentials Committee are used to determine the level of review required.

Level 1 (L1):
1. At recredentialing, issues were reviewed during the previous credentialing cycle and no additional issues have been identified
2. Absence of hospital privileges with a documented coverage arrangement through an affiliated provider or hospitalist
3. Voluntary resignation without adverse action from the hospital medical staff because of relocation, or the provider no longer wishes to maintain active hospital privileges
4. A physician who has completed the requisite training within the last three (3) years and is not yet board certified
5. A physician who has never been board certified, but has had formal training in the field of practice, and does not have any other issues
6. A physician who has allowed their board certification to lapse, and has no other issues
7. An allied provider (CNM, SLP, AUD) who is not board certified, or has allowed their certification to lapse, and has no other issues
8. Open/pending malpractice case(s)
9. Malpractice case(s) that occurred during residency, medical school, or training programs
10. Withdrawn or dismissed case(s) where no monies have been paid on behalf of the provider, except in cases involving death, which require an L3 review
11. Past history of a managed care organization discontinuing the relationship with the provider unless the relationship was discontinued for an adverse action
12. A complaint that was filed by a patient to the State Board, which was dismissed by the Board and no further action was taken
13. Licensure sanctions or restrictions that include: revocation, suspension, stipulation, or letter of admonition, etc., that have been previously reviewed and no further action has been taken by the licensing board
14. Work history gaps of less than two years
15. Any licensure sanctions, restrictions, malpractice cases, or issues that are greater than ten (10) years old
Level 3 (L3):

1. Licensure sanctions or restrictions that include: revocation, suspension, stipulation, or letter of admonition, etc. in the past ten (10) years
2. DEA restrictions
3. Hospital privilege suspension, restriction, revocation, non-renewal, refusal or denial, or where the hospital extended the provisional period
4. Two or more malpractice cases in the last five (5) years or three or more malpractice cases in the last ten (10) years
5. Denial, cancellation, restriction, or renewal denial of professional liability insurance
6. Past history of a managed care organization discontinuing the relationship with the provider that was discontinued for an adverse action
7. Any reportable incident appearing on the NPDB outside of a malpractice settlement within the past ten (10) years
8. "Yes" answers on the Professional Claims History Questions and/or Attestation Questions other than those already specifically addressed
   “Yes” answers on Supplemental A: Illegal Drug use and inability to perform essential functions Questions# 3, 4 & 5
   “Yes” answers on Supplemental B: Health Status-question# 1
   “No” answer on Supplemental B: Health Status-question# 3
9. Certification by the specialty board that has been suspended or revoked or denied
10. The physician is requesting to participate in a specialty for which the physician does not have the necessary formal education, training, experience and/or board certification
11. Work History gap of greater than two years
12. An adverse event or complaint has been filed with Colorado Access at the time of recredentialing.

A. The Credentialing Staff assigns a classification level (L1, L3).

1. Level 1 (L1) – The Credentialing Staff will provide a list of names meeting L1 criteria to the Senior Medical Director or designee who will review and approve the list of names. Files approved by the Senior Medical Director or designee are considered credentialed as of the date of the Senior Medical Director or designee electronic signature.

2. Level 3 (L3) – All Level 3 files are forwarded, following review by the Senior Medical Director or designee, to Credentials Committee for review. The Credentialing Staff gathers the applicable information, and completes a brief narrative describing the issue(s). The Senior Medical Director or designee may request additional information that is retrieved by the Credentialing Staff, and/or seek expert advice from a contracted provider of similar specialty.

15. Credentialing Determination Notification

A. Providers undergoing initial credentialing are notified in writing within thirty (30) business days of the Senior Medical Director weekly reviews and Credentials Committee decisions. Providers denied participation during initial credentialing are notified in writing of the decision by the Senior Medical Director within ten (10) business days and the documentation filed in the Provider’s credentialing folder. The Provider Contracting team is notified of the denied Providers.

B. A list of approved and, if applicable, denied Providers are forwarded to Provider Configuration and includes the provider’s full name, degree, specialties, date approved, NPI number, date of birth, primary and secondary practice locations, and other first/last names if applicable. The information is entered into Colorado Access claims transaction system by the Configuration
16. Provider Listings in the Directories

A. Colorado Access verifies that the information pertaining to credentialed Providers that is contained in member materials including provider directories is consistent with the information obtained during credentialing by conducting ongoing audits. Examples of elements audited may include verification of the Provider’s name, service location(s), and specialty.

B. The Providers will not be added to the provider directory until they have been approved by the Credentials Committee, or when the Senior Medical Director or designee has approved the Providers through the review of the clean files.

C. If the Provider ceases to comply with credentialing criteria as determined through the processes of continuous compliance monitoring, recredentialing does not take place within the time frame required by Colorado Access’ standards and/or the Provider chooses not to participate in the network, the Provider will be removed from the Provider directory within five (5) business days (see policy and procedure PNS201 Provider Manual, Directory and Communications Updates).