Marshfield Clinic Health System Credentialing and Privileging Policy

1. SCOPE

1.1. Providers and facilities requiring credentialing and privileging as applicable within Marshfield Clinic Health System.

2. DEFINITIONS & EXPLANATIONS OF TERMS

2.1. Marshfield Clinic Health System (MCHS): Entities included in the System are Marshfield Clinic (Clinic), Security Health Plan (SHP), Family Health Center (FHC) and all MCHS owned, operated or controlled ambulatory surgery centers and hospitals.

2.2. Credentialing: A process of establishing the qualifications of licensed professionals and assessing their background and legitimacy. Credentialing is typically undertaken at commencement of employment/contract (initial application) and at regular intervals thereafter (recredentialing).

2.3. Privileging: A process of authorizing a licensed or certified healthcare provider specific scope and content of patient care services. This process is performed in conjunction with an evaluation of an individual’s clinical qualifications and/or performance; it involves an assessment of competency. In the scope of this Policy privileging only pertains to the Clinic and FHC entities.

2.4. MC Provider: A licensed or certified healthcare provider who is employed by or performing patient care on behalf of Marshfield Clinic, Inc.

2.5. SHP Provider: A licensed or certified healthcare provider who is affiliated with SHP and provides patient care to members of SHP. These providers may or may not be employed by Marshfield Clinic, Inc.

3. POLICY BODY

MCHS has established a credentialing and privileging process for the purpose of ensuring that physicians and specified non-physician providers possess the credentials, including training and experience, to provide patients with a quality of care consistent with MCHS’s mission. The credentialing process defined within this Policy includes credentialing and recredentialing processes for individual providers and facilities that are affiliated with SHP.

This credentialing Policy outlines the standards, policies and processes for the credentialing and recredentialing of providers. It may be changed at the discretion of MCHS’s Credentialing Committee and/or MC Board of Directors. Any change in legal, regulatory, or accreditation requirements will be automatically incorporated into this plan as of the requirement’s effective date. Changes will be effective for all new and existing providers from the effective date of the change.
In addition to this Policy, MCHS hospital and ambulatory surgery center entities have bylaws that provide additional documentation relating to those specific facilities. Those bylaws outline the approval process for credentialing and privileging decisions at those entities.

MCHS Credentialing Office reviews the System Credentialing and Privileging Policy annually. All other related credentialing/recredentialing policies and procedures will be reviewed no less than annually.

3.1. Confidentiality

a. Information acquired through the credentialing/recredentialing process is considered confidential. All individuals with file access are responsible for ensuring that all credentialing/recredentialing information remains confidential except as otherwise provided by law. When a law enforcement agency or other government agency seeks provider credentials information, a Legal Department representative will be consulted prior to the release of any information. MCHS requires its credentialing staff and credentials committee members to adhere to its Credentialing Staff and Committee Confidentiality Policy.

b. The provider prohibits the release of any information obtained through the credentialing and recredentialing process without a written, signed and dated consent to the release of the information.

3.2. Non-Discrimination

a. MCHS does not make credentialing and recredentialing decisions based on an applicant’s race, ethnicity/national origin, gender, age, sexual orientation, disability, religion, military service or the types of procedures or types of patients in which the provider specializes. MCHS requires its providers and facilities to adhere to its Non-Discrimination Policy.

3.3. Credentialing files and database

a. A credentials/privileging record will be maintained in the MCHS Credentialing Office in an electronic database for each individually credentialed provider. The record at a minimum will include documentation of primary source verifications completed during the credentialing/recredentialing process. The electronic database stores provider information, dates of applications, MCHS Credentialing Committee action and Board action dates, as applicable.

b. Any provider has the right to review (in person at the credentials office and during normal business hours) his/her credentials record and a copy of the material regarding the provider that is contained in the electronic database. The provider must notify the MCHS Credentialing Office at least one business day in advance of their desire to review their material.

c. The provider will not be allowed to review any information that is peer review protected (including but not limited to references, peer review, quality of care reports, National Provider Data Bank (NPDB) results).

d. Although material may not be removed or altered (except for factual errors and then only by the MCHS Credentialing Office), the provider may, at his/her discretion, write statements of correction or clarification, which will also be kept in their credentials record.
3.4. Committee and staff structure

a. MC Board of Directors

- MC Board, while delegating credentialing responsibilities (approving policy, procedure and credentialing/recredentialing decisions) to the MCHS Credentialing Committee and MCHS Medical Director of Credentialing and Privileging or his/her physician designee, retains the ultimate responsibility for and authority over all credentialing activities. The MCHS Credentialing Committee presents its decisions to the MC Board of Directors regarding policies, procedures and credentialing/privileging decisions for MCHS entities for ratification.
- Decisions made for the SHP entity do not require Board ratification as the accrediting agency for SHP considers the MCHS Credentialing Committee decision to be the final approval.

b. MCHS Medical Director of Credentialing and Privileging or his/her physician designee

- The MCHS Medical Director of Credentialing and Privileging or his/her physician designee is Chair and a voting member of the MCHS Credentialing Committee and is responsible for overseeing credentialing/recredentialing processes and policies.
- The MCHS Medical Director of Credentialing and Privileging or his/her physician designee reviews provider and facility credentialing and recredentialing applications that meet MCHS’s Administrative and Professional Criteria and has the authority to approve applications that meet MCHS’s Administrative and Professional Criteria. (See MCHS’s Clean File Definition Policy).
- The MCHS Medical Director of Credentialing and Privileging acts as a resource to credentialing staff.

c. MCHS Credentialing Committee

- The MCHS Credentialing Committee is an all physician committee and includes representatives from a variety of specialties including primary and specialty care areas. When questions arise regarding a credentialing file where the provider’s specialty is not represented on the Credentialing Committee, the credentialing office, MCHS Medical Director of Credentialing and Privileging will consult with a provider of the same specialty of the provider in question for their professional opinion. This information will be shared with the MCHS credentialing committee to assist in the decision making process. Any communication with the specialty representative will be blinded so as not to release the applicant’s name.
- Others that regularly attend the MCHS Credentialing Committee meetings include the manager of the MCHS Credentialing Office and MCHS credentialing staff. Current membership and staff are listed in the Additional Resources section at the bottom of this Policy.
- The MCHS Credentialing Committee is a standing Committee that meets once a month. Members are appointed by the Clinic Executive Director or his/her physician designee. The Chair of the MCHS Credentialing
Committee is appointed by the MCHS Chief Medical Officer (CMO) and approved by the Clinic Executive Director. The Chair and members do not have defined term limits.

☐ The MCHS Credentialing Committee presents issues regarding appeals or conflicts that may periodically arise with respect to specific credentialing and privileging decisions to the MCHS Clinical Care Operational Leadership Team (CCOLT) and/or the MC Board. Appeals or conflicts related specifically to providers and/or facilities requesting affiliation only with SHP are addressed in the SHP Addendum of this Policy.

☐ The MCHS Credentialing Committee is responsible for

- Establishing and implementing credentialing and recredentialing policies and procedures.
- Reviewing provider credentialing and recredentialing applications that do not meet MCHS’s Administrative and Professional Criteria as defined in this Policy. The MCHS Credentialing Committee also reviews related performance monitoring as is applicable to the specific MCHS entity.
- Implementing and maintaining a comprehensive credentialing and privileging system including initial credentialing and recredentialing.
- Maintaining compliance with necessary regulatory, accrediting and licensing agency requirements.
- Making recommendations to the identified governing bodies regarding credentialing/recredentialing decisions and policies and procedures.
- Reviews/approves the Administrative and Professional Criteria as defined in this Policy used by the MCHS Medical Director of Credentialing and Privileging or his/her physician designee and MCHS Credentialing Committee to make credentialing/recredentialing decisions. The MCHS Credentialing Committee has delegated to the MCHS Medical Director of Credentialing and Privileging the authority to approve provider and facility credentialing/recredentialing applications that meet MCHS’s Administrative and Professional Criteria and facility Administrative Criteria as found in MCHS’s Facility Credentialing and Recredentialing procedure.
- Reviewing credentials of and approve or disapprove affiliation of applicant providers that do not meet one or more of MCHS’s Administrative and Professional Criteria.
- Reviewing credentials, peer review materials, complaints and other information as appropriate to approve/disapprove continued credentialing and privileging (as applicable) with MCHS entities.
- Establishing standards for and participate in provider performance monitoring in each MCHS specific entity including assessment of provider performance, evaluation of patient/member/provider complaints, review of specific provider or practice as needed.
- Conducting both initial and ongoing assessment reviews (at least every three (3) years) of facilities and other organizational providers with
which SHP contracts to provide services to members. The focus of these reviews is to determine if the facility meets licensing and regulatory requirements and other credentialing standards set by SHP.

- Credentialing/recredentialing the following: hospitals, home health agencies (HHA), clinical laboratories, skilled nursing facilities (SNF), rehabilitation centers, comprehensive outpatient rehabilitation facilities (CORF), free-standing ambulatory surgery centers (ASC), end-stage renal dialysis (ESRD), portable imaging suppliers, freestanding rural health centers (RHC), and federally qualified health centers (FQHC), day treatment centers and inpatient, residential & ambulatory mental health care facilities

- Providing feedback and direction to the MCHS credentialing staff on the implementation of credentialing and recredentialing policies and procedures.

- Initially approving and annually evaluating the performance of any agency delegated to provide credentialing or recredentialing services for the SHP entity.

☐ Annually, each voting member of the MCHS Credentialing Committee will attest that all credentialing decisions will be made in a non-discriminatory manner, without regard to race, ethnicity/national origin, gender, age, sexual orientation, disability, religion, and military service and without consideration of the types of patients treated by the applicant or the types of medical/surgical procedures provided. In addition, each member signs a confidentiality statement.

d. Reporting

☐ MCHS Credentialing Committee reports to the MC Board of Directors for ratification of credentialing decisions and policy. Credentialing decisions associated only with the SHP entity do not require Board ratification.

☐ MCHS Credentialing Committee reports credentialing and recredentialing decisions to the ASC Privileging Committee to assist in privileging decisions.

☐ MCHS Credentialing Committee recommends to the MCHS hospital entities Medical Executive Committees who then makes a recommendation to the hospital governing body who makes the final decision regarding appointment and reappointment of privileges.

e. SHP Quality Improvement Committee (QIC)

☐ The QIC is a SHP standing Committee that meets semiannually. Annually, the MCHS credentialing office reports statistical data on provider and facility credentialing, recredentialing and terminations.

f. MCHS Credentialing Staff

☐ MCHS credentialing staff verifies provider information through primary sources as outlined in the Primary Source Verification Details document found in the Additional Resources section at the bottom of this Policy. The credentialing staff provides administrative support, including maintaining credentials files and the credentials database for the MCHS credentialing
and privileging processes. The credentialing staff forwards the files of providers to the MCHS Medical Director of Credentialing and Privileging or his/her physician designee or MCHS Credentialing Committee along with specific information on each applicant’s credentialing/recredentialing for final determination.

☐ All credentialing information is available to all MCHS Credentialing Committee members.

g. Notice of Meetings

☐ The Chair may provide notice of MCHS Credentialing Committee meetings in any reasonable manner he/she deems appropriate under the circumstances (e.g., orally, electronically, written, by agenda distribution).

☐ The Chair shall make an effort to provide at least 24 hours notice of MCHS Credentialing Committee Meetings, but shall not be required to do so whenever the nature of the subject matter(s) deems it necessary to convene an emergent or urgent meeting.

h. Frequency of Meetings

☐ The Chair shall determine the frequency of the MCHS Credentialing Committee meetings. However, Committee meetings will generally be scheduled monthly and at other times if a critical issue necessitates more expeditious review.

☐ The Chair may undertake on his/her own to conduct investigations and/or make inquiries in furtherance of the formal MCHS Credentialing Committee proceedings or as recommended by the MCHS Credentialing Committee from time to time in order to facilitate the review process.

i. Manner of Participant Attendance

☐ Participants may appear at the MCHS Credentialing Committee meeting in-person, via televideo, or telephonically at the discretion of the Chair. Those participants appearing via video or telephone shall ensure that the proceedings are not overheard.

☐ Meetings and decisions may take place in real-time, virtual meetings (i.e., through video conference or Web conference with audio), but may not be conducted only through email.

j. Manner of Voting

☐ Any vote to be taken shall be taken by any manner deemed acceptable at the discretion of the Chair of the Committee (e.g., voice vote, by ballot, etc.). However, the outcome of the vote shall be recorded in the meeting minutes.

☐ During the course of any vote, the Chair may choose to excuse non-voting members of the MCHS Credentialing Committee.

k. Quorum

☐ At least 30% of voting members of the MCHS Credentialing Committee must be present (in person, via telephone or televideo) to constitute a
quorum for purposes of any vote. If a quorum is not present and cannot be obtained in a reasonable time, the meeting will be adjourned.

I. Majority vote

☐ Any matter to be acted upon shall require at least a majority vote of those members present at any meeting at which a quorum is present.

3.5. Providers subjected to the credentialing process through MCHS

a. Please see the specific MCHS entity addenda in this Policy for providers subject to credentialing and/or privileging through each MCHS entity.

3.6. Application Process

a. Credentialing and recredentialing require the completion of a standard application to initiate the processes. Identified required fields in the electronic application prevent the application from being submitted if it is incomplete. The application includes a statement informing the applicant that the National Provider Data Bank (NPDB) and the relevant state licensing board will be queried and reviewed as part of the application process.

b. Applications must contain all required information and be signed prior to submission to the MCHS Credentialing Office. As part of the application, all providers for initial credentialing must submit the following:

☐ demographic information (name, professional credentials, gender, and birth date)

☐ information regarding education and training (including board certification/eligibility)

☐ current state of Wisconsin license number, or other state license number where patient care is being provided

☐ current DEA certification number or CDS. DEA must be registered in the state where patient care is being provided

☐ professional liability claims history

☐ information regarding licensure/registration denial, revocation, suspension, reprimand, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitations

☐ DEA certificate suspension or revocation

☐ complaints or adverse action reports filed against applicant with a local, state, or national professional society or licensure board

☐ current professional liability coverage and information regarding refusal or cancellation of professional liability coverage

☐ denial, suspension, limitation, termination, or non-renewal of professional privileges at any clinic, hospital, health plan, or other institution

☐ lack of present illegal drug use

☐ criminal felony convictions

☐ current physical, mental health, or chemical dependency problems that would interfere with an applicant’s ability to provide high quality
professional service or an inability to perform the essential functions of their position with or without accommodation

☐ hospital privileges at hospital designated as the primary admitting hospital (as applicable and in compliance with MCHS’s Hospital Privileging Policy)

☐ sanctions by Medicaid or Medicare

☐ signed consent to disclose employment, ongoing professional practice evaluations, focused professional practice evaluations, other peer review and credentialing information and a signed release and waiver of liability for such disclosures

☐ signed attestation from the applicant indicating that the information is complete and correct to their knowledge

3.7. Processing application and verification procedures for the initial credentialing and recredentialing processes

a. MCHS Credentialing Office will collect and verify all provider credentials in accordance with the National Committee for Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC) and Joint Commission (JC) standards for primary source verification.

b. Applicants will fully cooperate with the MCHS Credentialing Office in obtaining all documents requested by MCHS to satisfy primary source verification requirements. In the recredentialing process primary source verification will occur to confirm/update information in the recredentialing application.

c. The MCHS credentialing staff will initially process applications and determine that the application is complete and, if not, contact the provider to facilitate completion. While the credentialing staff will help facilitate completion, the applicant has the burden of producing information.

3.8. Burden of Providing Information

a. The applicant has the burden of producing information deemed necessary by the MCHS Credentialing Office for a proper evaluation of current competence, character, ethics, and qualifications.

b. The applicant has the burden of providing evidence that all the statements made and information given on the application are accurate.

c. An application shall be complete when all questions on the application form have been answered, all requesting supporting documentation has been supplied, and all necessary information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete thirty (30) days after the individual has been notified of the additional information required shall be deemed to be withdrawn and will not be processed.

3.9. Administrative Review for Initial Credentialing and Recredentialing

a. Administrative Criteria

When document is printed it becomes an uncontrolled copy. Please refer to DCS system for most current version.
Prior to submitting an application to the MCHS Medical Director of Credentialing and Privileging or his/her physician designee or the MCHS Credentialing Committee, the MCHS credentialing staff determines whether the applicant satisfies all credentialing requirements. MCHS credentialing requirements include, but are not limited to:

- An applicant’s level of professional liability insurance must meet minimum limits as determined by MCHS or SHP contract specifications, if only contracted with the SHP entity.
- An applicant must maintain hospital privileges in good standing to allow for necessary patient hospital admissions if his/her practice requires it. (See MCHS’s Hospital Privileging Policy).
- An applicant must have graduated from an acceptable training program, as defined by the appropriate state licensing or registration agency of the applicant’s profession, or as otherwise defined by MCHS.
- An applicant must have completed the appropriate post-graduate training or residency program, as required by state licensing agencies, or accrediting bodies. An appropriate post-graduate training or residency program is defined as a program being accredited by the Accreditation Council for Graduate Medical Education (ACGME) in the United States, or the Royal College of Physicians and Surgeons of Canada.
- An applicant must have current unrestricted licensure or certificate /registration to practice in his/her profession in the state where services are being provided.
- An applicant must have a current and valid DEA certificate in the state in which they provide patient care, or CDS via copy of current certificate (as applicable).
- An applicant must not have misrepresented, misstated or omitted relevant or material facts on the application, disclosure statements or any other documents provided as part of the credentialing process. If primary source verification (PSV) identifies a significant discrepancy in information, MCHS credentialing staff will notify the applicant by telephone, email or certified letter and allow him/her to review and correct potential PSV erroneous information. It may be determined by the MCHS Credentialing Committee that the omission warrants an immediate withdrawal of request for credentialing and privileging.

b. Professional Criteria

- Upon receipt of a completed application and administrative review by the credentialing staff, the application will be taken to the MCHS Medical Director of Credentialing and Privileging or his/her physician designee and/or MCHS Credentialing Committee for consideration and delegated approval action.
- The MCHS Credentialing Committee reserves the right to request additional information when reviewing applications. The MCHS Medical Director of Credentialing and Privileging or his/her physician designee or MCHS

When document is printed it becomes an uncontrolled copy. Please refer to DCS system for most current version.
Credentialing Committee may elect to waive one or more criteria, if it is determined that one or more criteria are not relevant to a particular applicant or that noncompliance with one or more criteria does not indicate a potential or existing professional performance issue. Each applicant must satisfy the following criteria:

- The applicant has not engaged in conduct that violates state or federal law or the ethical standards of professional conduct governing his/her practice.
- The applicant has not been the subject of professional disciplinary action by a managed care plan, insurer, clinic, hospital, training program, medical review board, peer review organization, or other administrative body or government agency this includes but is not limited to, the imposition of disciplinary or administrative sanctions for inappropriate, inadequate or tardy completion of medical records.
- The applicant has not been the subject of disciplinary action by a licensing board. An applicant may receive disciplinary action but may obtain a stay of action enabling him/her to practice.
- The applicant has not been sanctioned by Medicaid or Medicare, and has not been the subject of adverse action.
- The applicant has not engaged in any conduct resulting in a misdemeanor or felony conviction, charge or indictment which, in the MCHS Credentialing Committee’s opinion is related to the provider’s position. This includes but is not limited to professional behavior.
- The applicant does not have a history of professional liability lawsuits or other incidents which constitute a pattern and/or indicates a competency or quality of care problem.
- Applicant does not have a history of unprofessional or unsafe behavior documented through credentialing information which constitutes a pattern and/or indicates a competency or quality of care problem.
- The applicant has not been involuntarily terminated from professional employment or a hospital medical staff membership or resigned from professional employment or hospital medical staff membership after knowledge of an investigation into his/her conduct, or in lieu of disciplinary action.
- The applicant has no history of denial, cancellation or failure to renew professional liability insurance.
- The applicant has no current substance abuse, medical or physical condition likely to adversely affect the essential functions of his/her profession or constitute a direct threat to the health or safety of others.
- Applicant is able to obtain and retain necessary hospital credentials and/or privileges.
- Applicant has not had credentialing revoked by a managed care organization, insurer, clinic, hospital, medical review board, peer review organization, or other administrative agency.
- Applicant has not falsified or misrepresented information during the application process.

c. Status of the credentialing/recredentialing application

☐ Upon request from the provider, the MCHS credentialing staff will inform the applicant of the status of their application. The applicant will not be allowed to review references, recommendations or other information that is peer review protected or information obtained from the NPDB or similar restricted sources.

3.10. Administrative Action

a. If the application is complete and meets all elements of the established Administrative and Professional Criteria (see MCHS’s Clean File Definition Policy), the MCHS Medical Director of Credentialing and Privileging or his/her physician designee may approve the applicant for appointment or reappointment.

b. If the application is complete but does not meet one or more elements of the established Administrative and Professional Criteria, and it is determined by MCHS credentialing staff and the MCHS Medical Director of Credentialing and Privileging that the unmet criteria is relevant to the applicant’s request for credentialing/recredentialing, the application is forwarded to the MCHS Credentialing Committee for consideration.

3.11. MCHS Credentialing Committee action for initial credentialing and recredentialing

a. The MCHS Credentialing Committee and MCHS Medical Director of Credentialing and Privileging or his/her physician designee will use good faith discretion in reviewing applications and making credentialing decisions. The MCHS Credentialing Committee and MCHS Medical Director of Credentialing and Privileging or his/her physician designee will base their decisions on any facts and circumstances deemed appropriate.

b. The MCHS Credentialing Committee will review all applications that do not meet the Administrative and Professional Criteria identified in this Policy and, by a majority vote of Committee members present, make one of the following three decisions which will be presented to the appropriate governing body for ratification and/or review:

☐ The application be approved
☐ The application be denied
☐ The application be tabled to allow further information to be obtained and reviewed

c. The Committee may obtain professional review of the information provided for decision making to provide an opinion on clinical skills, competencies and/or other related skills required to provide quality care. The professional opinions obtained are peer review protected consistent with Wisconsin statute.

d. The Committee may request and utilize provider data such as practice summaries, volume data, and additional training documentation, etc. in their decision making process.
e. The Committee decision will be based on the written information available to them in the application and additional information requested during review and verification. In limited circumstances, the Committee may request the presence of the applicant to clarify information. The credentialing decision is between the Committee and the applicant and requests for additional information and communication will be between the Committee and the applicant. While a department/center/SHP affiliated practice/medical director may be involved in discussions about an applicant’s file and assessment of competency, they are not permitted to participate in the decision making process.

f. The MCHS Credentialing Committee Chair or his/her physician designee will provide a summary of the Committee’s decisions to the entity identified governing body in as timely a fashion as possible.

g. No more than 180 calendar days will elapse from the date the applicant completes the application (as indicated by the date written next to the applicant’s signature on the attestation statement on the application that he/she submits) to the credentialing approval date. If the process is going to exceed 180 days:

☐ MCHS credentialing staff will return the application to the applicant. The applicant may complete a new application or resubmit the application with an updated signature attesting to the accuracy and completeness of the information.

h. Within sixty (60) calendar days, MCHS credentialing staff will send a letter to the applicant communicating MCHS’s credentialing decision.

i. The MCHS Credentialing Committee retains the right to review a provider’s credentials and privileges any time within the re-credentialing/privileging period. The right to review includes but is not limited to events related to medical examining board actions, liability concerns, peer review, or MCHS policy non-compliance concerns.

3.12. Appeals

a. Applicants have the right to appeal adverse credentialing decisions. Please refer to the specific entity addenda for this process.

3.13. Provider Recredentialing

a. Application Process

☐ MCHS will recredential providers every two years using the process outlined below, (with the current cycle being in force until the last day of the 24th month). Any provider not recredentialed within 24 months is considered non-compliant with MCHS policy. Exceptions will be granted if a provider is on active military leave, maternity leave or other leave of absence or sabbatical and will not meet the 24-month recredentialing time frame. In these instances the provider’s license will be verified prior to providing patient care and recredentialing will be completed within 60 days of the provider’s return to practice.

☐ Note: Individual provider and facility credentialing and recredentialing through SHP will follow a three (3) year recredentialing cycle. The current
cycle will be in force until the last day of the 36th month. Individual providers that have a contract with FHC will be required to complete the recredentialing process within 24 months.

☐ MCHS will electronically send each credentialed provider a pre-printed recredentialing application and privileging form (as applicable), requesting review and update of professional information. Applications must contain all required information and be signed prior to submission to the MCHS Credentialing Office. Identified required fields in the electronic application prevent the application from being submitted by the applicant if it is incomplete.

☐ A thirty (30) calendar day due date is set in the electronic application service when the recredentialing application is sent. If the recredentialing application materials are not received by the due date, the application service will automatically send a reminder until the completed application is received. The MCHS Credentialing Committee will be notified of any providers that have not returned their recredentialing application and are in jeopardy of not meeting the applicable 24 month or 36 month recredentialing cycle.

☐ The recredentialing process will be completed within 180 days of the date of the provider’s attestation signature on the application.

☐ If a provider fails to complete the re-credentialing/re-privileging process, their credentials and privileges (as applicable) at the MCHS entity where they are credentialed and privileged (as applicable) are not considered denied but will expire on the last day of the last month of the applicable credentialing cycle (i.e. the last day of the 24th month for all MCHS entities other than SHP and the last day of the 36th month for SHP). After that date the provider will no longer be considered credentialed or privileged within the MCHS.

☐ If a provider resigns from an MCHS entity or their contract with an MCHS entity expires, that provider’s credentials and privileges (as applicable) will expire thirty (30) calendar days after their reported termination date.

3.14. Recredentialing Criteria

a. MCHS credentialing staff will evaluate a credentialed provider based on the defined Administrative and Professional Criteria in this Policy. Failure to satisfy any of the Administrative or Professional Criteria or presence of an unacceptable performance profile at recredentialing may be grounds for termination of credentialing and privileging (as applicable) or other disciplinary action.

b. Recredentialing files that do not meet the Administrative and Professional Criteria of MCHS will be presented to the MCHS Credentialing Committee for review. Credentialing staff will provide to the Committee:

☐ Results of the verification process that reveal inconsistencies with information submitted by the provider.

☐ Any other specific issues identified from either the application or verification process including but not limited to:

- malpractice payments
- disciplinary actions
• licensure restrictions
• indications of investigation or potential problems
• hospital privileges not in good standing
• inability to verify information
• quality indicator concerns

3.15. Ongoing Performance Monitoring
   a. Ongoing performance monitoring is completed by each MCHS entity according to their accrediting agency’s requirements. Please refer to the attached MCHS entity addenda for entity specific processes.

3.16. Credentialing and Recredentialing primary source verification details can be found in the Additional Resources section at the end of this Policy.

3.17. Marshfield Clinic Entity Addendum
   a. The information in this section applies to all Marshfield Clinic Providers that provide patient care at an outpatient and/or inpatient facility owned, operated or controlled by MCHS.
   b. Marshfield Clinic does not delegate any credentialing activities.

3.18. The following Marshfield Clinic Providers must be credentialed and have privileges delineated:
   □ Physicians (MD’s, DO’s, and Oral Surgeons)
   □ Acupuncturists (L.A.C.)
   □ Audiologists (C.C.C. AuD or C.C.C.A)
   □ Athletic Trainers (L.A.T.)
   □ Chiropractors (D.C.)
   □ Dentists (D.D.S.)
   □ Dietitians (R.D. or C.D.)
   □ Massage Therapists
   □ Midwives (C.N.M.)
   □ Nurse Anesthetists (C.R.N.A.)
   □ Nurse Providers (N.P. or A.P.N.P.)
   □ Nurse Specialist (C.N.S.)
   □ Occupational Therapists (O.T. or O.T.R.)
   □ Optometrists (O.D.)
   □ Physical Therapists (P.T., M.S.P.T., or DPT)
   □ Physician Assistants (P.A. or P.A.C.)
   □ Podiatrists (D.P.M.)
   □ Professional Counselors (L.P.C.)
   □ Psychologists (PhD and PsyD)
   □ Social Workers (I.C.S.W. M.S.W., L.C.S.W., M.S.S.W.)
   □ Speech Pathologists (S.L.P.)

3.19. Application process
   a. In addition to the Application Process identified earlier in this Policy, references will be obtained on Marshfield Clinic Providers being credentialed. Professional references must be familiar with the Provider’s qualifications during the two (2) years immediately preceding the application. A total of three (3) references will be collected. One professional reference must be
from the chief of the department or service where the Provider last furnished professional services. The other references will be collected from peers. Providers who are less than three (3) years out of training must include one professional reference from the program director where they are either enrolled in training or completed their training. This reference will replace the chief of department or service reference.

b. For non-physician Providers one professional reference must be from prior supervisors/managers, supervising physicians, program directors or another reference that provided a supervisory role. Two peer references will also be collected.

c. In some situations new Providers may have outpatient privileges approved prior to obtaining hospital privileges. When this occurs, the Provider’s file will be updated once hospital privileges are available.
   □ If hospital privileges are required for the Provider’s scope of practice, the MCHS credentialing office will obtain a statement from the department indicating the Provider may start without hospital privileges and that another provider within the department will be responsible for any hospital needs until such privileges are granted.
   □ The MCHS credentialing office will follow up with the hospital to verify privileges once they have been granted.

d. In some situations, hospital privileges are not required as the Provider’s scope of practice is strictly outpatient. In such situations, the department must notify the credentialing office that the Provider does not require hospital privileges; the requirement is then waived.

e. FDA websites will be queried for restricted, debarred and disqualified individuals.

3.20. Delineation of clinical privileges

a. At the time of initial credentialing and recredentialing, Marshfield Clinic Providers will request privileges for those procedures that they would perform within a MCHS entity.

b. Note: MCHS ASC’s and hospitals have their own delineation of privileging processes. Providers must be granted specific procedural privileges by the Marshfield ASC Privileging Committee and identified hospital’s governing body. These processes can be found in the MCHS ASC Bylaws and the specific MCHS hospital bylaws.

c. Each specialty will have a privileging form, which will include:
   □ A statement regarding minimum criteria to be eligible to request clinical privileges, which will include educational and previous experience requirements.
   □ A statement regarding privileges to perform procedures that are felt to be commonly and appropriately performed in an office setting by any Provider in that specialty.
   □ A statement regarding emergency privileges such that any Marshfield Clinic Provider may provide emergent patient care services that include, but are not limited to, emergency assessment, stabilization, and determination of disposition.
   □ A list of other procedures a Provider in that specialty might perform in an office setting outside of the core privileges which are judged to be:
      ▪ High risk or
- Problem prone or
- Infrequently performed or
- Usually require additional training/experience beyond standard training for that specialty

The respective Service Line Medical Director or his/her physician designee, as appropriate, will review these privileging forms as needed. Both the initial forms and any revisions will be approved by the MCHS Credentialing Committee.

d. Providers will apply for privileges at initial credentialing and at recredentialing. Providers may also submit to the MCHS Credentialing Committee requests to remove privileges or add privileges at any time, using the same privileging form. If additional privileges are needed that are not included in the specialty specific privileging form, the Provider may contact the MCHS credentialing office to help facilitate the request.

- If the Provider is requesting additional privileges, the request must be supported with documentation of training to provide those additional privileges.
- All revisions to the privileging forms must be reviewed and approved by the Service Line Medical Director or his/her physician designee. If neither is available, that review and approval process will be by the Provider’s respective Specialty Lead or Clinic CMO.
- The revisions are also subject to approval by the MCHS Credentialing Committee.

e. Providers who provide clinical services in more than one department/regional center are not required to request privileges in each separate department/center since the recommendation for approval is made by the Service Line Medical Director who has oversight over all assigned departments/centers with MCHS. The recommendation is then approved by the MCHS Credentialing Committee. MCHS ASC and hospital entities will require separate privileging at each location.

f. Advanced practice providers (i.e. nurse providers, physician assistants) may only be granted privileges that are within the scope of the physician(s) who are supervising that clinical care.

g. During the credentialing and recredentialing process for Marshfield Clinic Providers, the Service Line Medical Director or his/her physician designee must complete and sign the Service Line Medical Director Attestation Form indicating his/her professional opinion that the Provider is qualified and competent to be credentialed and have privileges granted as requested. This assessment may be based on (but not limited to) the following information:

- Review of training and experience.
- Review of references or other information (for newly hired Providers).
- Review of ongoing professional practice evaluations, focused practice evaluations, associate evaluations or other peer review either directly or by other Providers (for existing Providers and as available for newly hired Providers).
- Review of any incidents from the medicolegal department (for existing Providers).
- Personal interviews with the department/regional center that were conducted as part of the employment application and hiring process.
☐ Practice summaries, ongoing professional practice evaluations, focused practice evaluations and other peer review documents, procedural logs obtained from inpatient and outpatient facilities where the Provider has had privileges or received training (as applicable – e.g., former residents or non-class A contract providers).

☐ Review of practice summaries or procedural logs as appropriate.

☐ The MCHS Credentialing Committee will generally be guided by the principle that on-site supervision and direct peer review are the most reliable methods of ascertaining a Provider’s competence to perform a procedure. Therefore, the primary determinants of appropriateness of privileges will be:
  ▪ The procedure is within the generally accepted scope of practice for the Provider’s specialty.
  ▪ The Provider’s Service Line Medical Director or his/her physician designee attests to the Provider’s ability to perform the procedures in a competent manner.

☐ When the Provider is also the Service Line Medical Director, the attestation form will be completed and signed by the Provider’s respective Specialty Lead or Clinic CMO.

h. Some Providers, such as hospitalists, may not require outpatient clinic privileges to provide care. However, an attestation form will be completed by the Service Line Medical Director or his/her physician designee so that the credentialing office has documentation of the clinic department accountable for providing practice review.

i. In the event that a Provider transfers from one department to another that Provider’s new Service Line Medical Director or his/her physician designee must complete a new attestation form. If such a transfer requires a change in the Provider’s scope of practice, documentation of applicable training, proctoring, chart review and/or other methods of competency assessment, including the expectations outlined in the re-entry process, will be considered by the MCHS Credentialing Committee.

j. Documentation of proctoring, as directed by MCHS policy and/or deemed appropriate by the MCHS Credentialing Committee must be completed in collaboration with the Service Line Medical Director and his/her physician designee and the department.

k. In cases where a Provider has not been providing direct patient care for a period of greater than or equal to six months, the MCHS Credentialing Committee will follow Committee guidelines related to a re-entry process.

l. Laser use should be within the scope of practice, training and experience of the user. A Provider requesting laser privileges may be asked to provide documentation of such training and experience to the MCHS Credentialing Committee. It is the responsibility of the Service Line Medical Director or Specialty Lead to review such documentation and attest to the Provider’s ability to perform the laser procedures in a competent manner. In addition, the department manager is required to attest that the Provider has record of a baseline eye exam, has completed appropriate Marshfield Clinic computer based training related to laser use and laser equipment safety and that the lasers in the department are in safe, proper working order and are maintained as recommended.
m. Some privileges have defined educational and/or volume criteria that must be met by a Provider to be eligible for that privilege due to the nature and required expertise of such privileges. Such criteria are established by those specialties identified with the most expertise in the clinical area and must be based on literature, consensus statements and/or similar practice models. Such criteria must also be approved by CCOLT and the MCHS Credentialing Committee. The number of Providers privileged in such situations may also be limited in order to maintain the needed case volume for those Providers so privileged.

n. The MCHS Credentialing Committee will review privileging requests and make decisions subject to affirmation by the MC Board of Directors regarding a Provider’s request for privileges at the same time as they are reviewing the Provider’s application for credentialing and recredentialing.

o. If a Provider requests privileges but does not meet the applicable criteria for the specialty, it is not considered a denial. The Provider will be contacted to withdraw the request based on not meeting privileging requirements.

p. A Provider may be credentialed in cases where the Provider does not have any direct patient care activities and does not need to apply for privileges in a specific clinical area. In such cases, the provider will complete an administrative privileging form which will include a signed attestation from their supervisor. The signed attestation will indicate that in their supervisor’s judgment the Provider is qualified and competent to perform their administrative responsibilities and that clinical privileges are not required for the Provider to carry out those responsibilities. The supervisor’s judgment will be based on similar information as found above in Paragraph 3.20 (g) and the Provider’s general performance review. If such Provider chooses to return to direct patient care, a privileging request must be completed and the process used for other Providers will be followed.

3.21. Ongoing performance monitoring (refer to Ongoing Monitoring Policy)

   a. MCHS credentialing staff complete ongoing monitoring that includes:
      □ A monthly review of Medicare and Medicaid sanctions and license limitations.
      □ An expirables report that includes licenses, DEA’s, Board certifications and other certifications/licenses that are about to expire and are required for credentialing/privileging.
      □ The MCHS credentialing staff communicates monthly with MCHS’s Peer Review Office regarding any concerns that have been identified with a credentialed provider’s practice.

3.22. MCHS Credentialing Committee process and decision-making mechanisms specific to Marshfield Clinic Providers

   a. Marshfield Clinic requires their physicians to be Board Certified. The Board Certification Policy states: For contracts issued on or after January 1, 2000, Marshfield Clinic requires, as a condition of Associate and Shareholder status, that physicians are American Board certified or American Board eligible in their primary specialty (the specialty or subspecialty that is the primary focus of the individual’s practice). If Board eligible, they must obtain Board certification within five years of becoming eligible. For those Boards that require mandatory recertification, physicians must maintain Board
certification. Exceptions can be granted by the Clinic CMO if, in his/her judgment, the physician has comparable training and/or expertise to provide the equivalent quality care. (Approved by Board of Directors September 14, 1999).

☐ Board certification through the American Osteopathic Association (AOA) or the Royal College of Physicians and Surgeons of Canada are considered comparable training and/or expertise to provide the equivalent quality care. Maintenance of Certification is required with these certifications as well.

☐ If the physicians’ board has a Maintenance of Certification program, then that physician is required to be enrolled in the program so as to maintain their board certification status (if contracted on or after 1/1/2000).

☐ If a physician is not board certified upon initial contract, the physician must obtain board certification within five (5) years of the contract of employment.

☐ The MCHS Credentialing Committee will review all physicians who are required but not board certified within five (5) years of initial credentialing to determine a plan for becoming board certified. The MCHS Credentialing Committee will work with the Clinic CMO to approve any plan where an extension of the five (5) year requirement is considered.

b. In addition to meeting the Administrative and Professional criteria identified in this Policy, Marshfield Clinic Providers will not be eligible to request privileges if:

☐ They are a physician that has not completed all formal training requirements for board eligibility in their specialty or have not sought board certification by sitting for their primary specialty board exams at least once within two years of becoming eligible, or

☐ The Clinic does not provide the particular service where privileges are requested, or Clinic administratively has limited a service/privilege to a specific center or department, or to a specific type and/or number of specialists to provide a service, etc.

c. Temporary Credentialing

☐ Extenuating circumstances may result in a Provider being granted temporary credentials/privileges. Circumstances that qualify for temporary privileges include:

- Applicant performs specialized procedure/services that no other Provider on staff can perform.
- Patient volume exceeds the capacity of current Providers practicing in the specialty area.

☐ The Clinic CMO may after appropriate review and recommendation from the Service Line Medical Director or his/her physician designee grant temporary credentials/privileges in the event a Provider is scheduled to start practice but, the MCHS Credentialing Committee has not had time to review the completed application. In no case will granting of temporary credentials/privileges be for greater than 120 calendar days. Providers may only be considered for temporary privileges if they meet the Clean File Definition Policy.

☐ For Providers granted temporary credentials/privileges, the MCHS credentialing staff will have obtained as a minimum:

- Completed signed application for credentials/privileges
- Current state of Wisconsin license number, primary source verified
- Wisconsin DEA certification number (as applicable), primary source verified
- Current competencies
- National Provider Data Bank (NPDB) query
- Two peer references
- Two affiliation verifications
- Confirmation that the provider is acceptable for coverage through the Marshfield Clinic professional liability insurance program and the Wisconsin Injured Patients and Families Compensation Fund (if applicable) or other relevant professional liability insurance plan.
- Attestation from the Provider’s Service Line Medical Director or his/her physician designee that the Provider is judged competent to practice and have privileges granted as requested and recommends temporary credentialing and privileging.

3.23. Appeals - Hearing Notice and Hearing Procedures – Marshfield Clinic Providers

a. Notice
☐ The Notice of an adverse credentialing decision shall inform the affected individual that an adverse credentialing decision was made and the reasons for the decision; that the individual has the right to request a hearing on the decision within thirty (30) calendar days; and a summary of the rights in the hearing. If the affected individual does not request a hearing within thirty (30) calendar days, then the decision of the MCHS Credentialing Committee shall be fully implemented as a final determination.

b. Procedure to Request Hearing
☐ The affected individual shall serve his or her request for hearing to the Marshfield Clinic Executive Director (Executive Director).

c. Request for Hearing
☐ If the affected individual timely requests a review of the MCHS Credentialing Committee decision, the Executive Director or his/her designee will give the affected individual notice (Hearing Notice) stating: (a) the place, time and date of the hearing, which shall be at least thirty (30) calendar days after the date of the Notice of Hearing; and (b) a list of witnesses (if any) expected to testify at the hearing on behalf of Marshfield Clinic. This list may be modified before the hearing.

d. Hearing
☐ If the affected individual timely requests a hearing, the hearing shall be held before the voting members of the Marshfield Clinic Board of Directors ("Board"). The Board shall determine one representative to chair the proceedings. Alternatively, in its discretion, the Board may choose to hire an external hearing officer who is not in direct competition with the affected individual, in which case the external hearing officer will chair the proceedings. If the affected individual fails, without good cause, to appear at the hearing, the right to hearing will be forfeited. At the hearing, the affected individual has the following rights: to representation by an attorney or other person of the affected individual’s choice and at the affected individual’s expense; to a record made of the proceedings, copies of which may be obtained by the affected individual upon payment of any reasonable charges associated with preparation thereof;
to call, examine and cross-examine witnesses; to present evidence determined to be relevant by the hearing Chair, regardless of its admissibility in a court of law; and to submit a written statement at the close of the hearing.

☐ The hearing shall be conducted in the manner chosen by the Chair of the hearing. The hearing will not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. The Board may consider any testimony, documents or other material deemed appropriate. The hearing need not be conducted as a court trial. No specific testimony, documents or materials, or types thereof, are required to be presented or considered in order to support a valid final determination. Upon completion of the hearing, the affected individual has the right to receive the written recommendation/decision of the Board, including a statement of the basis for the recommendation/decision.

☐ The affected individual who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the proposed adverse recommendation or action should not be undertaken.

e. Appellate Review

☐ A Marshfield Clinic Provider aggrieved by a decision of the original hearing body ("Appellant") shall have ten (10) calendar days following his or her receipt of the written decision of the original hearing body to file a written request for an appellate review, which must be delivered to the Executive Director, accompanied by a written statement if desired. An affected individual who fails to request an appellate review within the time and in the manner specified waives any right to such review.

☐ Upon receipt of a timely request for appellate review, the Executive Director and Clinic CMO shall appoint an ad hoc appellate review committee consisting of five (5) members ("Appellate Review Committee"). The membership of the Appellate Review Committee shall include one physician employed by Marshfield Clinic and one community member of the MC Board of Directors. None of the members of the Appellate Review Committee shall have served on the original hearing body.

☐ The Appellate Review Committee shall meet within twenty (20) business days after the date of the Appellant’s request for review and make a determination whether to uphold, overturn or modify the decision of the Board, based upon the record of events up until that point including, the hearing record, the original hearing body recommendation and any written statements. The Appellate Review Committee shall render its written decision within ten (10) business days of the meeting, and shall provide copies to the affected individual, the Executive Director, the Clinic CMO and a copy to the original hearing body. The decision of the Appellate Review Committee shall be final and effective immediately, with no further right of review.

f. Notices

☐ Any notice required by this Policy may be delivered by any reasonable means.

g. Interpretation

☐ The provisions of this Policy shall be interpreted in a manner consistent with the best interests of MCHS and its patients. In any particular case, the fact
that certain provisions of this Policy are not strictly followed will not invalidate any final determination.

h. Adverse MCHS Credentialing Committee Decision Non-Physician
   □ Any adverse credentialing or re-credentialing decision of the MCHS Credentialing Committee with respect to a non-physician Provider, may be appealed to the CCOLT, or designated subcommittee appointed by the Clinic CMO to act on behalf of the CCOLT.
   □ The MCHS Credentialing Committee shall notify the affected individual in writing of its adverse decision and the reason for such decision (i.e. administrative, clinical competence)
   □ Within fifteen (15) calendar days of such notice, the affected individual must notify the Clinic CMO if he/she wishes to appeal the decision of the MCHS Credentialing Committee to the CCOLT. The appeal must be in writing and submitted within that same time period.
   □ The review by the CCOLT shall be as soon as practicable after request by the affected individual. The written information provided by the affected individual and any additional information from the MCHS Credentialing Committee requested by the Clinic CMO will be reviewed to determine if the Policy was followed.
   □ The CCOLT may uphold or reverse in whole or in part the action of the MCHS Credentialing Committee.
   □ Any decision of the CCOLT is subject to the ratification of the Board. The Board may uphold or reverse in whole or in part the decision of the CCOLT.
   □ Any decision of the Board shall be final in all respects.

i. Adverse MCHS Credentialing Committee decision and reapplication
   □ An applicant may reapply for credentials and/or privileges only after a period of twelve (12) months. The information in the applicant’s file will be updated with any additional information provided through the employment and credentialing process. However, the information previously obtained will also be maintained in that file and available for review in the decision making process.

3.24. Security Health Plan (SHP) Addendum
   a. The information in this Addendum applies to all SHP affiliated providers and facilities that are contracted with SHP to provide care to SHP members. It outlines the processes for:
      □ disciplining and terminating affiliated providers in the Protocol for Assessing the Quality of an Affiliated Provider Practice as found in Paragraph 3.39. The MCHS Credentialing Committee may deny or restrict participation by a provider, terminate a provider’s participation with SHP or take other disciplinary action in accordance with the provider’s written contract, this Policy, or the due process document.
      □ affiliated practices to delegate credentialing with SHP
      □ credentialing facilities and organizations that are contracted to provide services to SHP members, including: hospitals, home health agencies (HHA), clinical laboratories, skilled nursing facilities (SNF), rehabilitation centers, comprehensive outpatient rehabilitation facilities (CORF), freestanding ambulatory surgery centers (ASC), end-stage renal dialysis (ESRD), portable imaging suppliers, freestanding rural health centers (RHC), and
3.25. Provider Credentialing
   a. Any interested physician (MD/DO) may complete a credentialing application. Non-physician providers may complete an application if SHP determines that a business need exists for their services. SHP is not required to reimburse for services provided to members prior to credentialing approval. For new practice sites, office managers are required to complete the Practice Information Form.
   b. SHP currently credentials providers with whom SHP contracts who treat members outside the inpatient setting and who fall within SHP’s scope of authority and action. These providers include:
      - Physicians (MDs, DOs)
      - Dentists and Oral Surgeons
      - Podiatrists
      - Optometrists (ODs)
      - Clinical Psychologists
      - Social Workers and Drug and Alcohol Counselors (MSWs, SAC and CSAC)
      - Chiropractors
      - Other licensed independent providers (i.e. Nurse Midwives, Audiologists, PTs, OTs, SLPs, NPs, PAs, Autism providers)
      - Clinic locum tenen providers
      - Telemedicine providers at a clinic setting
   c. Any provider who disaffiliates from SHP’s network (whether voluntarily, lay off or through termination) and later wishes to re-affiliate is subject to initial credentialing (if the break in affiliation is thirty (30) calendar days or more).
   d. SHP does not credential:
      - Athletic Trainers
      - Hospital owned providers who practice exclusively within the inpatient setting (e.g. Pathologists, Radiologists, Anesthesiologist, ER physicians)
      - Hospital locum tenen providers
      - Providers who practice exclusively within freestanding facilities (e.g., Skilled Nursing Facilities, Ambulatory Surgery Centers, etc.)
      - Providers who do not provide care to members in a treatment setting (e.g., board certified consultants)
      - Providers that fall under a Vendor Agreement (e.g. transplant agreements, repricer agreements). A vendor agreement allows SHP to access the Vendor’s contract to obtain discounted pricing.
      - Individual Hearing Instrument Specialist providers. The practice will be listed in the provider directory with a specialty of “Hearing Aid Provider”

3.26. Application process
   a. Although professional references are not collected at the time of initial credentialing and recredentialing providers for the SHP entity, there may be times when additional information obtained through references may assist the MCHS Credentialing Committee in their decision making. In these instances, MCHS credentialing staff may collect references from contacts that are familiar with the provider’s qualifications during the two (2) years immediately preceding the application. This may include but is not limited to:
The chief of the department or service where the provider last furnished professional services.

The program director where the provider was enrolled in training (if the provider is less than three (3) years out of training).

If the provider is a non-physician provider acceptable references may include prior supervisors/managers, supervising physicians, program directors or another reference that provided a supervisory role.

3.27. Site Visits/Medical Record Keeping Standards
   a. SHP Account Managers (AM) will, as part of contracting, require the potential offices of any new practice to complete and submit a Self-Site Visit Survey form prior to signing an Affiliated Provider Agreement. The purpose of this form is to assess compliance with minimal SHP site visit and medical record keeping standards prior to contracting.
   b. A complete copy of SHP’s site visit and medical record keeping standards are attached to the Self-Site Visit Survey form to educate potential providers on SHP complete performance expectations.
   c. SHP AM’s may conduct a complete on-site visit to a practice. See Site Visit/Medical Record Keeping Review Policy for complete standards, compliance and follow-up requirements on on-site visits.

3.28. Ongoing Monitoring
   a. The SHP AM responsible for the National Committee for Quality Assurance (NCQA) CR Standard relating to Ongoing Monitoring and Interventions will monitor member complaints reports, monthly, to detect deficiencies after an initial site visit.
      □ Complaints will be reviewed to identify practice site quality issues relating to physical accessibility, physical appearance and adequacy of waiting and examining room space.
      □ If SHP’s Practice Site Complaint Threshold is met, the CR AM will notify the appropriate AM to conduct an office-site visit. This visit will be conducted within forty-five (45) calendar days of the complaint threshold being met.
   b. SHP staff responsible for NCQA QI Standard relating to Member Satisfaction, reviews member complaints to identify complaints related to the quality of an affiliated practice sites.
      □ Staff forwards this information to CR AM responsible for the NCQA CR Standard relating to Ongoing Monitoring and Interventions who will review the practice sites file and complaint with the SHP Medical Director.
      □ If the complaint threshold is met or the SHP Medical Director believes the complaint warrants an on-site visit, the appropriate AM is notified to conduct an onsite visit. See Site Visit/Medical Record Keeping Review Policy for complete standards, compliance and follow-up requirements.
   c. If, at any time during a provider’s affiliation with SHP, a member lodges a complaint or files a grievance against the provider for issues concerning quality of care or service:
      □ The SHP Medical Director or his/her physician designee will communicate the member’s complaint to the provider.
      □ The provider will be given the opportunity to respond to the member’s complaint/grievance.
The member’s complaint/grievance and provider’s response will be placed in a performance review file and trended.
- If a provider has two (2) member complaints in a 1-year period or the SHP Medical Director determines a complaint needs further review, the information is presented to the MCHS Credentialing Committee Chair for review.
- The MCHS Credentialing Committee Chair makes a determination as to what type of follow-up and/or intervention is needed (e.g. communication to provider, on-site visit or implementation of the due process as outlined in Paragraph 3.39.
- SHP also reviews adverse events monthly to identify provider trends.
- Medicare and Medicaid sanctions and license limitations are reviewed and presented to the MCHS Credentialing Committee on a monthly basis.
- Specific provider access issues, member complaints and adverse events are all reviewed as part of a provider’s recredentialing.

3.29. Administrative review for SHP affiliated practices
   a. All physician and non-physician providers must maintain their primary office in SHP’s service area and must provide information relative to after-hours and weekend coverage
   b. All non-physician practice sites (allied practice sites) are affiliated based on business need. The determination of business need includes, but is not limited to:
      - whether or not the allied provider(s) of the practice site are part of an already affiliated practice
      - the need for the allied practice site’s expertise in a given geographic area
      - the network’s ability to provide “reasonable access” to members
      - the availability of timely appointments for members
      - current and projected enrollment
      - significant continuity of care issues
      - member requests
   c. A practice requesting affiliation must agree to complete a Self-Site Visit Survey.
   d. When necessary, they must allow the SHP AM to conduct an on-site review and an audit of medical records, which will include, but is not limited to:
      - the physical accessibility of the office
      - the physical appearance of the office
      - the adequacy of waiting and examining room space
      - the availability of appointments and follow-up with patients
      - policies and procedures
      - fire/safety
      - the adequacy of medical record keeping
      - the adequacy of medical record filing and confidentiality

3.30. Appeals
   a. Applicants who are denied initial affiliation based on credentialing issues can appeal the denial by following MCHS’s New Provider Appeal Policy.
   b. While there is no appeal process for denials based on lack of business need these applicants may reapply after twelve (12) months.
c. Providers have the right to appeal a decision by the MCHS Credentialing Committee to deny continued affiliation with SHP. This process is outlined in the Protocol for Assessing the Quality of an Affiliated Provider Practice in Paragraph 3.39.

3.31. Listings in SHP provider directories and other member materials
a. Provider information that is supplied through member materials (i.e., provider directories, member newsletters) will be consistent with information that was obtained during the credentialing process. This includes the provider's education, training, and certification in regard to specialty areas.

3.32. Facility credentialing and recredentialing
a. SHP has established policies and procedures for the initial approval and re-approval of facilities and organizations contracted to provide services to SHP members.
b. The scope of facilities approved includes:
   - Hospitals
   - Home Health Agencies (HHAs)
   - Clinical Laboratories
   - Skilled nursing facilities (SNFs)
   - Rehabilitation centers (RCs)
   - Comprehensive Outpatient Rehabilitation Facility (CORF)
   - Freestanding ambulatory surgical centers (ASCs)
   - End-Stage Renal Dialysis (ESRDs)
   - Portable Imaging Suppliers
   - Freestanding Rural Health Center (RHC)
   - Federally Qualified Health Center (FQHC)
   - Day Treatment Centers
   - Inpatient, Residential and Ambulatory Mental Health
c. The Payor Strategy and Network Contracting department of SHP is responsible for notifying MCHS credentialing staff if they will be contracting with a new facility that needs to be credentialed. The assigned MCHS credentialing staff coordinates this process.
d. All facilities are credentialed before services are approved to SHP members. Facility recredentialing takes place at least every three years.

3.33. The Facility Credentialing & Recredentialing for Security Health Plan procedure outlines:
a. The Administrative Criteria for the credentialing and recredentialing of facilities that SHP contracts with.
b. Recognized accreditations for facilities.
c. The primary source verifications required for facilities that have a recognized accreditation.
d. The primary source verifications required for facilities that are not accredited.

3.34. Site Visits for Non-Accredited Facilities
a. The assigned SHP AM will conduct a quality assessment to any site that is unable to prove acceptable JC; AAAHC; BQA; CARF; HFAP; AAAASF/RHC or CCAC accreditation; or AMS review that meets SHP’s standards.
b. SHP may conduct a site visit to any other facility. Such visits will be conducted in accordance with SHP standards for site visits.

c. For facilities seeking initial approval, the assigned SHP AM will evaluate medical record policies and procedures.

3.35. Administrative review for facility recredentialing

a. The MCHS credentialing staff will conduct a review of the SHP affiliated facilities credentials no less than every three (3) years during the contract period.

3.36. MCHS Medical Director of Credentialing and Privileging

a. The MCHS Medical Director of Credentialing and Privileging or his/her physician designee reviews facility information that meets SHP’s Administrative Criteria as found in Facility Credentialing & Recredentialing for Security Health Plan procedure.

b. The MCHS Medical Director of Credentialing and Privileging or his/her physician designee has the authority to approve facility credentialing and recredentialing information that meets SHP’s Administrative Criteria for facility credentialing and recredentialing as identified in this Policy.

3.37. MCHS Credentialing Committee

a. The MCHS Credentialing Committee is responsible for reviewing facility credentialing and recredentialing information that does not meet SHP’s Administrative Criteria for facilities and has authority to approve/disapprove facility credentialing/recredentialing.

b. If any of the required documentation for credentialing/recredentialing is not provided, or if the assessment does not demonstrate that the facility is in good standing with regulatory bodies, the MCHS Credentialing Committee will withhold approval until further review can demonstrate that the facility meets SHP requirements.

3.38. Delegated credentialing and recredentialing

a. Credentialing/recredentialing of providers may be delegated by SHP to affiliated practices in the event required criteria are met by the delegated organization. Please refer to Process for Delegation Agreements for Security Health Plan Entity procedure.

b. The MCHS Credentialing Committee retains the right, based on quality issues, to approve and/or terminate individual providers and/or sites.

c. SHP currently subcontracts with the following organizations to perform credentialing and recredentialing functions:

- Allied Insurance Solutions, LLC for management of chiropractic services. Subsequently, Allied Insurance Solutions, LLC, per Delegation of Credentialing Agreement, performs credentialing/recredentialing.

- Essentia for management of the medical services provided through its own health system. Subsequently, Essentia, per Delegation of Credentialing Agreement, performs credentialing/recredentialing.

- Aspirus Network Inc., for management of the medical services provided through its own health system. Subsequently, Aspirus Network Inc., per Delegation of Credentialing Agreement, performs credentialing/recredentialing.
3.39. Protocol for Assessing the Quality of an Affiliated Provider Practice

When document is printed it becomes an uncontrolled copy. Please refer to DCS system for most current version.
a. This process is not intended for routine recredentialing but for exceptional circumstances.

b. Under the direction of SHP’s QIC, the SHP Chief Medical Officer (CMO) and/or his/her physician designee shall have the responsibility and authority to review and evaluate the professional activities and conduct, as well as the utilization of services and reasonableness of charges, of affiliated providers regarding SHP members. Such review shall be performed in accordance with this Policy, the Affiliated Provider Contract and sections 146.37 and 146.38 of the Wisconsin statutes.

c. For purposes of this document, affiliated providers include the following:
   - affiliated physicians (including SHP sponsor physicians)
   - affiliated hospitals
   - all other health care providers affiliated with SHP or reimbursed by SHP

d. Practices of affiliated providers may be reviewed on the basis of any of the following:
   - index cases suggesting possible quality of care and/or service problem
   - data generated through SHP’s Quality Improvement Program
   - charging patterns
   - utilization of medical services
   - failure to adhere to the rules and regulations of SHP
   - any other matter involving the care and treatment of SHP members

e. The purpose of review shall be to evaluate an affiliated provider's practice in relation to affiliation with SHP. Documentation may include positive and negative elements of a practice and affiliation, which shall be communicated to the provider.

f. Where indicated, SHP's CMO and/or his/her physician designee, any other affiliated provider, MCHS’s Credentialing Committee, or SHP's QIC may suggest corrective action. Requests for corrective action shall be in writing where appropriate, and shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request.

g. In addition to the review anticipated in the section above, whenever the professional activities or conduct, as well as the utilization of services or reasonableness of charges of any SHP affiliated provider is considered to be unacceptable to the affiliated provider's professional peers, or are judged to be seriously disruptive to SHP operations, corrective action may be requested by any affiliated provider or SHP member. All requests for corrective action:
   - shall be in writing
   - shall be made to SHP's CMO or his/her physician designee
   - shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request

h. SHP's CMO, and/or his/her physician designee, shall investigate and evaluate the complaint and, where appropriate, may meet with and counsel the affiliated provider and inform the provider of those areas wherein it is considered that the professional activities or conduct, utilization of services or reasonableness of charges are unacceptable. Alternatively, SHP's CMO and/or his/her physician designee may refer the matter to the MCHS Credentialing Committee for investigation and evaluation.

i. If the affiliated provider fails to improve the activities or conduct in question within sixty (60) days after being directed to do so by SHP's CMO and/or
his/her physician designee, the matter may be referred to the MCHS Credentialing Committee.

j. In those cases where a matter is referred to the MCHS Credentialing Committee, the MCHS Credentialing Committee will investigate and implement peer review, as appropriate to evaluate the provider’s practice and/or affiliation. The affiliated provider shall, as appropriate, be evaluated as to the ability to:
   - diagnose and treat patients
   - work with others
   - patient relationships
   - utilization of services
   - charging patterns

k. In addition to the foregoing, the MCHS Credentialing Committee may consider the following elements in its investigation:
   - adequacy of medical records
   - ethical behavior
   - judgment
   - patient complaints
   - complications from patient care
   - use as a consultant, and proper use of consultants
   - technical proficiency
   - procedure for filing claims

l. The affiliated provider shall have an opportunity to meet with the MCHS Credentialing Committee to discuss, explain or refute the activities or conduct in question.

m. MCHS’s Credentialing Committee shall prepare a recommendation and report that includes the reasons for the action within thirty (30) days of referral to the Committee unless additional information is needed.
   - The report shall be sent certified mail to the affiliated provider and will advise of the appeal rights referenced below.
   - The MCHS Credentialing Committee may, where indicated, recommend further professional training, a limitation in the provider’s practice, a limitation on utilization of services or charging practices, or disaffiliation as a SHP affiliated provider.
   - The MCHS Credentialing Committee may recommend better work habits; improvement in interpersonal relationships, peer supervision, or the Committee may recommend counseling or impose other sanctions.

n. An affiliated provider may, within thirty (30) days after receipt of a copy of the MCHS Credentialing Committee’s report, appeal the recommendation and report to SHP’s QIC. SHP’s QIC may accept the MCHS Credentialing Committee’s report or substitute its own recommendation and report after its own investigation.

o. The affiliated provider shall have the opportunity to meet with SHP’s QIC to discuss, explore, or refute the activities or conduct in question. The affiliated provider shall receive a copy of SHP’s QIC’s report.

p. As an alternative appeal mechanism, in lieu of (but not in addition to) appealing the MCHS Credentialing Committee’s recommendation and report to SHP’s QIC, an affiliated provider may request a meeting before a three-member panel appointed by MCHS’s Credentialing Committee Chair or his/her physician designee.
Two of the three Panel members will be in a practice similar to the affected provider.

None of the three Panel members shall be in direct economic competition with the affiliated provider in question.

If the affiliated provider requests a meeting, SHP shall give at least thirty (30) calendar days’ notice regarding the place, time and date of the meeting.

The Panel meeting will be chaired by the Chair of the MCHS Credentialing Committee or his/her physician designee.

The Panel shall prepare a recommendation and report.

q. SHP shall allow the affiliated provider to be represented by an attorney or another person of their choice.

r. SHP’s QIC may accept the Panel’s report, as appropriate, or substitute its own recommendation and report after its own investigation.

s. The affiliated provider shall receive a copy of SHP’s QIC decision, which shall be final. (See MCHS’s Reporting Serious Quality Deficiencies and/or Adverse Clinical Privileges Actions Policy).

t. Notwithstanding the above, SHP’s Medical Director and/or his/her physician designee, shall have the authority, whenever action must be taken immediately in the best interest of SHP members, to summarily suspend all or any portion of the affiliation of an affiliated provider and such summary suspension shall become effective immediately upon imposition.

u. An affiliated provider whose affiliation has been summarily suspended or limited shall have the right, upon request to SHP’s QIC, to have the suspension reviewed de novo by SHP’s QIC within seven (7) days of the suspension.

4. ADDITIONAL RESOURCES

4.1. References:
- Credentialing Staff and Committee Confidentiality Policy
- Non-Discrimination Policy
- Clean File Definition for Credentialing and Recredentialing Files
- Current MCHS Credentialing Committee Membership
  (Q:/AccrediationPub/Credentialing/MCHS/Policies/MCHS Credentials Committee Membership Roster 072117)
- Primary Source Verification Details
  (Q:/AccrediationPub/Credentialing/MCHS/Policies/MCHS System Policy Resource Guide Credentialing 052517)
- Hospital Privileging Policy
- Ongoing Monitoring Policy
- New Practitioner Applicant Appeal Process for Security Health Plan Entity
- Reporting Serious Quality Deficiencies and/or Adverse Clinical Privileges Actions Policy

4.2. Supporting documents available:
- Facility Credentialing & Recredentialing for Security Health Plan
  (Q:/AccrediationPub/Credentialing – SHP/SHP Procedures/Facility Credentialing & Recredentialing for Security Health Plan)
• Process for Delegation Agreements for Security Health Plan Entity

(Q:AccrediationPub/Credentialing – SHP/SHP Procedures/Process for Delegation
Agreements for Security Health Plan Entity)

5. DOCUMENT HISTORY

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<thead>
<tr>
<th>Version No.</th>
<th>Revision Description</th>
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<tbody>
<tr>
<td></td>
<td>This policy replaces SHP policy. Document was archived as a Security Health Plan of Wisconsin, Inc. policy and approved as a MCHS policy on 08/09/2017. Revisions made were to reflect a system policy. 1/10/18 MCHS CC reviewed &amp; approved</td>
</tr>
<tr>
<td></td>
<td>This policy will be reviewed annually.</td>
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6. DOCUMENT PROPERTIES

Primary Author: Watson, Kari L.
Co-Author(s):
Approver(s): This document has been electronically signed and approved by: Sinha, Julie A on: 1/12/2018 11:09:12 AM