No. CD1003	Credentialing POLICY AND PROCEDURE MANUAL	
Page: 1 of 14		
Effective Date: 01/01/2021	Section: Initial and Recredentialing	
Committee Approval 01/19/2021 Previous Versions Dated: 01/01/2019, 01/01/2018	Practitioner Initial Credentialing	

I. SCOPE

This policy applies to (1) Canopy Health, LLC ("Canopy Health") and its subsidiaries and affiliates (each, an "Affiliate"); and (2) any other entity or organization with which Canopy Health contracts for such entity or organization to perform provider credentialing on Canopy Health's behalf (each a "Contractor"). To the extent that any Contractors perform functions set forth herein, references to "Canopy Health" or the "Credentialing Department" shall be interpreted to refer to such Contractors.

II. PURPOSE

The purpose of this policy is to implement a fair and reasonable process to evaluate the qualifications of practitioners seeking participation in Canopy Health's network.

III. DEFINITIONS

Credentialing: The process by which Canopy Health evaluates providers prior to contracting said providers to render services to members. Eligibility for network participation is determined by the extent to which applicants meet defined requirements for education and training, licensure and certifications, professional standing, service availability and accessibility, and quality requirements.

Attestation: The statement which attests to the validity of information contained in the application and releases Canopy Health to obtain primary source verifications.

Credentialing Peer Review Committee: A group of providers selected by Canopy Health that evaluate the qualifications and make the final determination regarding the status of providers applying for participation in Canopy Health's network, and evaluate the necessity, quality or utilization of care rendered by providers in the network. Peer review is conducted by other health care providers from the same discipline or with similar or essentially equal qualifications who are not in direct economic competition with the health care professional under review.

Participating Provider: Any practitioner or organization that is contracted or employed by Canopy Health to render services to members.

Primary Source: An organization or entity with legal responsibility for originating a document and ensuring the accuracy of the information it conveys.

IV. POLICY

A. It is the policy of Canopy Health to implement a credentialing program to verify the professional qualifications of providers prior to said providers rendering services to members.

B. Providers of medical services are categorized as either requiring credentialing through Canopy Health, e.g. joining Canopy Health via direct contract, or not requiring credentialing through Canopy Health, e.g. delegated network or hospitalists.

C. In instances where a provider is determined to require credentialing per CD1001 "Determining Provider Credentialing Eligibility", Canopy Health ensures that providers are thoroughly and appropriately credentialed per standards of the National Committee for Quality Assurance ("NCQA") and all other state and federal regulations, as applicable, prior to rendering services to members.

D. Providers who do not meet the criteria set forth in this policy are either not eligible for participation or must be presented to the CPRC for review and determination. The CPRC retains the final authority to make the determination about which practitioners participate within Canopy Health's network.

E. If a practitioner terminates and later wishes to rejoin, the practitioner must undergo the initial credentialing process if the break in service is greater than 30 days. The credentials of the practitioner will be re-verified following the same guidelines as described in this policy. Canopy Health is not required to re-verify credentials that do not expire, such as, completion of education and training and board certification that is not time-limited.

F. All documents and information obtained during the credentialing process are confidential and access is limited to committee members and Canopy employees who are directly involved in the process.

1. Electronic information is stored on secure servers.
2. Hard copy information is housed in locked file cabinets and/or other locked area(s) with access limited to Canopy Credentialing Department employees.
3. The credentialing application, its contents and the information obtained during the credentialing process are protected from discovery under Section 1157 of the California Evidence Code.
4. Contents of the credential file may not reproduced or distributed, except for purposes of confidential peer review and credentialing consistent with §1157 or for the express purpose of contracted health plan/National Committee for Quality Assurance (NCQA) delegation oversight processes.

V. PROCEDURE

A. The Canopy Health credentialing department ("CD") will determine whether or not a practitioner is eligible for credentialing. Once a determination is made that a provider

must be credentialed then the initial request document will be loaded into the credentialing database.

B. Within five business days of receipt of an initial credentialing request from a provider, the credentialing database will be populated to indicate that the request for credentialing has been received and credentialing is now in process.

C. Providers are required to submit a credentialing application using the state-mandated credentialing application. The credentialing process begins upon receipt of an initial request document, completed and signed application and supporting documents, including the following information:

1. History of education, professional training and board certification status
2. Work history; minimum five years required, unless enrolled in professional training program; gaps of over 6 months must be explained
3. State licensure information of current and previously held licensure in all jurisdictions
4. Evidence of current Drug Enforcement Agency ("DEA") certificate or state controlled dangerous substance certificate, or covering provider information, if applicable
5. Current hospital affiliations or privileges, or covering information, if applicable
6. History of loss or limitation of privileges or disciplinary action
7. Current professional liability coverage clearly identifying the provider, expiration date, and coverage type
8. Professional liability claims history
9. Reasons for inability to perform the essential functions of the position, with or without accommodation
10. Lack of present illegal drug use
11. History of loss of license, felony convictions, or sanctions
12. A signed attestation from the provider as to the correctness and completeness of the application
13. A signed release from the provider authorizing the disclosure, inspection, and copying of information and documents pertaining to credentialing qualifications between authorized Healthcare Organizations
14. Signed and dated statement authorizing collection of any information necessary to verify the information in the application; CAQH electronic attestation date is sufficient for this element as long as a copy of a signed attestation, regardless of date, is present in the application
    a. Pertaining to signatures, in instances where a provider is physically impaired, a stamp signature is acceptable.

D. Application and documentation must be attested to within 180 days of CPRC committee decision.

E. Where applicable, explanations must be provided for gaps in work history, responses to disclosure questions, etc.

F. In instances when the application is faxed or emailed directly to the Credentialing Department, the providers will be notified within two business days that their application has been received. Within 15 business days from receipt of application the CD will review the documents to ensure it is complete. If upon initial assessment, one of the above items is missing, or the information contained in the application is inconsistent, the CD will notify the applicant, by phone or in writing, of all missing or incomplete information.

If there are any corrections to the application, the practitioner must initial, re-sign and re-date the attestation questionnaire.

G. Credentialing will be complete within 45 business days from receipt of a complete application. The CD will enter the credentialing application data into the credentialing database.

H. Once the submitted application is complete, primary source verification is conducted for the following items as detailed below (in some instances, as described below, a copy of the original document meets this standard):

1. State License
    b. Verification Time Limit: 180 calendar days prior to CPRC committee decision
    c. A current valid state license must be obtained from the appropriate issuing State Board; if applicable, must indicate whether there are State sanctions, restrictions on licensure/limitations on scope of practice
    d. The verification includes the following: name, expiration date of the license and any actions against the license, initials/identifying signature and date stamp indicating when and by whom the verification was conducted

2. Drug Enforcement Agency License
    e. Verification Time Limit: 180 calendar days prior to CPRC committee decision

f. Verification must be obtained through issuing agency, e.g. DEA or official NTIS website
g. All DEA certificates must be issued in state of provider's practice
h. This organization allows participation of a provider who does not have an active DEA registration provided there is a practitioner with a valid state specific DEA certificate who will provide DEA coverage until the provider secures his/her own.
   (i) Provider must explain why he or she does not have an active DEA registration and whether or not one is in process
   (ii) Provide coverage letter with covering provider's DEA certificate and agreement for coverage
   (iii) The covering provider's DEA certificate must be primary source verified with schedule 2-5 dispensing capacity

3. Board Certification, if applicable
   i. Verification Time Limit: 180 calendar days prior to CPRC committee decision
   j. This organization recognizes the following certifying boards:
      (i) MDs/DOs
         a) American Board of Medical Specialties (ABMS)
         b) American Osteopathic Association (AOA)
         c) American Medical Association (AMA)
         d) American Board of Podiatric Medicine (ABPM)
      (ii) DDS/DMD
         a) American Board of Oral Maxillofacial Surgery (ABOMS)
      (iii) DPM
         a) American Board of Podiatric Medicine (ABPM)
         b) American Board of Podiatric Surgery (ABPS)
      (iv) Anesthesia Assistant (AA)
         a) National Commission for Certification of Anesthesiologist Assistants (NCCAA)
      (v) APN/ARNP/CNP
         a) American Nurses Credentialing Center (ANCC)
         b) American Academy of Nurse Practitioners Certification Program (AANPCP) AACN Certification Corporation
         c) Pediatric Nursing Certification Board (PNCB)
         d) National Certification Corporation (NCC) for Women's Health (OB/GYN) Nurse Practitioners (WHNP) or Neonatal Nurse Practitioner (NNP)

e) Accreditation Board for Specialty Nursing Certification (ABSNC)

(vi) CNM/LMW
- a) American College of Nurse Midwives (ACNM)
- b) American Midwifery Certification Board (AMCBE)

(vii) CNS
- a) American Nurses Credentialing Center (ANCC)
- b) AACN Certification Corporation
- c) Oncology Nursing Certification Corporation (ONCC)

(viii) CRNA
- a) American Association of Nurse Anesthetists (AANA)
- b) American Nurses Credentialing Center (ANCC)
- c) National Board on Certification/Recertification of Nurse Anesthetists (NBCRNA)
- d) Council on Certification of Nurse Anesthetists (CCNA)
- e) American Nurses Credentialing Center (ANCC)

(ix) PA
- a) National Commission on Certification of Physician Assistants (NCCPA)

k. The verification includes the following: expiration date of the certificate, initials/identifying signature and date stamp indicating when and by whom the verification was conducted

4. Highest Level of Education/Training, if provider is not board certified in contracted specialty
   a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
   b. The organization must verify the highest level of education and training obtained by the practitioner:
      (i) Graduation from medical or professional school
      - a) AMA Masterfile
      - b) AOA Masterfile
      - c) Educational Commission for Foreign Medical Graduates ("ECFMG") for international medical graduates licensed after 1986
      - d) Sealed transcript from medical school or professional school
      - e) Board certification, if the Board performs primary-source verification of education/training. At least annually, the organization must obtain written confirmation from the Board

that it performs primary-source verification of education/training.

(ii) Residency training

a) This organization recognizes only the following residency programs: ACGME, AOA, CFPC, or the Royal College of Physicians and Surgeons of Canada

b) AMA Masterfile

c) AOA Masterfile

d) State licensing agency, if the state agency performs primary-source verification of education/training. At least annually, the organization must obtain written confirmation from the state licensing agency that it performs primary-source verification of education/training.

c. In the case that the degree/training issuing institution outsources verification to a third party, a signed statement from the institution stating that said third party conducts the primary verification of education and internship/residency on behalf of the institution must be filed with the application.

d. The verification includes the following: initials/identifying signature and date stamp indicating when and by whom the verification was conducted

5. Work History

a. Verification Time Limit: 180 calendar days prior to CPRC committee decision

b. Information pertaining to the last five years of work history is attained from the completed application or CV; work history must be in month/year format, unless the practitioner has had continuous employment for five or more years with no gap. In instances where the work history is less than five years, the time frame for review will start from date of initial licensure

c. CD must clarify either verbally or in writing each gap in employment that exceeds six months. CD must clarify in writing all gaps in work history that exceeds one year

d. The verification includes the following: initials/identifying signature and date stamp indicating when and by whom the verification was conducted; the review is documented on the credentialing checklist or with a memo to file, if applicable.

6. History of Professional Liability Claims

a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
b. Verification is conducted through the National Practitioner Databank (NPDB)
   (i) This organization requires a review of all past claims to make the appropriate determination of whether or not the practitioner meets the criteria set forth in policy CD 1006 "Criteria for Clean or Case File Review".
c. The verification includes the following: initials/identifying signature and date stamp indicating when and by whom the query was conducted

7. Hospital Privileges, if applicable
   a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
   b. Verification of privileges must be conducted directly from the hospital
      (i) Confirmation can be documented via telephone, written confirmation or through the hospital's website.
      (ii) Provider's privileges must be in "Good Standing"
   c. If the practitioner does not have admitting privileges, the practitioner must have a formal inpatient coverage arrangement with another provider or with a Hospitalist Network; in such instances a memo to file is acceptable detailing the arrangement.
   d. The verification includes the following: end date/reappointment date of privileges, initials/identifying signature and date stamp indicating when and by whom the verification was conducted

8. Professional Liability Insurance
   a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
   b. Current copy of liability insurance cover sheet with legible name, expiration date, and liability covered or a copy of the federal tort letter for providers with tort coverage.
   c. Insurance coverage limits: 1M-3M; Provider Extenders: .2M-.6M
   d. The verification includes the following: initials/identifying signature and date stamp indicating when and by whom the verification was conducted

9. Sanctions or Limitations on Licensure, or Other NPDB Data
   a. Verification Time Limit: 180 calendar days prior to CPRC committee decision

b. Verification is conducted through the National Practitioner Databank (NPDB)
   (i) This organization requires a review of all past sanctions or limitations to make the appropriate determination of whether or not the practitioner meets the criteria set forth in policy CD 1006 "Criteria for Clean or Case File Review".
   (ii) Any other documents submitted by the practitioner and represented as originating from NPDB must be verified against the practitioner's NPDB record.
c. The verification includes the following: initials/identifying signature and date stamp indicating when and by whom the query was conducted

10. Medicaid/Medicare Sanctions
    a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
    b. This organization prohibits contracting/employing practitioners who are identified as having Medicaid/Medicare sanctions
    c. Verification is conducted through the following sources:
       (i) Health and Human Services-Office of Inspector General ("HHS-OIG") List of Excluded Individuals/Entities ("LEIE")
       (ii) System for Award Management ("SAM") which verifies General Services Administration ("GSA")
       (iii) California Suspended and Ineligible Practitioner List
    d. The verification includes the following: initials/identifying signature and date stamp indicating when and by whom the verification was conducted

11. Medicare Opt-Out Report
    a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
    b. This organization prohibits contracting/employing practitioners who are identified on the Medicare Opt-Out Report
    c. Practitioners will be queried for all names, current and previous
    d. Noridian, the California Medicare Administrative Contractor, is queried for Medicare Opt Out status of practitioners.
    e. The verification is evidenced on the checklist and includes the date the report was run, date it was verified, and staff initials.

12. Social Security Death Master File as applicable (based on product line)
    a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
    b. The verification is evidenced on the checklist and includes the date the report was run, date it was verified, and staff initials.

13. Office of Foreign Assets Control
    b. Verification Time Limit: 180 calendar days prior to CPRC committee decision
    c. The Office of Foreign Assets Control (OFAC) administers and enforces economic sanction programs primarily against countries and groups of individuals who are debarred from doing business in this country.
    d. The verification is evidenced on the checklist and includes the date the report was run, date it was verified, and staff initials.
    e. It is the policy of Canopy Health not to contract providers in any government line of business that are identified on the OFAC sanctions report.

14. Medi-Cal NPI Type I Enrollment Verification
    a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
    b. The verification is evidenced on the checklist and includes the date the report was run, date it was verified, and staff initials.
    c. Providers who will be contracting to provide services to Medi-Cal members must be enrolled in the Medi-Cal Program under their Type I individual NPI. If a provider is not registered or cannot show proof of enrollment with Medi-cal, it will depend on the IPA/Medical Group's decision on whether to continue to discontinue the credentialing process.

15. Medicare Enrollment Verification
    a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
    b. The verification is evidenced on the checklist and includes the date the report was run, date it was verified, and staff initials.

16. NPI Registry Verification
    a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
    b. The verification is evidenced on the checklist and includes the date the report was run, date it was verified, and staff initials.

17. Preclusion List - The Preclusion List is a list generated by CMS that contains the names of prescribers, individuals, and/or entities that are unable to receive payment for Medicare Advantage (MA) items and service and or Part D drugs prescribed or provided to Medicare beneficiaries.
    a. Preclusion list is sent by the health plans.
    b. List is checked for any precluded provider
    c. Canopy Health is notified if provider is on the list. Members will be supported in finding a new provider by the health plan or the delegated medical group as appropriate.

18. Facility Site Review: *PCP Category Physicians and Provider Extenders, if applicable*
    a. Verification Time Limit: must be within the last three years
    b. It is the policy of Canopy Health in compliance to state specific regulations that any practitioner, i.e. physician or provider extender, contracting as a PCP have a complete and current facility site review.
        (i) FSR evidence will be gathered via:
            a) *PCP Physicians in Orange County*
                (i) CalOptima Report
                (ii) If not on report, email sent to CalOptima requesting confirmation of FSR
            b) *PCP Physicians and Provider Extenders in LA County*
                (i) LA Care Website
        (ii) Confirm that practice address and Supervising Physician have a current FSR
    c. In instances where a PCP (physician or provider extender) does not have a current FSR, the Credentialing Specialist must submit a request to the appropriate health plan for processing.

I. At any time throughout the credentialing process, a practitioner has the right to review information obtained by Canopy Health for the purpose of evaluating the practitioner's credentialing application.

1. This includes non-privileged information obtained from any outside source (e.g. malpractice insurance carriers, state licensing boards, National Practitioner Data Bank), but does not extend to review of information, references or recommendations protected by law from disclosure.
2. Practitioners are notified of these rights prior to the start of the credentialing process.

d. Addendum A to the California Participating Practitioner Application notifies practitioners of their rights during and after the credentialing process

3. Canopy Health will provide documentation or provide for review at Canopy Health's offices, as allowable by this policy and law, within 72 hours of receipt of request.

J. At any time throughout the credentialing process, a practitioner has the right to be informed of the status of the credentialing application. Canopy Health will provide status within 7 business days of receipt of request.

1. Addendum A to the California Participating Practitioner Application notifies practitioners of their rights during and after the credentialing process

K. A practitioner is notified by the CD if information obtained from another source varies substantially from information provided in the application.

1. Examples of information at substantial variance include reports of a practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form.
2. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.
3. The practitioner also has the right to revise information that they may feel was submitted erroneously from another source.
    a. CD will notify the applicant by phone or in writing.
    b. The notification will include the name, email, address and telephone number of the CD.
    c. If a response is not received within two business days of Notification of Discrepancy, CD will notify the practitioner that their application is no longer in process of credentialing and will issue an administrative termination until such items are received.
    d. If a timely response is received, Canopy Health will reverify the primary source information in dispute.
        (i) If the primary source information has changed, correction will be made immediately to the practitioner's file.
        (ii) The practitioner will be notified in writing, via letter or fax, that the correction has been made.
        (iii) If upon reverficiation, primary source information remains inconsistent, the CD will notify the practitioner.

a) The practitioner may then provide proof of correction by the primary source body to Canopy Health CD within 10 business days.
b) The Credentialing Department will re-verify primary source information if such documentation is provided.
c) If after 10 business days, primary source information remains in dispute, the practitioner will be subject to administrative action.

L. The practitioner's complete application and attestation information, primary source verifications, and any other pertinent information used in determining if the provider has/has not met credentialing standards is saved in electronic format in the practitioner's record in the credentialing database.

M. Prior to CPRC review or Clean File submission to Medical Director, 10% of completed files are audited by a CD staff member who did not previously work the file to ensure completeness and consistency in information.
1. Audit Time Limit: 180 calendar days prior to CPRC committee decision
2. The credentialing application is signed and dated by the auditor to evidence review of credentialing information.
3. If the auditor identifies any deficiencies in the file, it is returned to CD for completion.
4. Any identified trends will be brought to the Manager's attention who will then ensure that proper training is complete.

N. Based on the criteria set forth in this policy and detailed further in CD1006, if the file meets the criteria for a "clean" file, a clean file list is sent to the Medical Director for signed approval. If the file does not meet the criteria for a "clean" file, a committee packet that includes all issue summaries is prepared. This packet, along with the complete credentialing file, is presented to the CPRC for review and decision. Practitioners will be notified in writing within 60 business days from receipt of initial request/application and within 30 business days of CPRC decision of their participation status with Canopy Health.

O. All of the procedures set forth in this Policy will be complete in adherence to the strict confidentiality and security standards set forth in Canopy Health's privacy and security policies and procedures.

VI. ENFORCEMENT

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with

this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VII. REFERENCES

1. NCQA: CR 1 Element A, B