Provider Credentialing and Recredentialing— CR301

Subject: Provider Credentialing and Recredentialing	**Revised Effective:** 2-20-24
Policy #: CR301	**Review Schedule:** Annual or as needed

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

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

Definitions:

DEA (Drug Enforcement Agency):	The federal agency that issues licenses to prescribe and dispense scheduled drugs.
Provider:	A state-licensed, state-certified, or state-authorized facility or a practitioner or physician delivering healthcare services to individuals.
Primary source verification:	The process by which an organization validates credentialing information from the organization that originally conferred or issued the credentialing element to the provider.
Credentials Committee	The Credentials Committee is a **"**Professional review committee" that reviews and evaluates the professional conduct of and the quality and appropriateness of patient care provided by individuals licensed under Title12, Colorado Revised Statutes. The credentials committee is a peer review or professional review committee as defined by Colorado statute, C.R.S. 12-30-202(7).

Procedures:

1. Credentialing and Recredentialing Scope

A. Colorado Access conducts credentialing and recredentialing at least every 36 months for all participating Providers who are contracted to provide health care services. Credentialing requirements apply to:

- Providers who are licensed or certified by the state to practice independently.
- Providers who have an independent relationship with Colorado Access. (Note - An independent relationship exists when Colorado Access directs its members to see a specific provider or group of providers, including all providers whom members can select as a primary care practitioner.)
- The following is a list of providers in the scope of credentialing:
    a. Medical providers
        i. Medical Doctors
        ii. Oral Surgeons
        iii. Osteopaths
        iv. Podiatrists
        v. Advanced Practice Nurses (NP, CNM, CNS)
        vi. Physician Assistants
        vii. Therapists (physical, speech, occupational)
        viii. Audiologist
        ix. Optometrist
        x. Volunteer Physicians
    b. Behavioral healthcare providers
        i. Psychiatrists
        ii. Licensed Addiction Counselors
        iii. Licensed Psychologists
        iv. Licensed Clinical Social Workers
        v. Licensed Marriage Family Therapists
        vi. Licensed Professional Counselors
        vii. Volunteer Physicians
- The criteria listed above apply to providers in the following settings:
    a. Individual or group outpatient practices
    b. Individuals practicing at Federally Qualified Healthcare Centers and Rural Health Clinics

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

- Covering Providers;
- Locum tenens;
- Providers who practice exclusively within the inpatient setting or are hospital-based and who provide care to Colorado Access members only as a result of the member being directed to the hospital or another inpatient setting (e.g. anesthesiologists, pathologists, radiologists, emergency medicine providers, neonatologists, and hospitalists);

- Providers who practice exclusively within free-standing facilities and who provide care to Colorado Access members only as result of members being directed to the facility (e.g. mammography centers, urgent care centers, surgery centers, and ambulatory behavioral health facilities);
- Dentists who provide primary dental care only under a dental plan;
- Pharmacists;
- Unlicensed Doctoral or Master's Level Providers; and
- Providers who provide services exclusively in facilities assessed as organizations by Colorado Access and provide care only as a result of members/consumers being directed to the organization. (CR305 Assessment of Organizational Providers).

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

2. Non-Discrimination

A. Colorado Access and its Credentials Committee will make credentialing and recredentialing decisions after review and consideration of information provided through an individual's application for credentials and through background checks and research. Colorado Access makes credentialing decisions based on an individual's professional competency, quality of care and the appropriateness of health services provided by the individual. This does not preclude Colorado Access from including Providers in its network who may meet certain demographic, cultural, or special needs. Colorado Access will conduct audits, at least annually or as needed, of files that suggest potential discriminatory practice at selecting practitioners or organizations, and if a practitioner complains about alleged discrimination.

B. Colorado Access requires those responsible for credentialing decisions to sign an acknowledgement form stating they do not discriminate based on an individual's gender, sexual orientation, gender identity, age, race, religion, disability, ethnic origin, national origin, and any other such prejudicial policies when making credentialing and recredentialing decisions. In addition, Colorado Access and its Credentials Committee will not discriminate against Providers seeking qualification who serve high-risk populations or who specialize in the treatment of costly conditions.

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

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

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

3. **Program Resources.** The Colorado Access Medical Directors Chair the Credentials Committee and are responsible for the clinical aspects of the credentialing department. The Chief Medical Officer (CMO) may appoint co-chairs with expertise in medical services and behavioral health. In addition to the Medical Directors and CMO, resources for the credentialing program include:
    - Manager, Credentialing Program – is responsible for the oversight of the credentialing program;
    - Credentialing Coordinators – process credentialing applications for weekly and monthly reviews;
    - Business Support Team
    - Director of Member and Provider Data Integrity; and
    - Quality Management Program.

4. Provider Rights

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

5. Delegation

A. Colorado Access may elect to delegate the functions associated with credentialing and recredentialing to a contracted entity after satisfactory completion of a pre-delegation audit and the Credentials Committee and the Compliance Department's approval of the entity's delegation status.

B. Delegated entities shall adhere to the requirements set forth in the delegation agreement and comply with delegation oversight activities conducted by Colorado Access. Colorado Access retains responsibility for ensuring that each function is performed in accordance with Colorado Access policies and those of regulatory and accreditation bodies.

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

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

6. File Maintenance and Confidentiality

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

B. Credentialing documents are maintained in either a secure electronic folder, or in the

credentialing application via web crawlers. The checklist in the application documents the verifier's name, the date the information was verified, and the verification source.

C. Annually, participants of the Credentials Committee sign a confidentiality agreement that addresses the confidential nature of the information reviewed, subsequent decisions, and conflict of interest.

7. Credentialing/Recredentialing Criteria and Verification Time Limits

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

Verification	Required at Credentialing (C) or Recredentialing (R)	Verification Time Limit
Completed application, including signed and dated attestation and authorization	C R	Within 365 calendar days of credentialing decision
Enrolled and validated for Medicaid and/or CHP HMO	C R	Must be enrolled and validated prior to credentialing and recredentialing
Licensure – current and unrestricted license to practice in the state at which they are practicing	C R	Within 180 calendar days of credentialing decision; license must be valid at time of credentialing decision
DEA or CDS certificates (if applicable) – current and unrestricted in state at which they are practicing	C R	None. Certificate must be effective at time of credentialing decision
Education and Training – satisfactory completion of residency or graduate program, or medical school	C	Within 180 calendar days of credentialing decision
Board Certification – if provider states they are board certified, and certification is in field of practice	C R	Within 180 calendar days of credentialing decision
Work History – a minimum of the most recent five years, or since their license was issued	C	Within 180 calendar days of credentialing decision
Malpractice Coverage – with minimum limits of liability of $1 million and $3 million	C R	Showing effective and expiration dates
Malpractice History/Medicare and Medicaid Sanctions	C R	Within 180 calendar days of credentialing decision

Collecting and reviewing complaints and information from identified adverse events – for all providers that fall under the scope of credentialing, and have a complaint filed	R	Upon notification of a complaint meeting the thresholds

8. Credentials Committee

A. Colorado Access maintains a heterogeneous Credentialing Committee Membership. Voting membership must be representative of the Colorado Access network. Some examples are, but not limited to include the following:

1. Psychiatrist
2. Psychiatric NP
3. Psychologist
4. Licensed Addiction Counselor (LAC)
5. Licensed therapist (LPC, LCSW, or LMFT)
6. Pediatric Provider
7. Primary Care Provider (Physician, NP, or PA)
8. Various Medical Specialist

Ex officio non-voting membership shall include the Sr. VP of Medical Services or designee and Credentialing Program Manager/Coordinators.

B. The Credentials Committee is designated as a peer review body. A simple majority of the Credentials Committee members will be a participating provider in the Colorado Access provider network who does not participate in the administrative aspects of the organization.

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

D. The Credentials Committee will have a specialist available to weigh in on a case if the Credentials Committee is unable to come to a decision. The chair or co-chair will seek the expert's input to present to the Credentials Committee.

E. Responsibilities of the Credentials Committee include:

- At least annually reviewing and approving the credentialing and recredentialing criteria, policy, procedures, and the process used to make credentialing and recredentialing decisions:
- Review and determine participation status of Providers who, at a minimum, do not meet the established credentialing criteria. The Committee may review a list of Providers who "meet criteria" if the Senior Medical Director or designee is not available to review and approve these Providers;
- Review and accept a list of delegated approved Providers;
- Approval of new Credentials Committee members;
- Ongoing monitoring of credentialed Providers, as described in Sections 10 and 11, below.

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

9. Credentialing and Recredentialing Application

A. Colorado Access requires all Providers to complete a credentials application to obtain and validate information attested to by the Provider that allows thorough evaluation for participation or continued participation. Colorado Access utilizes the Council for Affordable Quality Healthcare (CAQH) to obtain applications for credentialing and recredentialing. Colorado Access credentials providers within forty-five (45) calendar days for at least ninety percent (90%) of all provider applications.

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

C. If credentialing staff does not have the necessary information for recredentialing, a notification will be sent requesting the information at least thirty (30) calendar days prior to the recredentialing deadline. The notification will state that, without the information, the practitioner will be administratively terminated. The notification will be saved in the practitioner's file. If the practitioner is subsequently terminated for lack of information, the termination notice should be in the practitioner's file.

10. Ongoing Monitoring

A. Colorado Access conducts ongoing monitoring of credentialed Providers.

B. Colorado Access monitors available information regarding Medicare and Medicaid sanctions or exclusions, Colorado State licensing sanctions or limitations on licensure, Provider- specific member grievances, quality and/or patient safety issues and occurrences of adverse events.

C. Providers are required to notify Colorado Access if adverse actions are imposed on the provider by Medicare or Medicaid, or by any Colorado licensing board.

D. If a Provider is the subject of an adverse action taken against the Provider's credential or privileges by another entity, Colorado Access will retrieve documentation from the entity, if available. Failure by the Provider to comply with the corrective action plan as set forth by the

credentialing entity will be evidenced through ongoing monitoring activities as outlined in this policy.

11. **Participating Provider Quality Monitoring and Appeal Process.** Quality monitoring occurs continually during the credentialing cycle to ensure our Members' health and welfare. The Quality Management Department forwards quality of care concerns to the Credentialing department upon identification. The Credentialing department forwards such concerns to the Credentials Committee. The Credentials Committee may further investigate quality of care concerns and/or take action. Actions include but are not limited to: corrective action plans, limiting, suspending, or denying participation in the Colorado Access provider network until certain conditions improving provider performance are met, and termination from the network. Actions taken by the Credentials Committee may be appealed by the impacted provider within thirty (30) calendar days of receiving written notice of such actions. The impacted provider may appeal such actions by sending a written appeal letter and any supporting documentation that the impacted provider would like the Credentials Committee to reconsider during their review of the appeal. The Credentials Committee will have sixty (60) calendar days to review the appeal and provide written notice to the impacted provider of the result of the appeal.

12. **Reporting to the Appropriate Authorities.** Credentialed providers are subject to investigation and action based on quality concerns at any time. Certain actions may require potential reporting to appropriate authorities, including the National Practitioner Data Bank and the Provider's licensing board.

13. **Verification Process**

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

    B. Validation/Enrollment

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

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

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

- Primary source verification for Prescriptive Authority (RXN or RXN-P) is obtained from the Department of Regulatory Agencies (DORA) is acceptable source.
- For any DEA-eligible practitioner who does not have a DEA, and for whom prescribing controlled substances is within the scope of their practice, credentialing staff will note the lack of DEA and obtain documentation of the practice/practitioner who will write prescriptions on behalf of the applicant. If the practitioner states in writing that they do not prescribe controlled substances and that patients under their care do not require such substances, the file documentation in the credentialing file must indicate this and describe the provider's process for handling situations when a patient requires a controlled substance.

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

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

- OT board certification is verified with the National Board for Certification in Occupational Therapy website https://www.nbcot.org/en.

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

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

I. Malpractice History, Medicare/Medicaid Sanctions and Licensure Sanctions

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

   2. Verification of licensure sanctions:
      - For Physicians, verification is performed via the National Practitioner Databank-Healthcare Integrity and Protection Databank (NPDB-HIPDB), Federation of State

Medical Boards (FSMB) or the appropriate state licensing agency.

- For dentists, the State Board of Dental Examiners or the NPDB-HIPDB.
- For podiatrists, the State Board of Podiatric Examiners or Federation of Podiatric Medical Boards.
- For all other Providers, the appropriate state licensing agency.

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

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

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

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

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

A. The Credentialing Staff evaluates the file and assigns a classification level of Level 1 (LI) or Level 3 (L3). Files are processed according to the defined Level.
   - **Level 1 Criteria (meets criteria):**
     1. At recredentialing, issues were reviewed during the previous credentialing cycle and no additional issues have been identified
     2. Absence of hospital privileges
     3. Voluntary resignation without adverse action from the hospital medical staff because of relocation, or the provider no longer wishes to maintain active hospital privileges
     4. A physician who has completed the requisite training within the last three (3) years and is not yet board certified
     5. A physician who has never been board certified, but has had formal training in the field of practice, and does not have any other issues
     6. A physician who has allowed their board certification to lapse, and has no other issues
     7. An allied provider (PA, SLP, AUD, OT) who is not board certified, or has allowed their certification to lapse, and has no other issues
     8. Open/pending malpractice case(s)
     9. Malpractice case(s) that occurred during residency, medical school, or training programs

10. Withdrawn or dismissed case(s) where no monies have been paid on behalf of the provider
11. Past history of a managed care organization discontinuing the relationship with the provider unless the relationship was discontinued for an adverse action
12. A complaint that was filed by a patient to the State Board, which was dismissed by the Board and no further action was taken
13. Licensure sanctions or restrictions that include revocation, suspension, stipulation, or letter of admonition, etc., that have been previously reviewed and no further action has been taken by the licensing board
14. Work history gaps of less than five years, with no other issues
15. Any licensure sanctions, restrictions, malpractice cases, or issues that are greater than ten (10) years old

- **Level 3 Criteria (does not meet criteria):**
  1. Licensure sanctions or restrictions from any state that include revocation, suspension, stipulation, or letter of admonition, etc. in the past ten (10) years
  2. DEA restrictions
  3. Hospital privilege suspension, restriction, revocation, non- renewal, refusal or denial, or where the hospital extended the provisional period
  4. Two or more malpractice cases in the last five (5) years or three or more malpractice cases in the last ten (10) years
  5. Any settled malpractice cases involving death in the last ten (10) years
  6. Denial, cancellation, restriction, or renewal denial of professional liability insurance
  7. Past history of a managed care organization discontinuing the relationship with the provider that was discontinued for an adverse action
  8. Any reportable incident appearing on the NPDB outside of a malpractice settlement within the past ten (10) years
  9. "Yes" answers on any of the attestation questions other than those already specifically addressed
  10. Certification by the specialty board that has been suspended or revoked or denied
  11. A CNM who is not board certified or has allowed certification to lapse
  12. The physician is requesting to participate in a specialty for which the physician does not have the necessary formal education, training, experience and/or board certification
  13. Work History gap of greater than five years
  14. An adverse event or complaint has been filed with Colorado Access at the time of recredentialing.

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

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

15. Credentialing Determination Notification

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

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

16. Provider Listings in the Directories

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

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

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

17. Credentialing System Controls. Colorado Access implements controls to ensure security and integrity of credentialing information.

A. Colorado Access receives all primary source verified data electronically in the following ways: web crawlers and the internet. The data is saved in the credentialing software (web crawlers) or in a shared drive folder (internet). All data is tracked in a checklist as part of the credentialing software.

B. Modified data is tracked and dated in the electronic checklists that are generated in the

credentialing application at every credentialing cycle. Upon completion of the verification process, a report is generated and saved in the provider's folder, which summarizes who and when each primary source verification was modified.

C. Credentialing Coordinators, Provider Data Analysts, Business Support Analysts, and the Credentialing Manager are authorized to review, modify, and delete information in the credentialing software system. Deleting data is only necessary if the original data entered was incorrect.

D. Only the staff mentioned in 17.C. above are authorized to modify data in the credentialing software, which is password protected by the user's Windows log in information. The credentialing software system can only be accessed in the office or using the Colorado Access VPN. All other users are assigned to a user group with read-only access in the system. The electronic folders are only available to these staff and are not made available companywide.

E. Business Support Analysts audit initial and recredentialing files daily for compliance with NCQA standards and they share the results with the Credentialing Coordinator and Credentialing Manager. The Credentialing Coordinators make updates to correct the system immediately when errors are found. The auditors are members of the Business Support team and report to the Director of Member and Provider Data Integrity. The audit results are summarized by the Business Support Analyst and shared with the Director of Member and Provider Data Integrity and the Credentialing Manager monthly. The Credentialing Coordinators also receive their own monthly summaries of errors found.

1. For new credentialing staff, 100% of the files are audited until the audit score is at least 95%. Once a staff person reaches a score of 95%, the auditors review 25% of the staff's files.
2. If there is one or more findings in an audit, the rest of the staff's files will be audited for the applicable element(s).
3. Regular auditing is conducted using the logic below:

   95%– 100% accuracy - audit 25% of all files
   90% – 94.9% accuracy - audit 50% of all files
   85% – 89.9% accuracy - audit 75% of all files
   below 85% accuracy - audit 100% of all files

F. Annual audits are conducted in June by the Credentialing Manager to identify all modifications to credentialing information that did not meet our policies and procedures. The Credentialing Manager will then analyze all instances of such modifications that did not meet our policy and will act on the findings by implementing a quarterly monitoring process until improvement is demonstrated over three consecutive quarters.