Policy and Procedure

Policy Name: Provider Credentialing and Recredentialing	**Policy#:** CR-301	**Version#:** 39
Author Department: Credential Management	**Origination Date:** 01/1997	
Business Units Impacted: Credentialing, Provider Contracting, Provider Configuration	**Date Last Reviewed:** 01/20/2026	
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DEFINITIONS:

Adverse Event: An unexpected or undesirable outcome that is associated with the care provided to a member. Examples are injury, harm, or death from medical management or a situation where care did not go as intended.

Credentials Committee: The Credentials Committee is a “Professional review committee" that reviews and evaluates the professional conduct, 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, C.R.S. § 12-30-202(7).

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

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.

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

SCOPE:

This policy applies to all contracted providers in the scope of credentialing.

PURPOSE:

The purpose of this policy is to ensure that Colorado Access (COA or organization) is compliant with National Committee for Quality Assurance (NCQA) credentialing standards.

STATEMENT OF POLICY:

To maintain a quality provider network, COA will establish credentialing and recredentialing criteria and processes to evaluate and determine participation status for providers who are either applying for network participation (credentialing) or continued network participation (recredentialing). The COA credentialing program will satisfy the most recent applicable regulations/standards/instructions as required by NCQA, Centers for Medicare and Medicaid Services (CMS), Division of Insurance (DOI), Health Care Policy and Financing (HCPF), COA, and/or any other applicable federal or state regulatory authority. COA performs full credentialing of its providers and does not provisionally credential anyone.

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PROCEDURES:

A. Credentialing and Recredentialing Scope

1. COA conducts credentialing and recredentialing at least every 36 months for all participating providers who are contracted to provide health care services. Providers provide care to members under the organization's behavioral and medical benefits. Credentialing requirements apply to:
    - Providers who are licensed or certified by the state to practice independently.
    - Providers who have an independent relationship with COA. (Note - An independent relationship exists when COA directs its members to see a specific provider or group of providers, including all providers whom members can select as a primary care provider.)
2. The following is a list of providers in the scope of credentialing:
    a. Medical providers
        - Medical Doctors
        - Oral Surgeons
        - Osteopaths
        - Podiatrists
        - Advanced Practice Nurses (NP, CNM, CNS)
        - Direct Entry Midwives
        - Certified Midwives
        - Physician Assistants
        - Therapists (physical, speech, occupational)
        - Audiologist
        - Optometrist
        - Volunteer Physicians

    b. Behavioral healthcare providers
        - Psychiatrist
        - Licensed Addiction Counselors
        - Licensed Psychologists
        - Licensed Clinical Social Workers
        - Licensed Marriage Family Therapists
        - Licensed Professional Counselors
        - Volunteer Physicians

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3. The criteria listed above applies to providers in the following settings:
    - Individual or group outpatient practices
    - Individuals practicing at Federally Qualified Healthcare Centers, Rural Health Clinics, and School Based Clinics

4. Providers that are excluded from the credentialing process are listed below. However, COA 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 COA 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 COA 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 COA members only as a 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.
    - Chiropractors
    - Unlicensed doctoral or master's level providers; and
    - Providers who provide services exclusively in facilities assessed as organizations by COA and provide care only as a result of members/consumers being directed to the organization. (CR305 Assessment of Organizational Providers).

5. 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.

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B. Non-Discrimination

1. COA and its Credentials Committee will make credentialing and recredentialing decisions after reviewing and consideration of information provided through an individual's application for credentials and through background checks and research. COA makes credentialing decisions based on an individual's professional competence, quality of care, and the appropriateness of health services provided by the individual. This does not preclude COA from including providers in its network who may meet certain demographic, cultural, or special needs. COA tracks if a provider reports any discrimination during the credentialing process, and will conduct audits, at least annually or as needed, of files that suggest potential discriminatory practices at selecting providers or organizations, and if a provider complains about alleged discrimination. To further ensure prevention of discrimination, the files presented to the Credentialing Committee will be listed as Provider A, Provider B, etc. rather than by name. Documentation reviewed will have race, ethnicity, and gender redacted.

2. COA 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, COA 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.

3. COA 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.

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

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C. Program Resources

1. The COA Medical Directors Chair the Credentials Committee and are responsible for the clinical aspects of the credentialing department. They are responsible for reviewing and approving files that meet established criteria daily through Docusign. 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

D. Provider Rights

1. Providers have the right to review the information submitted in support of the credentialing application as permitted by law.

2. Providers will be notified during the credentialing process if information obtained varies substantially from provider's information. Some examples are actions on a license, malpractice claims history, board certification status, and whether they have the ability to perform their job.

3. Credentialing staff sends up to three email attempts to the provider describing which answer(s) need updating on the application based on the findings during the credentialing process. The staff does not reveal what was found but does include the verification sources used. All outreaches are saved in the provider's folder.

4. If, after three attempts, not to exceed 21 business days, the provider has not corrected the information in the Council for Affordable Quality Healthcare (CAQH), the provider will be withdrawn from the credentialing process. COA can share information with providers that relates to the status of their application, what erroneous information needs to be updated, and what resources were used to primary source verify information.

5. 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.

6. Credentialing Coordinators notify providers of time frames for completing corrections in CAQH or providing missing or expired documentation via email. COA processes several requests from providers in our personal emails, and also to the credentialing email box regarding the status of their application. COA responds to these emails the same day. These provider rights are included in the credentialing application, in the provider manual, and are published at least annually in the provider newsletter.

E. Delegation

1. COA 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.

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

3. COA retains the right to terminate providers in situations where it has delegated credentialing and re-credentialing activities (see policy and procedure ADM223 Delegation). COA retains authority to make the final credentialing determination regarding any provider, including providers credentialed through delegated entities.

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

F. File Maintenance and Confidentiality

1. 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.

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2. 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.

3. 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.

G. 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 180 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 120 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 120 calendar days of credentialing decision

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Board Certification – if provider states they are board certified, and certification is in field of practice	C R	Within 120 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 $500,000 per incident and $1,500,000 in aggregate	C R	Showing effective and expiration dates
Malpractice History/Medicare and Medicaid Sanctions	C R	Within 120 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

H. Credentials Committee

1. Colorado Access maintains a heterogeneous Credentialing Committee Membership. Voting membership must be representative of the COA network. Some examples are, but not limited to include the following:
    - Psychiatrist
    - Psychiatric NP
    - Psychologist
    - Licensed Addiction Counselor (LAC)
    - Licensed therapist (LPC, LCSW, or LMFT)
    - Pediatric Provider
    - Primary Care Provider (Physician, NP, or PA)
    - Various Medical Specialist

2. Ex officio non-voting membership shall include the Medical Director and Credentialing Program Manager/Coordinators.

3. The Credentials Committee is designated as a peer review body who provide meaningful

advice and expertise when making credential decisions.

4. The Credentials Committee participants consider the applications of providers for initial and ongoing participation in the COA provider network.

5. 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.

6. 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:
    - Reviewing and determining 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.
    - Reviewing and accepting a list of delegated approved providers.
    - Reviewing pre-delegation and annual delegation audit results.
    - Approval of new Credentials Committee members.
    - Ongoing monitoring of credentialed providers, as described in CR310 Ongoing Monitoring and Interventions.

7. 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 a minimum, the Credentials Committee will meet on a quarterly basis.

I. Credentialing and Recredentialing Application

1. COA 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. COA utilizes theCAQH to obtain applications for credentialing and recredentialing. COA credentials providers within forty-five (45) calendar days for at least ninety percent (90%) of all provider applications.

2. The provider's credentialing and recredentialing processes begin with the completion of an application, signed and dated attestation and submission of requested documentation

to either CAQH or COA. 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.
- Provider race, ethnicity, and language
- Current and signed attestation confirming the correctness and completeness of the application.

3. 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 provider will be administratively terminated. The notification will be saved in the provider's file. If the provider is subsequently terminated for lack of information, the termination notice should be in the provider's file.

J. Reporting to the Appropriate Authorities and Practitioner Appeal Rights

1. 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 (NPDB) and the provider's licensing board. The Credentials Committee may take action as a result of ongoing monitoring findings. Actions include but are not limited to corrective action plans, limiting, suspending, or denying participation in the COA 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.

K. Verification Process

1. 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.

2. Validation/Enrollment
    a. 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)

3. Licensure
    a. Current valid license and investigation of restrictions, limitations or sanctions are reviewed using the Department of Regulatory Agencies (DORA) website: https://apps2.colorado.gov/dora/licensing/lookup/licenselookup.aspx.
    b. The provider must have an active and unrestricted license to practice.
    c. Sanction activity, which may have occurred in other states, is obtained through a query of the NPDB.

4. DEA, CDS (Controlled Dangerous Substances) and Prescriptive Authority Certificates are verified for providers who indicate they prescribe controlled substances.
    a. 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 and needs to have a stamp of when it was saved/reviewed.
    b. Primary source verification for Prescriptive Authority (RXN or RXN-P) is obtained from DORA
    c. For any DEA-eligible provider who does not have a DEA certificate, and for whom prescribing controlled substances is within the scope of their practice, credentialing staff will note the lack of DEA certificate and obtain documentation of the practice/provider who will write prescriptions on behalf of the applicant. If the provider 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.

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5. Education and Training
    a. 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.
    b. 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 American Medical Association (AMA): https://commerce.ama-assn.org/amaprofiles/, or American Osteopathic Association (AOA): https://aoaprofiles.org/ Master File (Physician Profile).
    c. 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).

6. Board Certification
    a. Board certification is verified for MDs, DOs, DDSs, and DPMs only if the provider has indicated they are board certified.
    b. 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): https://certifacts.abms.org/Login.aspx, the AMA or AOA Physician Profile.
    c. DPM board certification is verified through the American Board of Foot and Ankle Surgery (ABFAS): https://verifications.abfas.org/. SLP and AUD board certification is verified with the American Speech Language Hearing Association website http://www.asha.org/Certification/cert-verify.
    d. 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.
    e. PA board certification is verified with NCCPA website https://www.nccpa.net/.

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

7. Work History
   a. 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.
   b. 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.

8. Malpractice Insurance Coverage
   a. COA requires providers to carry minimum professional liability insurance coverage amounts of $500,000 per incident and $1,500,000 million in aggregate.
   b. 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.
   c. 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 $500,000 per incident and $1,500,000 million in aggregate. A copy of the current FTCA certificate including a letter from the group the Provider is joining or/with will be sufficient. The document needs to have a stamp of when it was saved/reviewed.

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9. Malpractice History, Medicare/Medicaid Sanctions and Licensure Sanctions
    a. 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.

10. Verification of licensure sanctions
    a. 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.
    b. For dentists, the State Board of Dental Examiners or the NPDB-HIPDB.
    c. For podiatrists, the State Board of Podiatric Examiners or Federation of Podiatric Medical Boards.

11. For all other providers, the appropriate state licensing agency.
    a. COA does not offer chiropractic benefits and therefore, does not credential chiropractors.
    b. Verification of Medicare/Medicaid sanctions and exclusions:
        - NPDB-HIPDB, FSMB, Office of Inspector General (OIG) database, System for Award Management (SAM), or the American Medical Association (AMA) Physician Master File for physicians.
    c. 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.

12. Appropriate documentation
    a. COA documents verification in the credentialing files using primary source verification of credentialing documents that are dated. A checklist is saved to the provider file that includes the date of the verification, the username of the person who completed the verification, and the actual completion date of the verifications.

L. Decision-making Criteria and Process

COA credentials providers before providing care to members. The credentialing criteria

below are designed to assess a provider's ability to deliver quality care. The criteria is reviewed at least annually by the Credentialing Committee. 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. The Committee makes a final determination regarding which providers may participate in its network, based on the following criteria.

NOTE: Settlement/payment date of a claim and the date of the Credentials Committee are used to determine the level of review required.

1. 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.
   a. **Level 1 Criteria (meets criteria):**
      i. At recredentialing, issues were reviewed during the previous credentialing cycle and no additional issues have been identified
      ii. Absence of hospital privileges
      iii. Voluntary resignation without adverse action from the hospital medical staff because of relocation, or the provider no longer wishes to maintain active hospital privileges
      iv. A physician who has completed the requisite training within the last three (3) years and is not yet board certified
      v. 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
      vi. A physician who has allowed their board certification to lapse, and has no other issues
      vii. An allied provider (PA, SLP, AUD, OT) who is not board certified, or has allowed their certification to lapse, and has no other issues
      viii. Open/pending malpractice case(s)
      ix. Malpractice case(s) that occurred during residency, medical school, or training programs
      x. Withdrawn or dismissed case(s) where no monies have been paid on behalf of the provider
      xi. Past history of a managed care organization discontinuing the relationship with the provider unless the relationship was discontinued for an adverse action
      xii. A complaint that was filed by a patient to the State Board, which was dismissed by the Board and no further action was taken

xiii. 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
xiv. A letter of admonition issued for not responding to the State Board, with no other adverse actions
xv. Work history gaps of less than five years, with no other issues
xvi. Any licensure sanctions, restrictions, malpractice cases, or issues that are greater than ten (10) years old

b. Level 3 Criteria (does not meet criteria):

i. Licensure sanctions or restrictions from any state that include revocation, suspension, stipulation, or letter of admonition, etc. in the past ten (10) years
ii. DEA restrictions
iii. Hospital privilege suspension, restriction, revocation, non- renewal, refusal or denial, or where the hospital extended the provisional period
iv. Two or more malpractice cases in the last five (5) years or three or more malpractice cases in the last ten (10) years
v. Any settled malpractice cases involving death in the last ten (10) years
vi. Denial, cancellation, restriction, or renewal denial of professional liability insurance
vii. Past history of a managed care organization discontinuing the relationship with the provider that was discontinued for an adverse action
viii. Any reportable incident appearing on the NPDB outside of a malpractice settlement within the past ten (10) years
ix. “Yes” answers on any of the attestation questions other than those already specifically addressed, at the Manager’s discretion
x. Certification by the specialty board that has been suspended or revoked or denied
xi. A CNM who is not board certified or has allowed certification to lapse
xii. 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
xiii. Work History gap of greater than five years
xiv. An adverse event or complaint has been filed with Colorado Access at the time of recredentialing.

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2. **Level 1.** On a daily basis, the Credentialing Staff will provide a list of names meeting L1 criteria to the Senior Medical Director or designee through Docusign, 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.

3. **Level 3.** All Level 3 files are forwarded to the Credentialing Committee for review to make a final determination regarding which providers may participate in the network. The Credentialing Staff gathers the applicable information and completes a brief narrative describing the issue(s) being presented. The Committee members may request additional information such as a letter of recommendation, or more details surrounding the case. This information is retrieved by the Credentialing Staff and the requested information is brought back to the next scheduled meeting for further review.

M. Credentialing Determination Notification

1. Providers undergoing initial credentialing are notified in writing within thirty (30) days of the decision, however our internal process is to send notifications on a weekly basis. Providers denied participation during initial credentialing, or who are terminated during the recredentialing process, are notified in writing within ten (10) business days and the documentation is filed in the provider's credentialing folder. The Provider Contracting team is notified of any providers denied.

2. 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 COA claims transaction system by the Configuration Team with an effective date of approval.

N. Provider Listings in the Directories

1. COA ensures that all information provided in member materials of credentialed providers whose information is included in directories, newsletters, websites, and other materials intended for member use is consistent with the information verified during the credentialing process. Any discrepancies identified between credentialing files and published materials are investigated and corrected prior to publication. The directory data file is refreshed every day, to reflect changes and updates made daily. Updates to provider information are not published until the credentialing verifications

Policy Name: Provider Credentialing and Recredentialing	**Policy#:** CR-301	**Version#:** 39
Author Department: Credential Management	**Origination Date:** 01/1997	
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and approvals are complete. Board certification for physicians is listed in the directory, but fellowship data is not available for members in the online directory. Active hospitals are collected from the attestation of the CAQH application for physicians. These hospitals will appear in the directory and can be selected as part of the member search process.

2. 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 clean files.

3. 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 COA's 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.

REFERENCES:
PBC DP21 Monthly Provider Exclusion Checks
CR310 Ongoing Monitoring and Interventions

ATTACHMENTS: None

POLICY HISTORY:

SUMMARY OF REVIEW/REVISION/APPROVAL DATES:
Version 1: 01/01/1997, Version 2: 10/01/2004, Version 3: 12/01/2005, Version 4: 11/01/2006, Version 5: 08/01/2007, Version 6: 01/01/2008, Version 7: 04/01/2008, Version 8: 06/01/2008, Version 9: 05/01/2009, Version 10: 11/01/2009, Version 11: 01/01/2011, Version 12: 12/01/2011, Version 13: 06/01/2012, Version 14: 09/01/2012, Version 15: 01/01/2013, Version 16: 02/01/2013, Version 16: 05/01/2013, Version 17: 05/01/2014, Version 18: 10/01/2014, Version 19: 02/19/2015, Version 20: 03/23/2017, Version 21: 09/15/2017, Version 22: 10/02/17, Version 23: 12/14/2017, Version 24: 12/14/2017, Version 25: 07/01/2018, Version 26: 10/01/2019, Version 29: 11/01/2019 Version 30: 03/19/2020, Version 31: 10/21/2020, Version 32: 05/06/2021, Version 33: 07/01/2022, Version 33: 06/20/2023, Version 34: 02/25/2024, Version 35: 06/26/24 Version 36: 02/27/2025, Version 37: 06/26/2025, Version 38: 10/29/2025 NCQA updates, Version 39: 01/22/2026 removing ongoing monitoring language into new policy CR310

Policy and Procedure

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APPROVAL BODY: COA Core Policy Team **APPROVAL DATE:** 01/22/2026