Providence Health Plan

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2026 NCQA Credentialing Crosswalk

NCQA Element/Factor	Internal materials
CR 1: Policies and Procedures	
Element A - Practitioner Credentialing Guidelines	
Factor 1: Types of practitioners it credentials and recredentials	CR 2.0, pg 2-3 section Policy
Factor 2: The verification sources it uses	CR 2.0 pg 26-31 section V
Factor 3: The criteria for credentialing and recredentialing	CR 2.0 pg 1 section Policy CR 2.0 pg 4-24 Criteria Grid, sections I Credentialing procedure, section II Recredentialing procedure includes the following: and section III Nonresponsive to Credentialing Requests
Factor 4: The process for making credentialing and recredentialing decisions	CR 2.0 pg 1 section Policy CR 2.0 pg 5-24 Criteria Grid, sections I Credentialing procedure, section II Recredentialing procedure includes the following: and section III Nonresponsive to Credentialing Requests
Factor 5: The process for managing credentialing files that meet and do not meet the organization's established criteria	CR 1.0 pg 1 section I and pg 3 section III.F Responsibilities CR 3.0 pg 2 section Procedure E
Factor 6: The criteria for practitioner sanctions, complaints and other adverse events found during ongoing monitoring that need to be reviewed by the Credentialing Committee or other designated peer review body.	CR 1.0 pg 3 Section III.H CR 9.0 pg 1-2 section Policy pg 2 section I CR 9.0 pg 10 section II B
Factor 7: The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner	CR 1.0 pg 5 section-IV A CR 1.0 pg 5 Section IV B.2 CR 1.0 pg 5 section-IV B.3
Factor 8: The process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information, they provided to the organization	CR 4.0 pg 3 section II. A
Factor 9: The process for ensuring that practitioners are notified of the credentialing and recredentialing decision within 30 calendar days of the credentialing committee decision	CR 2.0 pg 2 section Policy
Factor 10: The medical director or other designated physicians' direct responsibility and participation in the credentialing program	CR 3.0 pg 1-2 A-E
Factor 11: The process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law	CR 1.0 pg 4, section III. J-K CR 4.0 pg 5 section IV A-B CR 17.0 pg 4 section II.D Confidentiality Agreement

NCQA Element/Factor	Internal materials
Factor 12: The process for ensuring listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty	CR 2.0 pg 36 section XII
Factor 13: The process for documenting information and activities in credentialing files.	CR 2.0 pg 33 section VI.C
Element B – Practitioner Rights	
Factor 1: Review information submitted to support their credentialing application	CR 4.0 pg 2 section I A-C
Factor 2: Correct erroneous information	CR 4.0 pg 3-4 section II A-F
Factor 3: Receive the status of their credentialing or recredentialing application, upon request	CR 4.0 pg 4-5 section III A-C
CR2: Credentialing Committee	
Element A Credentialing Committee	
Factor 1: Uses participating practitioners to provide advice and expertise for credentialing decisions.	CR 1.0 pg 3 section II B
Factor 2: Reviews credentials for practitioners who do not meet established thresholds.	CR 1.0 pg 2 section I CR 1.0 pg 3 section III Responsibilities B, C and F
Factor 3: Ensures that files that meet established criteria are reviewed and approved by a medical director or designated physician. *All meeting minutes and clean file lists are located in the T drive	CR 1.0 pg 3-4 section III G CR 3.0 pg 1 section Policy CR 3.0 pg 2 Procedure E
CR3: Credentialing Verification	
Element A Verification of Credentials	
Factor 1 A current and valid license to practice. (120 days)	Verification conducted during credentialing file audit
Factor 2 A valid DEA or CDS certificate, if applicable.	
Factor 3 Education and training as specified in the explanation.	
Factor 4 Board certification status, if applicable. (120 days)	
Factor 5 Work history. (180 days)	
Factor 6 A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner. (120 days)	
Element B Sanction Information	
Factor 1: State sanctions, restrictions on licensure or limitations on scope of practice. (120 days)	Verification conducted during credentialing file audit
Factor 2: Medicare and Medicaid Sanctions (120 days)	
Factor 3: Medicare and Medicaid Exclusions (120 days)	
Element C Credentialing Application	
Factor 1 Reasons for inability to perform the essential functions of the position (180 days)	Verification conducted during credentialing file audit – All factors in Element C are found on the OPCA & OPRA attestation
Factor 2 Lack of present illegal drug use. (180 days)	
Factor 3 History of loss of license and felony convictions. (180 days)	
Factor 4 History of loss or limitation of privileges or disciplinary actions. (180 days)	
Factor 5 Current malpractice insurance coverage. (180 days)	
Factor 6: Practitioner race, ethnicity and language (180 days)	
Factor 7: Current and signed attestation confirming the correctness and completeness of the application. (180 days)	
CR4: Recredentialing Cycle Length	
Element A – Recredentialing Cycle Length	

NCQA Element/Factor	Internal materials
The length of the recredentialing cycle is within the required 36-month time frame. (within 3 years to the day for OR Medicare/Medicaid)	Verification conducted during on-site credentialing file audit
Element A - Ongoing Monitoring and Interventions	
Factor 1: Collecting and reviewing Medicare and Medicaid sanctions	CR 9.0 pg 2-3 section I. A & B
Factor 2: Collecting and reviewing Medicare and Medicaid exclusions	CR 9.0 pg 3 section I.C & D
Factor 3: Collecting and reviewing sanctions, limitations and expiration on licensure	CR 9.0 pg 4 section I.F CR 9.0 pg 4 section I. G
Factor 4: Collecting and reviewing complaints	CR 9.0 pg 4-7 section I.H.1 and 2
Factor 5: Collecting and reviewing information from identified adverse events	CR 9.0 pg 4-6 section I.H.1
Element B - Appropriate Interventions	
Appropriate interventions	CR9.0 pg 1-2 section Policy CR9.0 pg 8-10 section II. A-B
Element A-Actions Against Practitioners	
Factor 1: The range of actions available to the organization	CR 9.0 pg 1 section Policy second paragraph CR 9.0 pg 8-10 section II Implementing Interventions sub-section A & B CR 9.0 pg 2 section Policy fourth paragraph-Reporting CR 9.0 pg 10-12 section III Reporting Process CR 10.0 pg 5 section II D CR 10.0 pg 3 section I Actionable Issues B.1
Factor 2: Making the appeal process known to practitioners	CR 10.0 pg 4-6 section III Appeal Process A & B
Element A Review and Approval of Provider	
Factor 1: Confirms that the provider is in good standing with state and federal regulatory bodies.	CR 11.0 pg 3, section I B.1 CR 11.0 pg 8-12 section IV
Factor 2: Confirms that the provider has been reviewed and approved by an accrediting body.	CR 11.0 pg 4-5 section I B.11 CR 11.0 pg 8-12section IV
Factor 3: Conducts an onsite quality assessment if the provider is not accredited.	CR 11.0 pg 5-6 section I B.12
Element B Medical Providers	
Factor 1 Hospitals	CR 11.0 pg 1, section Applies to:
Factor 2 Home health agencies.	CR 11.0 pg 1, section Applies to:
Factor 3 Skilled nursing facilities.	CR 11.0 pg 1, section Applies to:
Factor 4 Free-standing surgical centers	CR 11.0 pg 1, section Applies to:
Element C Behavioral Healthcare Providers	
Factor 1 Inpatient	CR 11.0 pg 1, section Applies to:
Factor 2 Residential	CR 11.0 pg 1, section Applies to:
Factor 3 Ambulatory	CR 11.0 pg 1, section Applies to:
Element D Assessing Medical Providers	
Assessment of medical providers tracking log	Verification conducted during credentialing file audit
Element E Assessing Behavioral Healthcare Providers	
Assessment of behavioral provides tracking log	Verification conducted during credentialing file audit

NCQA Element/Factor	Internal materials
CR8: Credentialing Information Integrity	
Element A – Protecting the Integrity of Credentialing Information	
Factor 1: The scope of credentialing information	CR 17.0 pg 2 section I
Factor 2: The staff responsible for performing credentialing activities	CR 17.0 pg 1 section Policy and pg 3-4 section II.A and B
Factor 3: The process for documenting updates to credentialing information	CR 17.0 pg 4-5 section III.A and B
Factor 4: Inappropriate documentation and updates	CR 17.0 pg 5 section III.A.3
Factor 5: The organization audits CR staff and the process for documenting and reporting identified information integrity issues	CR 17.0 pg 5-6 section IV.A, B and pg 8 section V. C and D
Element B – Information Integrity Training	
Factor 1: Inappropriate documentation and Updates (Element A factor 4)	CR 17.0 pg 8-9 section VI.A and B
Factor 2: Organization audits of staff, documenting and reporting information integrity issues (Element A, factor 5)	CR 17.0 pg 8-9 section VI.A and B
Element C – Audit and Analysis	
Factor 1: Audits for inappropriate documentation and updates to credentialing information	CR 17.0 pg 5 section IIIA.3 pg 6-7 section IV.B and C Audit tool
Factor 2: Conducts qualitative analysis of inappropriate documentation and updates	CR 17.0 pg 6-7 section IV.C Audit tool
Element D – Improvement Actions	
Factor 1: Implements corrective actions to address all inappropriate documentation and updates found in Element C	CR 17.0 pg 7 section V.A Audit tool
Factor 2: Conducts an audit of the effectiveness of corrective actions on findings 3-6 months after completion of the annual audit in Element C	CR 17.0 pg 7 section V.B Audit tool
CR9: Delegation of CR	
Element A – Delegation Agreement	
Factor 1: Is mutually agreed upon.	CR 6.0 pg 1-2 section Policy and pg 4 section II Delegation Agreement B Delegation Agreement pg 1 and pg 12
Factor 2: Describes the delegated activities and the responsibilities of the organization and the delegated entity.	CR 6.0 pg 4-5 section II Delegation Agreement B Delegation Agreement section III and section IV pg 2-11
Factor 3: Requires at least semiannual reporting of the delegated entity to the organization.	CR 6.0 pg 4 section II Delegation Agreement B Delegation Agreement pg 8-9 section III.H
Factor 4: Describes the process by which the organization evaluates the delegated entity's performance.	CR 6.0 pg 4 section II Delegation Agreement B Delegation Agreement pg 10 section IV. B
Factor 5: Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making	CR 6.0 pg 4 section II Delegation Agreement B Delegation Agreement pg 2 section II B
Factor 6: Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	CR 6.0 pg 4 section II Delegation Agreement B Delegation Agreement pg 11-12 section V Termination Process
Element B- Pre-Delegation Evaluation	

NCQA Element/Factor	Internal materials
For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.	CR 6.0 Pg 2-3 section I Pre-delegation Evaluation CQC oversight/Pre-delegation report
Element C-Review of Delegate's Credentialing Activities	
Factor 1: Annually reviews its delegate's credentialing policies and procedures.	CR 6.0 pg 4-5 section III A & B Evidence of Delegation Agreement/Annual Delegation Report
Factor 2: Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.	CR 6.0 pg 5 section III B Evidence of CQC annual oversight/Annual Delegation Report
Factor 3: Annually evaluates delegate performance against NCQA standards for delegated activities.	CR 6.0 pg 4-5 section III A-C Evidence of CQC oversight review Annual Delegation Report
Factor 4: Semiannually evaluates regular reports, as specified in Element A.	CR 6.0 pg 4 section III.A.2 CR 6.0 pg 6-7 section IV Reporting A-B Documented on Delegation Report Review Workbook
Factor 5: Annually audits each delegate's credentialing files for inappropriate documentation and inappropriate updates to credentialing information	CR 6.0 pg 5 section III B Evidence of CQC annual oversight/Annual Delegation Report
Factor 6: Implements corrective actions to address inappropriate documentation and inappropriate updates found in factor 5, for each delegate	CR6.0 pg 5 section III B Evidence of CQC annual oversight/Annual Delegation Report
Factor 7: Conducts an audit of the effectiveness of corrective actions (factor 6) on the findings for each delegated 3-6 months after completion of the annual audit for factor 5	CR 6.0 pg 5-6 section III.B Evidence of CQC annual oversight/Annual Delegation Report
Element D: Opportunities for improvement	
For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.	CR 6.0 pg 5 section III Annual Audit and Oversight of Delegation D Evidence of CQC annual oversight/Annual Delegation Report

Providence Health Plan
Credentials and Quality Committee Charter

Committee Scope and Purpose

Scope: Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies"). ***Purpose:*** The Credentials and Quality Committee (CQC) provides clinical oversight to the quality program. Its main purpose is to perform peer review and make decisions regarding initial credentialing and recredentialing applications based on peer review and quality of care information. The Committee may give input regarding utilization as it affects the member experience. The Committee may make decisions regarding approvals, reinstatement and terminations.

Attendees and Roles

Members	Functional Area	Subcommittee Role
Ruben Halperin, MD	Medical Director	Chair, Voting Member
Shama Hughes, CPMSM, Director	Credentialing	Nonvoting Member
Janelle Nitzke, CPMSM, Manager	Credentialing	Organizer, Nonvoting Member
Jolette Bome, Sr. Program Manager	Credentialing Delegation and Compliance	Nonvoting Member
Sheryl Pullen, RN	Patient Safety	Nonvoting Member
Nandish Dayal, FNP	Family Nurse Practitioner	Voting Member
Ryan Dix, PsyD	Psychology	Voting Member
Liberato Mukul, MD	OB/GYN	Voting Member
Olivia Kamayangi, MD	Family Medicine	Voting Member
Brian Kearns, MD	Hospitalist	Voting Member
Catherine Wagoner, MD	Pediatrics	Voting Member
Scott Soot, MD	General Surgery	Voting Member

The Medical Director or designee, acting as committee chair, has responsibility for the credentialing/quality program and the implementation of and compliance with The Company's policies and procedures. The Medical Director or designee has the right to approve any credential and/or recredential files that are determined to be complete and without exceptions.

A quorum of at least 50% of the voting members of the committee is necessary to perform committee business (in person, or via telephone). With respect to any voting member of the committee who considers themselves to be in direct economic competition with the practitioner being reviewed on a credentialing or peer review matter, such member should recuse themselves from voting on that matter.

Voting Members:

- Medical Director or physician designee
- Participating practitioners representing a variety of disciplines and when possible varying service areas.

Non-Voting Members:

- Credentialing and Patient Safety Staff

Committee Responsibilities and Decision Authority

The CQC has the authority and responsibility for the following functions:

- Review of practitioner and organizational provider qualifications that meet or do not meet established criteria and approving, deferring, modifying, or denying participation
- Making decisions regarding terminations related to issues of quality of care and patient safety
- Making decisions for exceptions to credentialing criteria
- Performing peer review which may result in corrective action against practitioners and organizational providers and monitoring of all ongoing corrective action plans
- Review findings and implement interventions related to all ongoing monitoring activities including Medicare or Medicaid sanctions, Medicare or Medicaid exclusions, licensing sanctions, licensing limitations, licensing expiration, Member complaints, and identified adverse events
- Evaluation of the reinstatement of practitioners or organizational providers whose licenses have been suspended and then reinstated by licensing bodies
- Annual review and approval of relevant Credentialing and Quality Management Policies and Procedures
- Approve credentialing and recredentialing criteria, as necessary
- Review of aggregate reports and make recommendations for improvement

Reporting Relationship(s)

The Credentials and Quality Committee reports to PHP Leadership as needed.

Meeting Structure, Document Management & Communications

CQC meets monthly. Pre-read materials are posted to a secure Microsoft Teams site.

Approval:

02/18/2026

Ruben Halperin
Medical Director
Providence Plan Partners

Date

Policy and Procedure	
SUBJECT: **Credentials and Quality Committee**	DEPARTMENT: **CR: Credentialing Services**
ORIGINAL EFFECTIVE DATE: **08/89**	DATE(S) REVISED: **08/09; 07/10; 07/11; 7/12; 4/13, 4/14, 6/15, 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23; 3/24; 2/25; 2/26**
APPROVED BY: DATE: **Medical Director** **02/18/2026**	NUMBER: PAGE: **CR 1.0** **1 of 6**

SCOPE:

Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

All practitioners
All organizational providers
All lines of business

Fully Insured					
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid
☐ Oregon On Exchange ☐ Oregon Off Exchange ☐ Washington Off Exchange	☐ Oregon On Exchange (SHOP) ☐ Oregon Off Exchange (SHOP)	☐ Oregon ☐ Washington	☐ ASO ☐ PBM	☐ Medicare	☐ Medicaid
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS					

POLICY:

All practitioners and organizational providers must successfully complete an initial credentialing and periodic recredentialing process. The credentialing and recredentialing process will ensure that all practitioners and organizational providers meet specific criteria and requirements that meet or exceed standards of the National Committee for Quality Assurance (NCQA), the Center for Medicare and Medicaid Services (CMS), and any applicable state or federal requirements. Selection for participation is also impacted by a need for additional practitioners or organizational providers with the specialty qualification, expertise, and geographic location of the applicant. The Credentials and Quality Committee (CQC) that uses a peer-review process is designated to make credentialing decisions.

At any time, the Medical Director or physician designee determines that an immediate danger to PHP Members/Eligibles is posed by a practitioner warranting summary

suspension, the Medical Director is authorized to issue such a suspension in accord with Credentialing Services policy CR 9.0 Ongoing Monitoring, Corrective Action and Intervention.

In addition, credentialing and recredentialing decisions will not be based on an applicant's race, ethnic/national identity, religion, age, gender, gender identity, sexual orientation, disability, patient's insurance coverage (e.g. Medicaid), the types of procedures or patient type in which the practitioner specializes, nor will any other such prejudicial policies be made. The Credentialing Department will monitor the provider complaints biannually to ensure that no concerns regarding discrimination exist.

DEFINITIONS:
See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

PROCEDURE:

I. Oversight

A comprehensive review and verification of credentials is conducted for each practitioner or organizational provider prior to initial approval for panel participation and at least every 3 years to the day thereafter.

The CQC is responsible for the oversight of the qualifications of applicants, participating practitioners, and organizational providers who meet or do not meet the Companies' established criteria. The Committee meets monthly, in person or by virtual meeting through video conference or web conference with audio, at a regularly scheduled time. The members provide meaningful advice and expertise while giving thoughtful consideration to the credentialing elements when assessing and reassessing practitioners or organizational providers that have been referred by the Medical Director. All CQC discussions and decisions are documented through meeting minutes.

A quorum is established when four voting members (50%) are present (or participating via phone).

II. Committee Members

The CQC utilizes participating practitioners to provide advice and expertise for credentialing decisions. The CQC is comprised of:

A. The Medical Director or physician designee – Voting

B. Participating practitioners from the range of practitioners in the organizations network who has no other role in the Companies – Voting

C. Quality Management and Credentialing Services Staff Members – Non-Voting

III. Responsibilities

A. Review all files that are considered exceptions as outlined in CR 16.0 Exceptions.

B. Review and approve, defer, modify or deny panel participation for initial applicants based on specific criteria and standards contained in Credentialing Services policy CR 2.0 Practitioner Credentialing or CR 11.0 Organizational Providers Credentialing.

C. Review and approve or terminate participating practitioners or organizational providers based on specific criteria and standards contained in Credentialing Services policy CR 2.0 Practitioner Credentialing and CR 11.0 Organizational Providers Credentialing.

D. Evaluate reinstatement of providers whose licenses have been suspended and then reinstated by licensing bodies.

E. Develop credentialing and recredentialing criteria as needed.

F. The CQC must review the files of practitioners or organizational providers who do not meet the Companies' established criteria.

G. Credential and/or recredential files that meet all criteria outlined in Credentialing Services policy CR 2.0 Practitioner Credentialing or CR 11.0 Organizational Providers Credentialing are considered to be complete and without exceptions "clean files", these files are reviewed and approved by the Medical Director or physician designee. Clean files that meet the Companies criteria may be reviewed and

approved by email. The CQC has final authority regarding panel participation for all practitioners and organizational providers.

H. On a monthly basis or at the meeting following the identified occurrence, the CQC reviews practitioner sanctions, exclusions, complaints, and other adverse events found during the ongoing monitoring process. All substantiated occurrences as defined in Credentialing Services Policy and Procedures CR 9.0 Ongoing Monitoring, Corrective Action, and Interventions are included in the monthly Credentialing report for review and decision.

I. CQC members shall not participate in decision making on a particular applicant or participating practitioner if the Committee member or the Committee feels there may be a conflict-of-interest issue.

J. The confidentiality of provider information is maintained as per Credentialing Services policy CR 4.0 Practitioners Rights and Confidentiality.

K. Members of the CQC will sign a confidentiality statement on an annual basis.

L. Each member agrees to respect and maintain the confidentiality of all discussions that occur during the committee meeting and related to specific committee delegated tasks, deliberations, proceedings, records, complaints, reports and all other information and documents created, collected and/or maintained in connection with these activities. Each member agrees to not disclose such information except to persons authorized to receive it in conducting Company business. All credentialing documentation presented during the CQC meeting should be returned to the Credentialing Department for disposal following the meeting. In the event of a virtual meeting, documentation will be accessed through a secure meeting link. CQC Members who are not in attendance are responsible for destroying credentialing documentation in a manner that maintains confidentiality. CQC members agree to conduct teleconferencing and virtual meetings in a location where their computer screen is not visible to others and where the meeting will not be heard by others. Members also agree to destroy informational materials received via mail or electronically for review purposes in a manner that maintains confidentiality.

M. Policies and Procedures will be reviewed by the CQC annually. After review, the policies and procedures will be signed off and approved by the Medical Director or physician designee.

IV. Non-discrimination

A. Members of the CQC will not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, religion, age, gender, gender identity, sexual orientation, disability, the types of procedures or patient's insurance coverage (e.g. Medicaid) in which the practitioner specializes nor any other such prejudicial policy.

B. Credentialing files will be reviewed by the Credentialing Department at least annually for any indication of discrimination within the decision-making process.

PHP monitors for and prevents discriminatory credentialing as follows:

1. The Companies do not require information on an applicant's race, ethnic/national identity, religion, age, gender, gender identity, sexual orientation, disability, the types of procedures nor patient type in which the practitioner specializes.
2. CQC members are required to attest at the start of each CQC meeting that they have read and understand the Non-discrimination Statement to assure credentialing and recredentialing decisions are not discriminatory or based on an applicant's race, ethnic/national identity, religion, age, gender, gender identity, sexual orientation, disability, the types of procedures nor patient's insurance coverage (e.g. Medicaid), in which the practitioner specializes.
3. Committee minutes will document reasons, for which providers were accepted, denied or terminated. Based on review of the committee minutes, annual audits will be conducted to ensure providers are not discriminated against.

REFERENCES:

NCQA Credentialing Standards
CMS Credentialing Standards
CR 2.0 Practitioner Credentialing
CR 4.0 Practitioners Rights and Confidentiality
CR 9.0 Ongoing Monitoring, Corrective Action and Intervention
CR 11.0 Organizational Providers Credentialing
CR 16.0 Exceptions Policy
CR 23.0 Credentialing Definitions and Acronyms

Policy and Procedure	
SUBJECT: **Practitioner Credentialing**	DEPARTMENT: **CR: Credentialing Services**
ORIGINAL EFFECTIVE DATE: **09/97**	DATE(S) REVISED: **4/13, 12/13, 4/14, 6/15, 2/16, 6/16; 6/17; 3/18; 6/18; 6/19; 5/20; 8/20; 5/21; 10/21; 05/22; 04/23; 03/24; 02/25; 02/26**
APPROVED BY: DATE: **Medical Director** **02/18/2026**	NUMBER: PAGE: **CR 2.0** **1 of 36**

SCOPE:

Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

All credentialed practitioners for the following lines of business:

Fully Insured					
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid
☐ Oregon On Exchange ☐ Oregon Off Exchange ☐ Washington Off Exchange	☐ Oregon On Exchange (SHOP) ☐ Oregon Off Exchange (SHOP)	☐ Oregon ☐ Washington	☐ ASO ☐ PBM	☐ Medicare	☐ Medicaid
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS					

POLICY:

All participating practitioners are required to complete initial credentialing prior to participation and providing care to members. The process includes completion of the application, primary source verification of specific elements, followed by review and decision by the Credentials and Quality Committee (CQC). This process supports The Companies' commitment that all members will receive quality care from qualified providers.

Recredentialing is completed within 3 years to the day of the previous credentialing decision. The recredentialing process establishes regular review of the practitioner's performance with respect to utilization, quality, access and administrative concerns and includes the following components, as available:

- Profiles on the utilization of resources
- Adverse outcome/sentinel event cases
- Member satisfaction

- Member complaints
- Medical record documentation audit results

Within thirty (30) days after the credentialing decision and recredentialing denials, the Credentialing Department sends practitioners written notification of the decision by e-mail.

Practitioners are required to meet and maintain compliance with credentialing criteria without limitation. Practitioners that fail to comply with credentialing criteria may result in the Companies' decision to terminate.

DEFINITION: Definitions and Acronyms

Credentialed practitioners: such practitioners include, but are not limited to the following:

- Medical Practitioners:
  - Medical doctors and Osteopath (MD and DO)
  - Oral surgeon (DMD)
  - Chiropractor (DC)
  - Dentist (DDS)
  - Podiatrist (DPM)
  - Certified Nurse Midwife (CNM)
  - Nurse Practitioner (NP)

- Other Medical Practitioners:
  - Audiologist (AuD)
  - Certified Anesthesiologist Assistant (CAA)
  - Certified Registered Nurse Anesthetist (CRNA)
  - Certified Registered Nurse First Assistant (CRNFA)
  - Certified Surgical Assistant (CFA, CST, SA-C)
  - Clinical Nurse Specialist (CNS)
  - Dietitian - Licensed Dietitian (LD) or Registered Dietician (RD)
  - Genetic Counselor (GC)
  - Lactation Consultant (LC)
  - Licensed Acupuncturist (LAc)Licensed Direct Entry Midwife (LDEM)
  - Licensed Massage Therapist (LMT)
  - Naturopathic Doctor (ND)

- Occupational Therapist (OT)
- Optometrist (OD)
- Pharmacist (RPh)
- Physical Therapist (PT)
- Physician Assistant/Associate (PA)
- Speech Language Pathologist (SLP)
- Other medical practitioners who may be within the scope of credentialing

- Behavioral Health Practitioners:
  - Addiction medicine specialist (requirements listed below under specific degree type)
  - Board Certified Assistant Behavior Analyst (BCaBA)
  - Board Certified Behavioral Analyst (BCBA-D, BCBA)
  - Licensed Marriage and Family Therapist (LMFT)
  - Licensed Mental Health Counselor (LMHC)
  - Licensed Professional Counselor (LPC)
  - Master's-level clinical nurse specialist (CNS)
  - Master's-level clinical social worker (LCSW)
  - Psychiatric Mental Health Nurse Practitioner (PMHNP)
  - Psychiatrists and Other physician (MD and DO)
  - Psychologist (Ph.D, Psy.D)
  - Other behavioral healthcare specialists who may be within the scope of credentialing

See below for the practitioner-specific credentialing criteria.

Type of Practitioner	Current Valid State License	Hospital Privileges	Valid DEA or CDS	Education	Board Cert.	Work History	Current Malprac. Insur.	History of Liability Claims	NPDB Queries	Medicare / Medicaid
Audiologist (AuD)	Oregon Board of Examiners for Speech-Language Pathology and Audiology, Washington State Department of Health	N/A	N/A	Graduate of approved program in Communicative Disorders & Internship	N/A	X	X	X	X	X
Board Certified Assistant Behavior Analyst (BcaBA)	Oregon Behavior Analysis Regulatory Board, Washington State Department of Health	N/A	N/A	Graduate of approved ABA program and documented participating supervising practicing as BCBA or BCBA-D	X	X	X	X	X	X
Board Certified Behavior Analyst (BCBA-D, BCBA)	Oregon Behavior Analysis Regulatory Board, Washington State Department of Health	N/A	N/A	Graduate of approved ABA program	X	X	X	X	X	X
Certified Anesthesiologist Assistant (CAA)	Washington State Department of Health	N/A	N/A	Master's level program including documented participating supervising physician arrangement	X	X	X	X	X	X
Certified Registered Nurse Anesthetist (CRNA)	Oregon State Board of Nursing, Washington State Department of Health	As applicable	As applicable	Graduate of approved Doctor of Nursing Program (DNP) or CRNA program required by licensing board	X	X	X	X	X	X
Certified Registered Nurse First Assist (CRNFA)	Oregon State Board of Nursing, Washington State Department of Health	N/A	N/A	Completion of perioperative nursing practice (CNOR) Graduation from an accredited RNFA nursing program associated with an institute of higher education	N/A	X	X	X	X	X

Type of Practitioner	Current Valid State License	Hospital Privileges	Valid DEA or CDS	Education	Board Cert.	Work History	Current Malprac. Insur.	History of Liability Claims	NPDB Queries	Medicare / Medicaid
Certified Surgical Assistant (CFA, CST, SA-C)	N/A	Affiliation with a participating physician	N/A	Graduate of approved Surgical Assist program	X	X	X	X	X	X
Certified Nurse Midwife (CNM)	Oregon State Board of Nursing, Washington State Department of Health	Admit plan with a participating practitioner with admitting and cesarean section privileges at a participating hospital.	X	Graduation from CNM program	X	X	X	X	X	X
Certified Nurse Specialist (CNs)	Oregon State Board of Nursing, Washington State Department of Health	As Applicable	X	Graduation from CNS program	X	X	X	X	X	X
Chiropractor (DC)	Oregon Board of Chiropractic Examiners, Washington State Department of Health	N/A	N/A	Graduation from Chiropractic College	N/A	X	X	X	X	X
Dentists (DDS)	Oregon Board of Dentistry, Washington State Department of Health	As Applicable	DEA	Grad. From Dental School, Completion of specialty training ADA Master file	N/A	X	X	X	X	N/A
Dietician – Licensed Dietician (LD) or Registered Dietician (RD)	Oregon Board of Licensed Dietitians, Washington State Department of Health	N/A	N/A	For LD and RD, Documented successful completion of an approved educational or specialty program And For RD, Documented registration with the Commission of Dietetic Registration (CDR).	N/A	X	X	X	X	X

Type of Practitioner	Current Valid State License	Hospital Privileges	Valid DEA or CDS	Education	Board Cert.	Work History	Current Malprac. Insur.	History of Liability Claims	NPDB Queries	Medicare / Medicaid
Genetic Counselor	Oregon Health Authority/ Health Licensing Office, Genetic Counseling Program, Washington State Department of Health	N/A	N/A	Documented successful completion of an approved specialty program Or Current certification by the American Board of Genetic Counseling	N/A	X	X	X	X	X
Lactation Consultant (LC)	Oregon Health Authority/ Health Licensing Office, Lactation Consultant Program	N/A	N/A	Documented successful completion of an approved specialty program Or Current certification as an International Board-Certified Lactation Consultant (IBCLC) issued by the International Board of Lactation Consultant Examiners (IBLCE)	X	X	X	X	X	X
Licensed Acupuncturist (LAc)	Oregon Medical Board, Washington State Department of Health	N/A	N/A	Graduate of approved acupuncture program	N/A	X	X	X	X	X

Type of Practitioner	Current Valid State License	Hospital Privileges	Valid DEA or CDS	Education	Board Cert.	Work History	Current Malprac. Insur.	History of Liability Claims	NPDB Queries	Medicare / Medicaid
Licensed Direct Entry Midwife	Board of Direct Entry Midwifery, Washington State Department of Health	Admit plan with a participating practitioner with admitting and cesarean section privileges at a participating hospital.	N/A	Graduate of a MEAC approved midwifery program	Certified Professional Midwife (CPM) credential from the North American Registry of Midwives (NARM)	X	X	X	X	X
Licensed Marriage and Family Therapy	Oregon Board of Licensed Professional Counselors and Therapists, Washington State Department of Health	N/A	N/A	Graduate of Master's Program	N/A	X	X	X	X	X
Licensed Massage Therapist (LMT)	Oregon Board of Massage Therapists, Washington State Department of Health	N/A	N/A	Approved massage education program	N/A	X	X	X	X	X

Type of Practitioner	Current Valid State License	Hospital Privileges	Valid DEA or CDS	Education	Board Cert.	Work History	Current Malprac. Insur.	History of Liability Claims	NPDB Queries	Medicare / Medicaid
Licensed Mental Health Counselor (LMHC)	Oregon Board of Licensed Professional Counselors and Therapists, Washington State Department of Health	N/A		Graduate of Master's Program	N/A	X	X	X	X	X
Licensed Professional Counselors (LPC)	Oregon Board of Licensed Professional Counselors and Therapists, Washington State Department of Health	N/A		Graduate of Master's Program	N/A	X	X	X	X	X
Master's-level Clinical Nurse Specialist	Oregon State Board of Nursing, Washington State Department of Health	As applicable	As applicable	Graduation from CNS program	X	X	X	X	X	X
Master's-level Licensed Clinical Social Workers (LCSW)	Oregon Board of Licensed Social Workers, Washington State Department of Health	N/A	N/A	Graduate of Master's Program	N/A	X	X	X	X	X
Medical Doctors (MD, DO)	Oregon Medical Board, Washington State Department of Health	As Applicable	X	Graduation from Medical School Completion of Residency Completion of Fellowship	X	X	X	X	X	X
Naturopath (ND)	Oregon Board of Naturopathic Medicine, Washington State Department of Health	N/A unless Acting as PCP (admit plan)	X	Graduate from accredited Naturopathic residency program	N/A	X	X	X	X	X

Type of Practitioner	Current Valid State License	Hospital Privileges	Valid DEA or CDS	Education	Board Cert.	Work History	Current Malprac. Insur.	History of Liability Claims	NPDB Queries	Medicare / Medicaid
Nurse Practitioners (NP)	Oregon State Board of Nursing, Washington State Department of Health	As Applicable	X	Graduation from NP education program Completion of Specialty Focus	See policy	X	X	X	X	X
Occupational Therapist (OT)	Oregon Occupational Therapy Licensing Board, Washington State Department of Health	N/A	N/A	Graduate of Master's Program	N/A	X	X	X	X	X
Optometrist (OD)	Oregon Board of Optometry, Washington State Department of Health	N/A	N/A	Graduate from accredited School of Optometry	N/A	X	X	X	X	X
Oral Surgeon (DMD)	Oregon Medical Board, Washington State Department of Health	As Applicable	X	Graduation from Medical School Completion of Residency Completion of Fellowship	X	X	X	X	X	X
Pharmacists (RPh)	Oregon Board of Pharmacy, Washington State Department of Health	N/A	N/A	Graduate from a PGY1 residency Or Approved board certification				X	X	X
Physical Therapy (PT)	Oregon Physical Therapy Licensing Board, Washington State Department of Health	N/A	N/A	Graduate from approved physical therapy program	N/A	X	X	X	X	X
Physician Assistant/Associate (PA)	Oregon Medical Board, Washington State Department of Health	As Applicable	X	Graduate from an Accredited MastersProgram	See policy	X	X	X	X	X

Type of Practitioner	Current Valid State License	Hospital Privileges	Valid DEA or CDS	Education	Board Cert.	Work History	Current Malprac. Insur.	History of Liability Claims	NPDB Queries	Medicare / Medicaid
Podiatrists (DPM)	Oregon Medical Board, Washington State Department of Health	As Applicable	X	Grad. from Podiatry School Completion of a residency program if applicable Completion of Fellowship	X	X	X	X	X	X
Psychiatric Mental Health Nurse Practitioner	Oregon State Board of Nursing, Washington State Department of Health	As Applicable	X	Graduation from NP education program Completion of Specialty Focus	X	X	X	X	X	X
Psychologists	Oregon Board of Psychologist Examiners, Washington State Department of Health	As Applicable	N/A	Graduation from a professional school	N/A	X	X	X	X	X
Speech Language Pathology (SP)	Oregon Board of Examiners for Speech-Language Pathology (Conditional license requires credentialed and contracted supervising SLP) and Audiology, Washington State Department of Health	N/A	N/A	Graduate from Master's Program, Internship	N/A	X	X	X	X	X

PROCEDURE:

I. Credentialing Procedure

The selection for participation is based on a need for additional practitioners with the specialty qualifications, expertise, and geographic location of the applicant to form a balanced, efficient network of practitioners within a service area.

A. At any point in the credentialing process, credentialing staff will submit applicants who do not meet credentialing criteria to the Provider Relations Department for Network Need assessment prior to taking any action.

B. All practitioners are required to respond to credentialing requests within 30 days unless otherwise specified. Noncompliance by the practitioner to provide requested information will be considered a voluntary withdrawal or termination. Credentialing staff will notify Provider Relations of noncompliance to take necessary actions which may include suspending active workflows or initiating termination process.

C. All practitioners must complete an approved application and attest to the following:

1. Reasons for any inability to perform the essential functions of the position with or without accommodation.

2. Lack of present illegal drug use

3. Any history of loss of license and/or felony convictions

4. Hospital privilege status, history of loss or limitations of privileges, or disciplinary activity

5. Current malpractice insurance

Practitioner race, ethnicity and language. Practitioner applications request race, ethnicity and language to be provided voluntarily. The Companies do not discriminate or base credentialing decision on a practitioner's race, ethnicity or language.

6.

7. Confirming the correctness and completeness of the application. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired, and the disability is documented in the practitioner's file.

D. Credentialing decisions will be based on the verification of a complete application. The Credentialing Department obtains all relevant documentation required in the application or as requested to address concerns identified by the CMO, CMO Physician Designee, or CQC. Primary (issuing) source verification of specific elements is completed by qualified Credentialing staff and may be written, electronic, or verbal. Verification requires documentation in the credentialing file that includes who verified the item, the date it was verified, and how it was verified. Credentialing staff review each required element of the credentialing file to ensure that the element is current at the time of credentialing approval and is void of derogatory information that would be considered an exception as outlined in Credentialing Services policy CR 16.0 Exceptions Policy. Credentialing applications will be processed within an average of 60 days of receipt of a complete application. Information contained in the complete application, including the signed release of information and the attestation shall be current and not be more than 180 days old at the time of the CQC's decision. Complete application includes, but is not limited to the following (primary source verification requirements are indicated by an asterisk *):

1. *Licensure - Any current, active, compact, or valid licensure and/or certification to practice within the applicable "Scope of Practice" rules by the appropriate State licensing authority in which the provider treats Members. Sanctions, limitations, and restrictions must cover the most recent five (5) years. The license must be in effect at the time of the CQC decision.

   Practitioners with a limited license can be reviewed and approved by CQC. The Credentialing Department will follow-up to verify permanent license.

   States that participate in a compact licensure arrangement are acceptable if the practitioner's license was primary source verified in the home state. Documentation of the compact agreement is required for evidence that the state recognizes the home state's license in lieu of its own state-specific

licensure.
Any practitioner who has an open investigation or pending action with a licensing board is ineligible for application.

2. DEA or CDS Certificates - Current, valid Drug Enforcement Agency (DEA) Certificate if applicable to the scope of practice. In the event a practitioner is in the process of applying for a DEA Certificate, they may submit documentation showing an alternative process where a practitioner with a valid DEA certificate has agreed to provide necessary prescriptions for patients until the practitioner's DEA Certificate has been issued.

   Practitioners must be registered in each state where Member care is provided. Credentialing Staff will review DEAs to ensure the registration corresponds to where the practitioner is providing care to Members. If an incorrect address is noted the practitioner will be notified. Follow-up documentation will be noted within the file. All updated DEAs will be added to practitioner files as received.

   If an eligible provider does not maintain or have a valid DEA or CDS certificate, an alternative process must be arranged for another participating practitioner to fill prescriptions. Specialties in which prescribing drugs is not the usual practice may not require a DEA certificate. For a list of exceptions refer to section VI. Primary Source Verification Procedure.

3. *Education and Training – During initial credentialing, the highest of the following three levels of education and training obtained by the practitioner must be verified (verification of Fellowship does not meet this intent).
   a. Graduation from medical school or professional training (If the state licensing agency performs primary-source verification of professional school training, confirmation may be received from the state licensing agency. An annual letter will be kept on file from the state licensing agency noting they perform primary source verification of a provider's education and training information.)
   b. Residency
   c. Board certification

d. Fellowship must be primary source verified if applicable to the practitioner's initial application or verified at recredentialing if completed between credentialing cycles.

e. Future program completion dates are not acceptable. If a program is completed earlier, primary source verification may be obtained stating the practitioner has completed all program requirements.

4. *Board Certification - Board certification is required for MDs, DOs, and DPMs. Physicians whose residencies were completed after 1980 must be board certified as recognized by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine (ABPM), American Board of Oral and Maxillofacial Surgery (ABOMS), The College of Family Physicians of Canada, or Royal College of Physicians and Surgeons, Canada. If the practitioner's specialty board requires periodic recertification or maintenance of certification, the practitioner is required to take all necessary steps to maintain board certification, or meet maintenance of certification, and be in good standing with their specialty board in order to remain a participating practitioner. Exceptions will be considered on a case-by-case basis by the CQC.
   a. Participating status may be granted without exception to a physician who has completed an accredited residency program within the past 5 to 8 years, depending on specialty type as defined by ABMS or ABPM, and shows intent to become board certified. Status will be reviewed on an ongoing basis.

   b. Failure to pass the board examination after three attempts and/or within 5 to 8 years will result in a review by the CQC and may result in a recommendation for denial or termination based on lack of compliance with the credentialing criteria.

   c. If a practitioner is board certified by a recognized board and practicing in a specialty they are not board certified in they may be subject to review by the CQC. This will be reviewed on a case-by-case basis and will require documentation of training and experience acquired in the specialty they are practicing. The following will be requested prior to CQC review:

i. Thirty (30) hours of Category I CME in the specialty area requested for the prior year or 60 Category I CME for the previous two years.

ii. Two peer references who have direct clinical observation of the applicant in the past 12 months and who can validate that the practitioner is adequately trained and demonstrates competency in the requested specialty.

iii. Scope of practice

d. Participating practitioners approved prior to January 1, 1996, who were not board certified are considered to be "grandfathered". All practitioners who are granted grandfathering status will be required to obtain 90 category 1 CMEs within the past three years or 60 category 1 CMEs in the past two years. If a "grandfathered" practitioner becomes board certified they must maintain their board certification in their practice specialty. Grandfathered practitioners who do not maintain their board certification status will be subject to termination.

e. Practitioners who are subject to suspension of board certification due to a pending or open licensing action may be granted exception upon review and approval by the CQC.

f. Board recertification and/or maintenance of certification may be waived for practitioners with a minimum of nine years of credentialing history with The Companies and intending to retire within 36 months of their board expiration. Applicable practitioners must submit notification stating intent to retire and a specific retirement date. Board certification waiver is non-renewable and practitioners utilizing this policy will be terminated no later than the retirement date specified. The following conditions apply:

- The applicant is in good standing.
- Practitioner must demonstrate compliance with continuing medical education requirements (90 hours of category 1 CME in the past three years or 60 in the past two years); and maintain compliance by submitting 30 hours of category 1 CME per year until their specified

retirement date. CME will be requested annually and must be within the practitioner's specialty.

- Practitioners with an inconsistent history of maintaining board certification are not eligible.

Requests to extend panel participation beyond 36 months of the practitioner's board certification expiration will not be considered under this policy; however, CQC may review if practitioner meets an exception allowed under CR policy 16.0 Exceptions Policy.

g. Practitioners who have not maintained board certification and who do not meet policies for exception or waiver will be sent notification upon discovery of the expired board certification to request their plan to become board certified within 12 months. The practitioner, with or without a plan to recertify will be presented to CQC for review and decision.

h. Board certification is primary source verified for all Nurse Practitioners and Physician Assistants/Associates who attest to having current board certifications at the time of initial and recredentialing.

5. Work History – Work history is requested from the end of training to current. A complete application includes a minimum of the most recent five years of work history (three years for recredentialing application) as a health professional and is confirmed by review of the practitioner's application or CV. The application or CV must include the beginning and ending (if applicable) month and year for each position of employment. If a practitioner has less than five years of work history, the time frame starts at the initial licensure date. An explanation is required for any gap in work history that is greater than two months.

6. *Malpractice History - History of professional liability claims that resulted in settlements or judgments-must cover most recent five-year period (three years for recredentialing application). Queries are completed via the NPDB.

7. Current Professional Liability Insurance – Practitioners must have current professional liability insurance effective at all times during participation

subject to limit, contract, and career requirements approved by the CQC, currently set at a minimum of $1 million each occurrence and $3 million aggregate.

Acceptable documentation includes:

- Evidence of private malpractice insurance coverage or employer professional liability policy must include the insurance effective and expiration dates and the name of the practitioner or a roster of all individuals in the practice who are covered under the policy, including the practitioner going through credentialing.
- Evidence of a face sheet, which may be provided by the practitioner, must be from the carrier, include the effective and expiration dates, the practice name and must include the practitioner name or a roster of all individuals in the practice who are covered under the policy, including the practitioner going through credentialing.
- Evidence of federal tort coverage must include effective and expiration dates but is not required to include a roster of all practitioners who are covered und the policy.
- If the practitioner's malpractice insurance coverage is current and is provided in the application, it must be current as of the date when the practitioner signed the attestation and include the amount of coverage the practitioner has on the date when the attestation was signed.
- If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates.

At the approval of the Medical Director and in certain instances of network need non-physician practitioners may be allowed to maintain lesser amounts.

8. *Medicare or Medicaid Sanction
    a. Medicare or Medicaid sanction information is collected from one of the following sources:
        - AMA Physician Master File
        - FSMB

- NPDB
- SAM.gov
- State Medicaid Agency

9. *Medicare or Medicaid Exclusions
    a. Medicare or Medicaid exclusion information is collected from any of the following sources:
        - State Medicaid agency
        - NPDB
        - List of Excluded Individuals and Entities (LEIE) maintained by the Office of Inspector General (OIG)

10. *Additional Medicare/Medicaid Activities
    a. Opt Out
    b. Preclusion
    Practitioners who have been precluded from participation with Medicare or Medicaid will not be considered for membership with any Medicare or Medicaid lines of business.

11. *National Practitioner Data Bank

12. Contact Information – All practitioners are required to provide current contact information including, but not limited to: current office addresses, phone, fax, and e-mail address.

13. *National Provider Identifier (NPI)

14. Call Coverage - Practitioners (MDs, DOs, DPMs, NPs, NDs as PCPs, and PAs) are expected to have continuous call coverage. The covering providers must be participating providers in the same or similar specialty. If the provider does not have the same specialty coverage, has out of plan coverage, or lacks coverage due to geographic location, they may be subject to review by the CQC.

15. Admitting Privileges or Admit Plan - Providers (including without limitation: MDs, DOs, DPMs, NPs, NDs as PCPs, and PAs) must have active admitting

hospital privileges at participating or contracted hospitals. These privileges will be verified at initial credentialing and recredentialing. If a practitioner does not have privileges at a participating or contracted hospital, they must submit a hospital admit plan which documents their process in the event of a Member requiring hospitalization.

a. The practitioner must have a system in place that allows a patient to be evaluated telephonically by a live person. The evaluator will be able to give the patient clinical advice or to facilitate contact with another individual who has that ability.

b. Contracts or agreements with hospitalists are considered to be an acceptable form of coverage. The agreement may include patient flow through the emergency room as established by the facility's Hospitalist program.

c. When considering a practitioner with hospital privileges at a contracted hospital only, PR must determine that the practitioner is practicing in a specialty that is of need for the Health Plan.

d. Practitioners that perform deliveries outside of a hospital setting must have formal documentation of a working relationship with a practitioner who has full obstetrical hospital privileges at a participating hospital.

E. Nurse Practitioners who request to be listed in the provider directory with a subspecialty will provide the following information:

1. Documented successful completion of specialty training in the requested specialty or current experience within the past three years

2. Two peer reference letters from practitioners who have had direct clinical observation of the applicant within the past twelve months, who can verify that the practitioner is currently competent in the requested specialty.

3. Provide verification of current accredited national board certification from a Nurse Practitioner national certification examination.

4. 90 hours of continuing medical education (CME) or ongoing education documentation from the past three years or 60 hours of CME in the past two

years within the requested specialty.

F. Supervising physician agreements, collaboration agreements, or other practice agreements as required by the applicable state licensing board are required as part of the credentialing process. Physician Assistant/Associate must have a practice agreement with a participating physician (MD, DO, DPM) or employer group with at least one participating physician identified on the group's roster who is competent to collaborate with the physician assistant/associate on the performance of medical services for which the physician has training and experience.

G. Applied Behavior Analysts must possess state licensure in states that license behavior analysts, a masters or doctoral degree with active certification from the national Behavior Analyst Certification Board as Board Certified Behavior Analysts (BCBA), and possess a minimum of six (6) months experience or training in applied behavior analysis/intensive behavior therapies under the supervision of a Board Certified Behavior Analyst or a licensed clinician. Board Certified Assistant Behavior Analysts (BCaBA) must have a participating supervising practitioner practicing as a Board Certified Behavior Analyst (BCBA) or Board Certified Behavior Analyst - Doctoral (BCBA-D).

H. On an individual basis and where professional conduct or competency concerns are identified through the credentialing process, additional information may be requested prior to making a credentialing decision or as a stipulation of credentialing. The need to request additional information may be identified by CMO, CMO physician designee, or CQC. Additional information requested may include the following without restriction:

    1. Specific health screening or evaluation (at the expense of the applicant)
    2. Peer reference
    3. Work history verification
    4. Completion of specific CME

I. Primary Care Practitioner (PCP) shall mean a participating practitioner who meets PCP criteria. Practitioners who typically provide primary care specialize in Internal Medicine, Family Practice, Pediatrics, Geriatrics, Advanced Nurse Practitioner (specializing in Family Practice, Internal Medicine, Pediatrics or Geriatrics), Physician

Assistants/Associates, or Naturopathic Doctors. Obstetrics/Gynecology practitioners may also apply as PCPs if they: (A) are the case manager who acts as a Member's point of entry to the delivery system; and (B) manage/oversee all services for the Member, including office care, routine preventive health maintenance and referral management.

All reviewed practitioners must meet the minimum threshold of the Clinical Review Program (CRP) audit to remain in the network.

1. PCP Scope of Practice

   The Companies maintains a panel of qualified practitioners who have agreed to be PCPs. The scope of practice of PCPs is inclusive but not limited to the following:

   a. Preventive services health maintenance and disease screening as defined by the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention (CDC).

   b. Evaluation and care of patients with undifferentiated complaints.

   c. Diagnosis and management of chronic clinical problems, which are common in the population being served

2. As a PCP, the following practice guidelines are required:

   a. Acceptance of members from all lines of business

   b. Practitioners are able to show evidence of coordination and continuity of care including referral management with a system in place in the office to accommodate referral notification to the Companies.

   c. Call Coverage – All PCPs are expected to have continuous call coverage. The covering providers must be participating providers in the same or similar specialty and also be designated as a PCP. If the provider does not have the same specialty coverage, has out of plan coverage, or lacks

coverage due to geographic location, they may be subject to review by the CQC.

3. Additional PCP Criteria for NPs, PAs, and NDs:

    a. NPs are to be certified by one of the following accredited organizations:
        - American Academy of Nurse Practitioner Certification Program (AANP)
        - American Nurses Credentialing Center (ANCC)
        - National Certification Corporation (NCC)
        - Pediatric Nursing Certification Board (PNCB)
        - American Midwifery Certification Board

    b. PAs are to be certified by the National Commission on Certification of Physician Assistants (NCCPA).

    c. NDs must have completed a residency in one of the following accredited naturopathic medicine programs. The following institutions have been approved by the Council on Naturopathic Medical Education (CNME):
        - Bastyr University
        - Canadian College of Naturopathic Medicine (CCNM)
        - National University of Natural Medicine (NUNM)
        - Sonoran University of Health Sciences (SUHS)
        - National University of Health Sciences (NUHS)

4. OB/GYN PCPs, including certified nurse midwives, will have no limitation of female age in the panel.

5. Practitioner specialties that do not typically provide primary care (e.g. gastroenterologists and emergency medicine practitioners) will be presented to the CQC for review and determination. At initial and recredentialing, 30 Category 1 CME for the prior year or 60 Category 1 CME for the previous two years in the area of primary care will be collected. Examples of primary care CME includes preventive care and chronic care.

II. Recredentialing procedure

A. Credentialing Services staff generates a list of practitioners to be credentialed prior to mail out date. This list is saved in the Provider Profile folder in Excel format and is utilized by Clinical Analytics to compile a practitioner performance profile. The practitioner performance profile includes any available information related to adverse events, member complaints, staff concerns and medical record documentation audit results.

1. Quality Management nursing staff (QM RN) reviews all practitioner performance profiles that exceeds a threshold of greater than 8% complication rate in the previous year.
2. If the practitioner fails to meet the threshold, Quality Management Nurse completes a more comprehensive Practitioner Performance Review. This documentation is submitted to the Medical Director for review. The Medical Director will either approve or refer the documentation to the CQC.
3. The Practitioner Performance Review will be assessed at the next meeting of the CQC and a recommendation sent back to the referring Credentialing Services staff.

B. Extending the Recredentialing Cycle Length - Providers who are on active military assignment, maternity leave or a sabbatical (will be documented in the credentialing database), and the contract between Companies and the practitioner remains in place, may possibly not be recredentialed within the 3-year time frame. The practitioner will be recredentialed within 60 calendar days of when they resume seeing patients. The practitioner must have a valid state license prior to seeing Members. If the contract is terminated while on active military assignment, maternity leave or sabbatical for more than 30 days the provider must be initially credentialed.

III. Nonresponsive to Credentialing Requests

A. Nonresponsive to initial application requests

All applicants must meet initial credentialing requirements. Failure to respond within 30 days to any request for information during the initial credentialing process will result in withdrawal of the application.

B. Nonresponsive to recredentialing application requests

All practitioners and organizational providers must meet recredentialing requirements. Failure to meet established standards or guidelines may result in termination.

1. The recredentialing process will begin at least four months in advance to ensure that participating practitioners and organizational providers are re-evaluated within 3 years of the previous credentialing decision.

2. The participating practitioner or organizational provider will be sent a recredentialing application and given 30 days to return the completed application.

3. If the practitioner or organizational provider fails to respond within 30 days, a second request for information will be sent, stating the practitioner must return the completed application within 14 days.

4. If the practitioner or organizational provider fails to respond within 14 days from the second request, a final request will be sent stating that a complete application must return within 14 days or be voluntarily resigned for failure to return a recredentialing application.

   A list of practitioners and organizational providers who were sent the third request is forwarded to Provider Relations.

5. If the practitioner or organizational provider fails to respond within 14 days of the final request, they will be presented to the Credentialing Quality Committee (CQC) for termination due to non-responsiveness.

6. Provider Relations will be notified of terminations due to non-responsiveness approved by CQC.

IV. Termination and Reinstatement - If a practitioner is terminated for administrative reasons (e.g. the practitioner failed to provide complete credentialing information) and not for quality reasons, the practitioner may be reinstated with their current recredentialing date within 30 calendar days of termination and will not be required to complete initial credentialing.

If the request to reinstate is more than 30 calendar days from the termination date, initial credentialing will be completed. Static information does not require reverification if confirmed by the Credentialing Coordinator to be previously verified.

V. Primary Source and Time Limit Verification Procedure

CREDENTIAL	VERIFICATION TIME LIMIT	CREDENTIALING SERVICES VERIFICATION SOURCE(S)	INITIAL	RECRED	Methods of receipt
Current, active, valid license to practice in the states where the provider sees our members	120 days	• Documented verbal contact with the appropriate state licensing or certification agency. • Electronic verification to state boards where active licenses are held.	X within the last 5 years	X within the last 3 years	Verbal Email Electronic
Clinical privileges in good standing at primary admitting facility (must be active admitting privileges at a participating hospital or a written admit plan)	120 days	• Documented verbal contact with the facility, • Copy of the practitioner directory/roster including name of the hospital, practitioner name, status of provider at hospital • Verification letter from the hospital noting admitting privilege status	X	X	Verbal Email Electronic
Admit Plan	180 days	• Documented admit plan describing their process in the event of a Member requiring hospitalization.	X	X	Email
Call Coverage	NA	• Documented call coverage with a participating provider.	X	As needed	Email
Current valid DEA and/or CDS DEA = Drug Enforcement Agency CDS = Controlled Dangerous Substance (required for Idaho)	120 days Must be in effect at time of decision	• Copy of DEA certificate showing expiration date • U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control • National Technical Information Service (NTIS) database • American Medical Association (AMA) Physician Masterfile or American Osteopathic Association Official Osteopathic Physician Profile Report (DEA only) • Address listed on the DEA is within the same state the practitioner is treating the member. • Exceptions for DEA include specialties in which prescribing drugs are not the usual practice (AuD, CRNFA, DC, CNS, LPC, LAc, LMT, OT, OD, RPh, PT, RD, SLP and certified first assists.	X	X	Email Electronic

CREDENTIAL	VERIFICATION TIME LIMIT	CREDENTIALING SERVICES VERIFICATION SOURCE(S)	INITIAL	RECRED	Methods of receipt
DEA Prescription Plan	180 days	• In the event a practitioner is in the process of applying for a DEA Certificate, they may submit documentation showing an alternative process where a practitioner with a valid DEA certificate has agreed to provide necessary prescriptions for patients until the practitioner's DEA Certificate has been issued.	X	X	Email
Education & training including graduation from medical school, completion of a residency program and fellowship if listed in the directory	Prior to the credentialing decision 120 days by board certification or 120 days by license	Any one of the following: • Board certification – ABMS or its member boards; or • Approved boards in the United States or Canada that are not members of ABMS; • AOA official Osteopathic Physician Profile Report or AOA Physician Master File; • Letter from school or facility; • Telephone verification to school/facility; • American Medical Association (AMA) Physician Master File; • Letter from Medical Board stating all education will be verified prior to licensing and it performs primary source verification; • Nurse Practitioner certifying board • Physician Assistants/Associates certifying board • Pharmacists – PGY1 ASHP accredited residency certificate of completion • National Student Clearinghouse (NSC) for educational programs who have an agreement with NSC to provider primary source verification. Verification must include programs proof of participation with NSC. • Commission of Dietetic Registration (CDR) for RD certification.	X		Verbal Email Electronic
Board Certification (all approved board	120 days	Any one of the following:	X (highest level of	X	Verbal Email Electronic

CREDENTIAL	VERIFICATION TIME LIMIT	CREDENTIALING SERVICES VERIFICATION SOURCE(S)	INITIAL	RECRED	Methods of receipt
certifications must be verified)		• ABMS or its member boards, or an official ABMS Display Agent, (*Certifax)* ABMS = American Board of Medical Specialties; • Approved boards in the United States or Canada that are not members of ABMS for all credentialed practitioner types as defined in this policy; • AMA Physician Master File; • AOA Official Osteopathic Physician Profile Report or AOA Physician Master File • American Academy of Nurse Practitioners • American Association of Critical-Care Nurses • American Nurses Credentialing Center • Pediatric Nursing Certification Board • American Midwifery Certification Board • National Commission on Certification of Physician Assistants	education must be verified when not board certified)		
Work history within the most recent 5-year period. Gaps not to exceed 2 months.	180 days	Completed practitioner application, Curriculum Vitae showing last five years of work history (includes the beginning and ending month and year for each position of employment experience). If a gap greater than 2 months is discovered, an explanation of the gap will be required.	X within the last 5 years	X Within the last 3 years	Verbal Email Electronic
Current adequate malpractice insurance within $1,000,000 for each occurrence and $3,000,000 aggregate.	180 days	Copy of insurance face sheet with practitioner's name, Attestation, letter of intent from malpractice carrier. Providers with federal tort coverage can include a copy of the federal tort letter or attestation from the practitioner of federal tort coverage.	X	X	Email Electronic
History of professional liability claims that resulted in settlements or judgments	120 days	Query to and report from NPDB NPDB = National Provider Data Bank	X	X	Electronic

CREDENTIAL	VERIFICATION TIME LIMIT	CREDENTIALING SERVICES VERIFICATION SOURCE(S)	INITIAL	RECRED	Methods of receipt
within the most recent 5-year period.					
Medicaid Exclusions	120 days	• State Medicaid Agency • List of Excluded Individuals and Entities (maintained by OIG)	X	X	Electronic
Medicaid Sanctions	120 days	• State Medicaid Agency And one of the following: • AMA Physician Master File • NPDB • SAM.gov	X	X	Electronic
Medicare Exclusions	120 days	• List of Excluded Individuals and Entities (maintained by OIG)	X	X	Electronic
Medicare Sanctions	120 days	One of the following: • AMA Physician Master File • NPDB • SAM.gov	X	X	Electronic
NPDB Query	120 days	Query to and report from NPDB	X	X	Electronic
State sanctions, restrictions on licensure and/or limitations on scope of practice. Covers most recent 5-year period in all states where the practitioner has practiced.	120 days	• Documentation from appropriate state agencies • NPDB	X	X	Electronic

CREDENTIAL	VERIFICATION TIME LIMIT	CREDENTIALING SERVICES VERIFICATION SOURCE(S)	INITIAL	RECRED	Methods of receipt
List of Excluded Individuals and Entities (LEIE) maintained by Office of Inspector General (OIG)	120 days	• List of Excluded Individuals and Entities (maintained by OIG)	X	X	Electronic
Opt Out Note: Opt Out applies to MD, DO, DDS, DMD, DPM, OD, PA, NP, CNS, CRNA, CNM, Psychologist, LCSW, RD, Nutrition professional	120 days	• CMS website: data.cms.gov	X	X	Electronic
GSA/System Awards Management (SAM)	120 days	• SAM.gov	X	X	Electronic
Preclusion	120 days	• CMS website: data.cms.gov	X	X	Electronic
State Medicaid Exclusion Lists	120 days	• State Medicaid Exclusion List verified through Credential Stream Individual list website: https://www.exclusionscreening.com/state-exclusion-databases-medicaid-exclusion/	X	X	Electronic
Collaborative Agreement	N/A	• Licensing board • Current collaboration agreement document	X	X	Electronic
NPI	120 days	• NPPES NPI Registry: npiregistry.cms.hhs.gov	X	X	Electronic
Death Master File	120 days	• ladmf.ntis.gov	X	X	Electronic

CREDENTIAL	VERIFICATION TIME LIMIT	CREDENTIALING SERVICES VERIFICATION SOURCE(S)	INITIAL	RECRED	Methods of receipt
Oregon Provider Enrollment List	120 days	P:\OMAP\Encounter Data\Provider Information***(Year)*** DMAP Provider Spreadsheets For Physical Therapists with a Medicaid Contract	X		Electronic

VI. Electronic Credentialing Process

The Credentialing Department works fully remote; therefore, only accepts credentialing information through electronic processes.

A. Application Process

Credentialing applications may be received utilizing the credentialing software, Council for Affordable Quality Healthcare (CAQH) or e-mail. When e-applications through the credentialing software is received, the application is automatically dated by the credentialing software and the practitioner's information is accepted or manually entered into the database by the Credentialing Staff. CAQH applications are downloaded and saved to the credentialing database. Applications received by e-mail are uploaded to the credentialing database. All credentialing information is stored in the practitioner's electronic file.

B. Primary Source Verification Process

All primary source verification is reviewed by Credentialing Staff to ensure the verification is current and meets credentialing requirements as defined in this policy. All credentialing data is entered and electronically tracked in the credentialing database and may be received as follows:

1. Verbal – When a verbal verification is obtained, the Credentialing Staff will document the verification in the credentialing database. The documentation will include the verification source, contact name from the verifying agency, information verified (i.e. status, date, standing), verification date and verifying credentialing staff initials. Documentation is scanned or imaged and stored in the practitioner's electronic file within the credentialing database.

2. Electronic Fax – When a verification is received by electronic fax, it is received in a secured folder on a system drive that is accessible by credentialing staff only, the document is date stamped with the date received, scanned, and stored into the practitioner's electronic file within the credentialing database.

3. Online – Online verification includes verifications from a source's website. The verification is saved as a PDF and stored in the practitioner's electronic file within the credentialing database. If the online verification is not already date stamped the credentialing coordinator will add a date stamp confirming the date received.

4. Web crawlers - Verifications that are obtained by web crawler technology from approved primary source websites through the credentialing software. An image of the verification is ingested into the practitioner's electronic file within the credentialing database. A web crawler verification is automatically date stamped with the date received and reviewed by the Credentialing Staff.

C. Appropriate Documentation for Credentialing Verifications and Activities

The Credentialing Department utilizes an electronic verification workflow within the credentialing software. The workflow is developed to function as a checklist for Credentialing Coordinators to document verifications and activities for each practitioner credentialed. The workflow includes all requirements of the initial and recredentialing process to ensure compliance with NCQA, CMS, and internal credentialing policies and procedures. Each workflow includes the following information for each verification or credentialing activity using the following methods or a combination:

1. Credentialing documents electronically signed, initialed or stamped, and dated by credentialing staff.

2. A checklist that includes, for each verification:
    - The source used
    - The date of verification
    - The electronic signature of the credentialing staff member who verified the information
    - The report date, if applicable
    - Issue and expiration date, if applicable
    - Findings, if applicable

VII. Storage

All credentialing documentation is stored in the credentialing database.

VIII. Residents

Providence Residents who moonlight during training will be credentialed if the following criteria are met:

A. Liability insurance that covers their activity in the practice setting.

B. Letter of permission from their Residency Director.

C. Assurance that a participating practitioner on panel will be available to them for consultation during their shifts.

IX. Practitioners Who Do Not Need To Be Credentialed

The following practitioners do not need to be credentialed:

A. Dentists who provide primary dental care only under a dental plan or rider.

B. Pharmacists who work for a pharmacy benefits management (PBM) organization to which the Companies delegate utilization management (UM) functions.

C. Locum tenens who do not have an independent relationship with the Companies and who do not practice in a clinical location for greater than sixty (60) consecutive days.

D. Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants).

E. Rental network practitioners that are specifically for out-of-area care, and there are no incentives communicated to members; members have no obligation to seek care from rental network practitioners and may see any out-of-area practitioner.

F. Hospital-based practitioners who practice exclusively within a credentialed facility (Organizational Provider) and provides care for members only as a result of

members being directed to the hospital or an inpatient setting, including but not limited to:

- Pathologists
- Radiologists
- Anesthesiologists
- Neonatologists
- Emergency room physicians
- Hospitalists
- Telemedicine consultants
- Wound Care providers

If the practitioner also has an independent relationship with The Companies (Members will be directed to see the practitioner specifically) and provides care under The Companies' medical benefits, the practitioner needs to be credentialed.

X. Auditing Process

Credentialing Department audits to ensure that practitioner credentialing meets the Companies' policies including compliance with NCQA and CMS standards for initial and recredentialing processes. In addition, the department audits credentialing system integrity.

A. File Audit for Credentialing and Data Integrity

Credentialing files are audited monthly and include a minimum of 200 files annually. Utilizing the monthly CQC credentialing report, the Credentialing Manager or designee randomly selects and reviews files for each Credentialing Coordinator. Audit includes without limitation the following:

- Compliance with required credentialing verifications as defined in the credentialing policies
- Review of data integrity, which includes reviewing primary source verifications and dates of the verifications are accurately recorded in the database
- Recredentialing cycle doesn't exceed three (3) years to the day or as otherwise approved by CQC
- Indications of discrimination

XI. Directory Maintenance

A direct systematic nightly feed from the credentialing database updates directory information to ensure that information provided to Members is consistent with the information obtained during the credentialing process. The nightly data feed includes practitioner education, including fellowship, training, board certification, hospital affiliation, and designated specialty for all actively licensed practitioners and organizational providers.

REFERENCES:

NCQA Credentialing Standards
CMS Credentialing Standards
CR 16.0 Exceptions Policy
CR 9.0 Ongoing Monitoring, Corrective Action, and Intervention
CR 23.0 Credentialing Definitions and Acronyms
The Controlled Substances Act: Drug Enforcement Administration

Policy and Procedure	
SUBJECT: **Medical Director – Role and Responsibilities**	DEPARTMENT: **CR: Credentialing Services**
ORIGINAL EFFECTIVE DATE: **11/90**	DATE(S) REVISED: **4/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23; 3/24; 2/25; 2/26**
APPROVED BY: DATE: **Medical Director 02/18/2026**	NUMBER: PAGE: **CR 3.0 1 of 2**

SCOPE:

Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Fully Insured					
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid
☐ Oregon On Exchange ☐ Oregon Off Exchange ☐ Washington Off Exchange	☐ Oregon On Exchange (SHOP) ☐ Oregon Off Exchange (SHOP)	☐ Oregon ☐ Washington	☐ ASO ☐ PBM	☐ Medicare	☐ Medicaid
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS					

POLICY:

A Medical Director or another designated physician will actively participate in the credentialing and patient safety program and is responsible for the following:

- Appropriateness and quality of care delivered to Members
- Chair the Credentials and Quality Committee
- Review and approve clean files

The Medical Director performs all duties in a manner which promotes the team concept and reflects the Companies' mission and core values.

DEFINITIONS:

See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

PROCEDURE:

A. The Medical Director actively participates in the credentialing and recredentialing process through membership on the Credentials and Quality Committee (CQC).

B. The Medical Director is responsible for monitoring practitioner and organizational provider performance and compliance with established standards through an active role in the peer review process.

C. The Medical Director communicates to physicians as needed and provides support and direction to staff pertaining to quality and credentialing issues.

D. In the event the Medical Director determines that a practitioner or organizational provider poses immediate danger to Members or Eligibles, the Medical Director is authorized to approve summary suspension or immediate termination.

E. The Medical Director reviews and approves clean files. A clean file is a file that meets established credentialing criteria, all information is current within the prescribed time limits and does not lack substantiating documentation. One report with all required credentials for all practitioners and organizational providers will be reviewed and approved with electronic signature via e-mail. The credentialing decision date for clean files will be the Medical Director's approval date. A credentialing report that includes all clean file approvals will be presented to CQC for review at the next scheduled meeting.

F. If the designated Medical Director is unavailable to fulfill the responsibilities of the position, the responsibilities will be delegated by the Medical Director or Chief Medical Officer to another qualified physician.

REFERENCES:
CR 23.0 Credentialing Definitions and Acronyms
NCQA Standards

Policy and Procedure	
SUBJECT: **Practitioners Rights and Confidentiality**	DEPARTMENT: **CR Credentialing Services**
ORIGINAL EFFECTIVE DATE: **9/97**	DATE(S) REVISED: **6/07; 06/08; 08/09; 07/10; 7/11; 7/12; 4/13; 4/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23; 3/24; 02/25; 02/26**
APPROVED BY: DATE: **Medical Director 02/18/2026**	NUMBER: PAGE: **CR 4.0 1 of 5**

SCOPE:

Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

All Practitioners

Fully Insured					
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid
☐ Oregon On Exchange	☐ Oregon On Exchange (SHOP)	☐ Oregon	☐ ASO	☐ Medicare	☐ Medicaid
☐ Oregon Off Exchange	☐ Oregon Off Exchange (SHOP)	☐ Washington	☐ PBM		
☐ Washington Off Exchange					
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS					

POLICY:

Participating practitioners, organizational providers, and applicants are afforded certain rights and protections during the credentialing and recredentialing process. These rights include the right to view and clarify discrepancies, have misinformation corrected, and to be informed of the status of their application during the credentialing process. These rights are made available to all applicants, participating practitioners, and participating organization providers at the time of initial and subsequent credentialing.

The Companies do not discriminate in the administration of these rights based upon the practitioner's race, ethic/national identity, religion, age, gender, gender identity, sexual

orientation, disability, patient's insurance coverage (e.g. Medicaid), the types of procedures, or patient type in which the practitioner specializes. The Companies credentialing policies apply equally and no more stringently to behavioral health practitioners or organizational providers.

The Companies respect and maintain the confidentiality of all practitioner information collected during the credentialing or recredentialing process. Confidential information is only available to authorized staff and cannot be disclosed to the public at any time as required by the laws and regulations governing this information.

All policies including those relating to practitioner rights are posted on ProvLink and included in the credentialing approval letter.

DEFINITION:
See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

PROCEDURE:

I. Right to Review Credentialing Information

The practitioner has the right to review information submitted from outside sources (i.e. malpractice insurance carriers, state licensing boards) in support of their credentialing application, except for protected information, such as references, recommendations, or peer review protected information. If copies of information are prohibited by the agency providing such information, the practitioner will be given the name and address of the agency to obtain a copy.

A. If a practitioner elects to review the information submitted in support of their credentialing application, the Medical Director or physician designee will be in attendance during the time the practitioner reviews their credentialing file.

B. The Credentialing Department must receive advance written notification from a practitioner or applicant to review contents of their credentialing file and will coordinate a scheduled time depending on the Medical Director's availability.

C. Subpoenas requesting information contained in the credentials file will be directed to legal counsel.

II. Notification of Erroneous or Varying Information

A. The applicant will be contacted by credentialing staff when credentialing information obtained from other sources during the credentialing process varies substantially from information provided by the practitioner in the credentialing application. Acceptable methods for contacting the practitioner may include telephone, fax, or e-mail. The practitioner has the right to correct the varying information or explain any discrepancy or omission that conflicts with information obtained from another party, except for peer references, peer review information, NPDB response, or other information that is peer protected. All correspondence, conversations and/or documentation related to this process will be documented in the practitioner credentialing file.

B. Credentialing Staff will notify the practitioner in writing via fax or e-mail of any information received that is possibly erroneous from the information provided by the practitioner in the credentialing application. Notification and request for clarification upon discovery of erroneous information will be sent to the practitioner within 14 days of discovery and will include the following:

- The information found to be erroneous.
- Request for explanation or correction of the erroneous information.
- Response must be received within 14 days of the date of the notification.
- Response to be submitted to Credentialing Department by fax or e-mail.

C. When the practitioner's correction/explanation is received, this information will be verified in the same manner that the original information was checked. The corrected information becomes part of the practitioner's credentials file and is maintained in the same manner as the other credentialing documentation.

D. The lack of response within the stated time frames may result in withdrawal of application.

E. If the practitioner's response and verification of the corrected information proves the information received from another party was erroneous, the information stands corrected in the credentials file.

F. If the practitioner's response and support does not prove the information received from another party was erroneous, the information does not stand corrected and will be presented to the Credentials and Quality Committee (CQC) for determination.

The practitioner will be notified of the CQC determination regarding the conflicting information within 30 calendar days. Acceptable methods for notifying the practitioner may include but are not limited to fax ore-mail.

III. Right to Know Status of Application

A. Practitioners and applicants have the right, upon request, to be informed of the status of their application. The practitioner may contact the Credentialing Department via email or in writing to request the status of their application. Within 14 days of the request the Credentialing Department will inform the practitioner of the status of the application, and this may include missing information.

B. Upon request, The Credentialing Department will inform the practitioner via email of any missing information that could be affecting the status of their application. The response could include any of the following, as applicable:

- Missing information that the practitioner is responsible for supplying that is delaying application processing, e.g., malpractice insurance face sheet, DEA certificate, a complete application.

- Missing information that must be primary source verified, or obtained from an outside source, that is delaying application processing, e.g., verification of board certification, licensure, hospital privileges.

- Any other circumstance that is delaying application processing, as long as release of the information is lawful and does not include

information such as references, recommendations, or peer review protected information.

IV. Confidentiality

A. Practitioner files are electronic. Per record retention requirements, all electronic documentation will be maintained on a permanent basis. Access to practitioner information is limited by levels of authorization as defined in CR 17.0 Credentialing Information Integrity.

B. Authorized staff are required to sign a confidentiality statement prior to accessing the credentialing database and confidential practitioner information.

REFERENCES:

CR 17.0 Credentialing Information Integrity
CR 23.0 Credentialing Definitions and Acronyms
NCQA Credentialing Standards

Policy and Procedure	
SUBJECT: **Delegated Credentialing**	DEPARTMENT: **CR: Credentialing Services**
ORIGINAL EFFECTIVE DATE: **9/95**	DATE(S) REVISED: **4/13; 4/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23; 3/24; 2/25; 2/26**
APPROVED BY: DATE: **Medical Director 02/18/2026**	NUMBER: PAGE: **CR 6.0 1 of 9**

SCOPE:

Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

This policy applies to all groups eligible and approved for delegated credentialing in the Companies' network(s).

Fully Insured					
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid
☐ Oregon On Exchange ☐ Oregon Off Exchange ☐ Washington Off Exchange	☐ Oregon On Exchange (SHOP) ☐ Oregon Off Exchange (SHOP)	☐ Oregon ☐ Washington	☐ ASO ☐ PBM	☐ Medicare	☐ Medicaid
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS					

POLICY:

Delegated credentialing may occur when The Companies agree to give another entity the authority to perform credentialing activities that The Companies would otherwise perform. The Credentials and Quality Committee (CQC) approves and maintains oversight of an entity's credentialing program prior to delegation and at least annually thereafter.

Unless otherwise defined in the Credentialing Delegation Agreement, credentialing activities summarized below and agreed upon must all be performed in a manner that meets or exceeds National Committee for Quality Assurance (NCQA) standards and, when applicable, Centers for Medicare and Medicaid Services (CMS) standards, Oregon Division of Medical Assistance (DMAP) standards, and any other applicable state guidelines, in addition to Companies' standards. A mutually agreed upon Credentialing Delegation Agreement describes the assigned responsibilities, reporting requirements, performance monitoring,

the right to approve, suspend, terminate, and the consequences for failure to perform. The credentialing process may be delegated to entities who meet the following criteria and as further defined in the Credentialing Delegation Agreement:

- The entity has a defined and documented credentialing process that will comply with Companies' credentialing standards.
- The entity has the ability to report at minimum the following data elements required to populate Companies' systems:
  - Full name
  - Degree
  - Specialty
  - Board certification information, including Board name, specialty, status, initial certification date and expiration date
  - Primary address (billing also if different) primary cannot be a PO box
  - Phone number
  - NPI number
  - Tax ID
- The entity allows audits at least annually, as required by NCQA standards.
- The entity provides reports semi-annually.
- The entity enters into a mutually agreed upon agreement.
- The entity agrees to provide notification of any material changes in their ability to perform delegated functions.

DEFINITION:
See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

PROCEDURE:

When an entity requests to be delegated, The Companies will confirm there is a need and mutual benefit. If it is determined there is a need the following activities will occur:

I. Pre-delegation Evaluation

Prior to delegating credentialing and recredentialing activities, a pre-delegation evaluation (either a site visit, or virtual review) will be performed for all delegation candidates to determine whether to delegate or not within the 12 months prior to implementing delegation. If the time between the pre-delegation evaluation and implementation of delegation exceeds 12 months, another pre-delegation evaluation will be conducted.

A. The pre-delegation evaluation will include a review and approval of the following:

1. Entity's policies and procedures as requested that outline the credentialing program.
2. Credentialing Committee membership roster and meeting minutes, which must show evidence of peer review and the committee's decision-making process.
3. File audit review of practitioners and organizational providers, as applicable.
4. Evidence of annual audit of credentialing information integrity
5. Evidence of implementation of corrective actions
6. Evidence of effectiveness of corrective actions audit
7. Evidence of annual staff information integrity training
8. Ongoing monitoring and interventions pertaining to practitioner sanctions, complaints, and quality issues

9. If applicable, documentation of delegation agreements and oversight evidence by the Company's delegate of any sub-delegated entity must include the elements outlined above in numbers 1-7.

B. Pre-Delegation Audit Results

The pre-delegation audit results are presented to the CQC for review. The CQC approves the delegation, pends a decision and requests a corrective action plan to address deficiencies, or denies the organization's request for delegation.

1. If the CQC approves the delegation, the Companies will proceed with a Credentialing Delegation Agreement.

2. If the delegation is denied, a letter is sent to the entity delineating the results of the CQC's review within seven (7) business days of the decision.

II. Delegation Agreement

A. Upon approval for delegated credentialing by the CQC, the Credentialing Delegation Agreement will be sent to the entity for signature.

B. The Credentialing Delegation Agreement states:

1. Effective date of the delegation agreement
2. Credentialing activities being delegated
3. Assigned credentialing responsibilities
4. Reports with required data elements and submission deadlines
5. Requirement to comply with Companies' credentialing policies and procedures
6. Companies retain the right to approve, deny, terminate, suspend, or restrict the participation of any individual practitioner, organizational provider or site even if the Companies delegate decision-making.
7. Responsibilities for sub-delegation
8. The process for performance evaluation at least annually

9. Effective July 1, 2025, credentialing Information Integrity requirements, which includes:
   a. Annual audit of credentialing files for inappropriate documentation and inappropriate updates of credentialing information
   b. The delegate's implementation of corrective actions to address inappropriate documentation and inappropriate updates
   c. The delegate conducts effectiveness audits on the findings pertaining to corrective actions within 3-6 months of the annual audit
   d. The Companies' monitoring of the delegate's credentialing information integrity oversight at least annually.
   e. Annually, the delegate conducts and documents Information Integrity Training provided to staff. Information Integrity Training includes to the auditing, documenting and reporting processes. .
10. Reports findings of any credentialing information fraud or misconduct to The Companies within 30 days of the finding.
11. Timely submission for requested documentation needed for regulatory or accrediting audits
12. Circumstances under which delegation is terminated or modified

A pre-delegation review will be conducted prior to delegating any additional credentialing activities.

III. Annual Audit and Oversight of Delegation

A. The Credentialing Department is responsible for the oversight of the Delegate's compliance with the delegation agreement and credentialing activities. Oversight responsibilities include without limitation:

1. Conduct audit at least annually
2. Monitor routine reporting, at least semi-annually
3. Review Delegate's sub-delegation oversight
4. Report to CQC at least annually or as needed
5. Provide the Delegate with opportunities for improvement

B. At least annually, an audit will be performed to assess the Delegate's credentialing processes. The audit will include the following as defined in the Credentialing Delegation Agreement:

1. Credentialing policies and procedures
2. Credentialing Committee roster and meeting minutes
3. Evidence of ongoing monitoring and interventions
4. Evidence of annual credentialing information integrity monitoring
5. Evidence of implementing corrective actions pertaining to inappropriate documentation and updates found during annual monitoring
6. Reporting findings of fraud or misconduct to The Companies
7. Evidence of audit completed within 3-6 months for effectiveness of corrective actions taken pertaining to the annual audit.
8. Evidence of annual Information Integrity Training for the delegate's credentialing staff.
9. Evidence of practitioner office site standards, as applicable
10. Sub-delegation oversight
11. File audit of five percent or 50 practitioner files, whichever is less, with a minimum of 10 credential files and 10 recredential files for practitioners, and organizational provider file audit as applicable. If fewer than 10 practitioners were credentialed or recredentialed within the look-back period, the universe of files will be audited rather than a sample. The NCQA 8/30 file review methodology may be used. File audit includes elements as defined in the agreement.

C. The audit findings are compiled and reviewed with the Delegate's credentialing staff in the exit interview at the time of the audit. During the exit interview the auditor provides the delegated entity with audit findings and any noted deficiencies. The auditor works with the delegate to resolve any disputes during the survey. File review results may not be disputed and may not be appealed once the survey is complete.

D. Audit results are presented to the CQC for review within 60 calendar days after the audit is performed. The completed audits include the scores, areas for improvement and recommendations.

E. The CQC reviews the audit outcomes and will decide to approve a score of 90% or above, or request a corrective action plan (CAP), require a re-audit within 3 to 6 months, or a termination of delegation. A delegated relationship will be terminated in the event of non-compliance with the established standards if a corrective action plan is not completed within the agreed time frame or if audit scores indicate excessive non-compliance. Delegates are required to obtain an overall score of 90% or higher and a score of 50% or higher within each element.

F. If the Delegate is approved with a CAP, the CQC will determine a deadline for the Delegate to submit the CAP. If necessary, a re-audit will be scheduled. Deadlines are established depending on the severity of noncompliance with standards. Subsequent action plans and audit results are reviewed by the CQC to determine if further action is needed for final approval.

G. In the event of termination, the Companies require an unbroken string of recredentialing at least every 3 years. If files can be obtained from the delegate, the Companies are not required to start over with initial credentialing; credentialing process may be continued by The Companies and recredential practitioners or organizational providers when they are due.

   If credentialing files cannot be obtained from the delegate, the Companies must perform initial credentialing within 6 months of the delegate's termination date.

IV. Reporting

A. The Delegate is required to submit the following reports within the timeframes stated:

   1. Practitioner Roster – Delegate submits rosters after credentialing decisions for all new and recredentialed practitioners (monthly or no less than twice annually), at least annually for Delegate's audit and as requested for audit or survey of Companies' networks. Delegate provides practitioner data in an excel format for all practitioners to include the minimum data elements of:
      a. Full name (as it appears in the license board)

b. Degree
c. Specialty practiced
d. Date of birth
e. Primary practice address, city, state, zip
f. Office phone and fax number
g. Initial credential date
h. Most current credential date
i. State license number
j. NPI number
k. Primary care provider designation
l. Name of medical/graduate school where degree was received
m. Graduation date from medical/graduate school
n. Board certification information, including Board name, specialty, status, initial certification date and expiration date

2. Practitioner race, ethnicity and language, if provided Evidence of System Security Control monitoring is required at least annually. Companies will review and document any of the delegates non-compliant modifications that do not meet the policies and procedures. Companies will implement a quarterly monitoring process with the delegate until the delegate demonstrates improvement for at least one finding over three consecutive quarters.

B. The Delegate and Companies report to each other any adverse action affecting a practitioner's appointment status, practice of clinical privileges, including termination, suspension, limitation, restriction, whether the practitioner is subject of a formal investigation within two business days of the action. The party taking adverse action is responsible for reporting to the National Practitioner Data Bank (NPDB) in the timeframe specified by the NPDB, respectively.

Delegate and Companies inform each other of any reports made about the practitioner to any state or federal regulatory agency such as the state licensing board, NPDB and CMS, whichever is applicable to the reporting party, within two business days.

V. Auto-Credit

Auto-credit for elements of the pre-delegation and annual audits may apply to Delegates who are accredited by NCQA as it applies to the Delegates accreditation and as defined by current accreditation standards.

REFERENCES:

CR 23.0 Credentialing Definitions and Acronyms
NCQA Credentialing Standards
CMS Credentialing Standards
Credentialing Delegation Agreement

Policy and Procedure	
SUBJECT: **Ongoing Monitoring, Corrective Action and Intervention**	DEPARTMENT: **CR: Credentialing Services**
ORIGINAL EFFECTIVE DATE: **11/02**	DATE(S) REVISED: **6/07; 6/08; 10/08; 08/09; 07/10; 7/11; 7/12; 4/13; 5/14; 6/15; 6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23; 3/24; 2/25; 2/26**
APPROVED BY: DATE: **Medical Director 02/18/2026**	NUMBER: PAGE: **CR 9.0 1 of 12**

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

All practitioners
All organizational providers

Fully Insured						
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid	Delegated Services to Ayin
☐ Oregon On Exchange	☐ Oregon On Exchange (SHOP)	☐ Oregon	☐ ASO	☐ Medicare	☐ Medicaid	☐ YCCO
☐ Oregon Off Exchange	☐ Oregon Off Exchange (SHOP)	☐ Washington	☐ PBM			☐ WHA
☐ Washington Off Exchange						
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS						

POLICY:

Practitioners and organizational providers will be subject to ongoing monitoring between credentialing cycles. Monitoring of Medicare /Medicaid Sanctions, Medicare/Medicaid Exclusions, limitations on licensure including sanctions and expiration, complaints, and adverse events will be obtained and reviewed as defined in this policy. When an assigned staff member discovers a finding through ongoing monitoring processes, it will be reported

to the Credentials and Quality Committee (CQC) for final determination and appropriate action at the next meeting after the identified finding.

Upon receipt of adverse information, the CQC may decide to restrict or terminate panel participation status or take other appropriate intervention if there is evidence of quality deficiencies related to professional conduct or competence that could adversely affect Member's health or welfare.

The CQC may also decide to place a practitioner or organizational provider in "Focused Monitoring" to review periodic progress with concerns identified. This allows practitioners and organizational providers who may have had deficiencies the opportunity to correct their issues while still participating under certain conditions, terms, or stipulations.

Participating practitioners and organizational providers have the right to appeal certain adverse actions pursuant to the Companies' Policies and Procedures. If the adverse action is upheld and is reportable by law to National Practitioner Data Bank and state licensing agencies, the appropriate authorities will be notified of the quality deficiency and related actions, as required.

DEFINITION:
See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

PROCEDURE:

I. Ongoing Monitoring Activities

All practitioners and organizational providers are subject to at least monthly monitoring or within 30 calendar days of a new alert between credentialing cycles and all findings will be reported to CQC for determination and appropriate intervention. Ongoing monitoring activities includes, but is not limited to the following:

A. Medicare Sanctions

To monitor for Medicare sanctions, Credentialing staff will review NPDB alerts no later than thirty (30) calendar days after the alert is received. If a NPDB alert is received related to a Medicare sanction, Provider Relations will be notified of the

practitioner or organizational provider, and all Medicare products will be terminated immediately.

B. Medicaid Sanction

To monitor for Medicaid sanctions, Credentialing staff will review the following sources at least monthly and NPDB alerts will be reviewed no later than thirty (30) calendar days after the alert is received. If a practitioner or organizational provider is identified, Provider Relations will be notified, and all Medicaid products will be terminated immediately. Any of the following sources are reviewed:

- State Medicaid Agency
- SAM
- NPDB Continuous Query

C. Medicare Exclusions

To monitor for Medicare exclusions, Credentialing staff will review the following sources at least monthly and NPDB alerts will be reviewed no later than thirty (30) calendar days after the alert is received. If a practitioner or organizational provider is identified, Provider Relations will be notified, and all Medicare products will be terminated immediately. Any of the following sources are reviewed:

- OIG
- NPDB Continuous Query
- State Medicaid Agency

D. Medicaid Exclusions

To monitor for Medicaid exclusions, Credentialing staff will review the following sources at least monthly or no later than thirty (30) calendar days of an NPDB alert. If a practitioner or organizational provider is identified, Provider Relations will be notified, and all Medicaid products will be terminated immediately. Any of the following sources are reviewed:

- State Medicaid Agency
- LEIE maintained by OIG
- NPDB Continuous Query

E. Additional Medicare/Medicaid Monitoring Activities

Additional Medicare/Medicaid monitoring activities conducted by Credentialing staff at least monthly includes review of the following sources. If a practitioner or organizational provider is identified, Provider Relations will be notified, and all Medicare/Medicaid products will be terminated immediately. All of the following are reviewed:

- Preclusion
- Opt Out

F. Sanctions and limitations on licensure

To monitor for sanctions and limitations on licensure, Credentialing staff will review NPDB alerts no later than 30 calendar days after the alert is received. If a practitioner or organizational provider is identified on an NPDB alert, the Credentialing Manager will be notified immediately for determination of further action. Further action may include notification to internal stakeholders such as Medical Director, Provider Relations, Contracting, Systems Administration, Directory Team, Regulatory Compliance and Government Affairs, and/or SIU.

G. License Expiration

All license expiration dates are primary source verified and updated in the database from the applicable specialty-specific state license boards on an ongoing basis. License expirations are updated by webcrawling technology through database functionality whenever possible. State licenses that fail to update through webcrawls are monitored through database reporting at least 30 days prior to expiration and updated by Credentialing Staff manually. Licenses not renewed within 7 days of expiration are reported to internal stakeholders including Provider Relations, Contracting, Systems Administration, and the Directory Team to remove the practitioner or organizational provider from all internal systems and the directory prior to the expiration date.

H. Complaints and Adverse Events Review Process

The Companies collects and reviews staff concerns and member complaints (referred to as "complaints" in this policy) to monitor practitioner performance on an ongoing basis. Upon receipt, all complaints are recorded in a complaint database and reviewed with any available history. Information may be received from the following sources:

- Claims (medical, pharmacy, labs)
- Plan Data (complaints, appeals, grievances, customer service)
- Staff member concern (internal or external)

Complaints related to poor quality or safety issues that would indicate a quality of care (QOC) concern are referred to Quality Management Nurses (QM RNs) to determine if a potential adverse event requires further escalation. All issues identified as potential quality of care complaints and/or adverse events are reviewed by the Medical Director. Non-clinical complaints are reviewed by QM RNs and tracked to determine if there is cause for further evaluation. Monthly or at least every 6 months, a history of all clinical and non-clinical complaints for all practitioners is generated by the QM RNs and forwarded to the Medical Director for review. If concerns are identified by the Medical Director, findings will be escalated to the CQC for further review or intervention.

1. Clinical Complaint Review Process

   a. All clinical complaints and potential adverse events are reviewed upon receipt. QM RNs may assign a severity level of zero (0) as defined in this section and close the complaint. All other practitioner issues related to a quality of care complaint are forwarded to the Medical Director for further review of the issue and any quality history that may include but not limited to complaints or adverse events.

   b. Upon receipt or at least monthly, the Medical Director reviews complaints or adverse events. Upon completion of the review a severity level greater than zero (0) may be assigned to substantiate a finding. The Medical Director may request additional information during the review process to assist in substantiating any finding. Additional information may include, but not limited to:
      - External review

- Peer references
- Internal review from appropriate Company stakeholders
- Additional organizational data
- Request for additional explanation from the involved practitioner(s)
- Site visit when there are concerns of conditions at a site that suggest compromised safety or other concerns related to the delivery of care

c. All findings or potential findings determined by the Medical Director are reviewed at the following CQC to determine appropriate interventions, as needed.

d. All substantiated findings are reported to the CQC monthly.

e. Severity Levels

Level	Severity	Description
0	No adverse Effect/No potential to adversely affect patient	Unfounded complaint, unavoidable complication, unavoidable disease progression
1	Near Miss Safety Event	Deviation from best practice that does not reach the patient, error is caught by a detection barrier or by chance
2	Minimal Adverse Effect	Deviation from best practice that reaches the patient, results in minimal or no detectable harm
3	Significant Adverse Effect	Deviation from best practice that reaches the patient, results in moderate to severe harm
4	Death	Deviation from best practice that reaches the patient, results in death
UO	Unresponsive Provider – No Adverse Effect	Unresponsive Provider - No Adverse Effect. Unable to review information from the facility/provider. Severity based on members allegation and internal review.
U1	Unresponsive Provider – Near Miss Safety Event	Unresponsive Provider - Near Miss Safety Event. Unable to review information from the facility/provider. Severity based on members allegation and internal review.
U2	Unresponsive Provider – Minimal Adverse Effect	Unresponsive Provider - Minimal Adverse Effect. Unable to review information from the facility/provider. Severity based on members allegation and internal review.

U3	Unresponsive Provider – Significant Adverse Effect	Unresponsive Provider - Significant Adverse Effect. Unable to review information from the facility/provider. Severity based on members allegation and internal review.
U4	Unresponsive Provider - Death	Unresponsive - Death. Unable to review information from the facility/provider. Severity based on members allegation and internal review.
DR	Declined to Respond	Declined to Respond - Provider/Facility declines to respond to any questions about member allegation due legal implications.

2. Non-clinical Complaints Review Process

   a. Credentialing staff reviews all non-clinical complaints upon receipt and evaluates the history of complaints.

   b. Non-clinical complaints may be related to the following:
      - Physical appearance, which may include cleanliness
      - Site safety
      - Adequacy of equipment including maintenance
      - Accessibility
      - Patient privacy and confidentiality
      - Medical records not maintained in a confidential, secure location
      - Cultural competency
      - Language assistance

   c. Each complaint is reviewed with any available history of complaints to identify a trend of three (3) or more similar complaints or a total of five (5) complaints in a 12-month period.

   d. If a trend is identified it will be reviewed by the Medical Director for further recommendation. The Medical Director may escalate the review to the CQC for determination.

   e. The Medical Director or CQC can request a site visit for practitioners who receive 5 or more complaints in a 12-month period.

f. If a site visit is required to complete the review, it will be conducted within 60 days of determination. All deficiencies will be documented on the site review checklist and saved to the practitioner file. A site review report will be presented to CQC for further determination that will be communicated to the practitioner. A Corrective Action Plan (CAP) is required for a score less than 85%. All CAPs will include follow-up visits to be conducted every six months until the CAP deficiencies are met. A practitioner may have multiple CAPs if additional deficiencies are identified subsequent to the initial site visit.

g. If the Companies become aware of conditions at a site that suggest compromised safety or concerns related to delivery of care, the Companies will perform a site visit to assess the facility and determine further actions which may include a corrective action or termination.

3. Site Review

All practitioners are subject to review of medical records, office sites, and office access through site review.

a. The Medical Director evaluates the outcome of the site review, reports, monitors for trends, and recommends actions.

b. If a corrective action plan is needed for the clinic site, medical records, or clinic access, the following timeframes will be followed:

1. The clinic site will be re-reviewed within 6 months following the corrective action.
2. Provider medical records and clinic access will be re-reviewed within 12 months.

c. If a passing score is not achieved on re-review the Medical Director may refer to CQC for further action.

II. Implementing Interventions

The Companies applies the following process for implementing interventions when reporting findings to the CQC:

A. CQC Review, Determination, and Action

When findings are identified and referred to CQC for review and determination, a complete report including at least the following will be presented:

- Affected practitioner or organizational provider
- Incident Date
- Quality Issue / Finding
- Historical information, if applicable
- Assessment, if applicable
- Recommendations, if applicable

The CQC may implement interventions as follows without limitations:

1. Determine that no quality or safety issue exists
2. Request further investigation
3. Issue a letter of reprimand or censure
4. Place the practitioner or organizational provider in focused monitoring status
5. Require a corrective action plan from the practitioner or organizational provider and place in focused monitoring status
6. Recommend that Member access be limited
7. Refer to Special Investigations Unit (SIU)
8. Require medical or professional consultation
9. Restrict or terminate the provider from panel participation

If the CQC determines that further information is required to make a decision, a formal request will be issued to the practitioner or organizational provider. The request will specify the additional information needed and must be responded to within fourteen (14) calendar days of the date of the request. Additional information or non-response will be presented to the next CQC meeting for decision or intervention.

All discussion and action by the CQC will be documented in meeting minutes and include at least the following:

- Affected practitioner
- Incident Date
- Quality Issue / Finding
- Historical information, if applicable
- Assessment, if applicable
- Date reported to the CQC
- CQC Intervention / Action

B. Focused Monitoring Status

All available data and reports of performance are reviewed to determine whether performance falls within acceptable quality standards. The CQC may place a practitioner or organizational provider in focused monitoring status due to, but not limited to the following:

1. An approved exception to credentialing criteria
2. Acts, demeanor, or conduct below applicable professional community or quality standards
3. Conduct which is reasonably likely to be disruptive to the care of the Member
4. Violation of the Companies' contracts, agreements or rules and regulations
5. Personal use of drugs and/or alcohol which affects professional performance
6. Revocation, suspension, or restriction of hospital privileges
7. Limitation on licensure
8. Actively pursuing, but not having received, board certification as required by the Companies' policy
9. Criminal conviction or violation
10. Substantiated findings related to complaints or adverse events
11. Corrective action plan

Upon the CQC's determination to place a practitioner or organizational provider in focused monitoring status, the Companies may send a letter to the practitioner or organizational provider outlining the review, determination, and any requirements, which may result in termination if requirements are not met.

III. Reporting Process

A. Grounds for reportable adverse actions based on professional competence or conduct may include, but are not limited to:

1. Acts, demeanor, or conduct below applicable professional community standards
2. Conduct detrimental to patient safety or the delivery of substandard quality patient care
3. Unethical practice
4. Conduct which is reasonably likely to be unduly disruptive to the care of the patient
5. The cause of a conviction of a felony or misdemeanor related to the practitioner's practice
6. Violation of contracts or rules and regulations
7. Personal use of drugs and/or alcohol which affects professional performance as identified by a facility, adverse outcomes or by patient complaints
8. Revocation, suspension, or restriction of hospital privileges or health plan participation
9. Probation, limitation, or restriction of license
10. Loss of professional liability coverage in required amounts
11. The provision of false or misleading information to patients or in the medical record concerning the Companies' requirements or actions
12. A refusal or failure to cooperate in credentialing, investigative or hearing procedure
13. Practitioner admits to, or is found to have engaged in, sexual misconduct
14. Practices considered to include fraud, waste, or abuse
15. The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession
16. Incompetence, negligence, or malpractice which creates unreasonable risk that a patient may be harmed
17. Aiding or abetting an unlicensed person to practice when a license is required
18. Practicing beyond the scope of practice as defined by law or rule.

B. Practitioners or organizational providers subject to reportable adverse actions will be reported to the National Practitioner Data Bank (NPDB), and the appropriate state licensing board as required by law.

C. An Adverse Action Report (AAR) will be completed within 30 days of the date of the adverse action and submitted electronically to the NPDB.

D. The Report Verification Document (RVD) provided by the NPDB will be submitted to the appropriate state licensing board.

E. A copy of the report will be maintained in the practitioner's credentials file.

F. Changes in previously reported adverse actions must be submitted directly to the NPDB as soon as possible after the discovery of an error or omission in a report, with a copy of the modified RVD mailed to the appropriate state licensing board. Changes can include:

1. Correction or modification (supersedes the contents of the original report)
2. Void previous report (retraction of report)
3. Revision to action (considered a new action which is related to and which modifies a previously submitted adverse action)

REFERENCES:

NCQA Credentialing Standards
CMS Credentialing Standards
CR 10.0 Actions and Appeals Process
CR 23.0 Credentialing Definitions and Acronyms
Practitioner Office Site Visit Tool and Corrective Action Plan
Revised Code of Washington State, 7.71.010 Health Care Peer Review
Oregon Revised Statutes 41.675 Peer Review of Healthcare Providers

Policy and Procedure	
SUBJECT: **Actions and Appeals Process**	DEPARTMENT: **CR: Credentialing Services**
ORIGINAL EFFECTIVE DATE: **09/95**	DATE(S) REVISED: **6/07; 6/08; 09/08; 08/09; 07/10; 9/10; 7/11, 7/12, 2/13; 4/13; 5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 5/23; 3/24; 02/25; 02/26**
APPROVED BY: DATE: **Medical Director** **02/18/2026**	NUMBER: PAGE: **CR 10.0** **1 of 10**

SCOPE:

Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

All Practitioners
All Organizational Providers

Fully Insured						
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid	Delegated Services to Ayin
☐ Oregon On Exchange	☐ Oregon On Exchange (SHOP)	☐ Oregon	☐ ASO	☐ Medicare	☐ Medicaid	☐ YCCO
☐ Oregon Off Exchange	☐ Oregon Off Exchange (SHOP)	☐ Washington	☐ PBM			☐ WHA
☐ Washington Off Exchange						
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS						

POLICY:

Practitioners or organizational providers who fail to comply with established standards relating to quality of patient care, utilization of resources, compliance with administrative processes, and/or credentialing standards may be subject to termination or other corrective action. The purpose of this policy is to protect Members from inappropriate care and from medical malpractice, and otherwise to enforce credentialing and contract requirements. This policy defines:

- The process when a need to take action with regard to limiting or terminating credentialing occurs.
- Appeal rights to notice and opportunity to be heard when there is an action to remove or to limit participation.

DEFINITION:
See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

PROCEDURE:

I. Actionable Issues

A. Credentialing or Contract Issues

1. All participating practitioners and organizational providers are required to meet and maintain compliance with credentialing criteria as defined in Credentialing Services Policy CR 2.0 Practitioner Credentialing, CR 9.0 Ongoing Monitoring and CR 11.0 Organizational Providers Credentialing.

   Credentialing or contract issues include, without limitation, the following:

   a. Failing to maintain required professional liability insurance coverage

   b. Leaving active practice in contracted service area

   c. Failing to meet credentialing criteria

   d. Failing to comply with billing or coding standards generally accepted by the profession

   e. Submitting inaccurate or false information

   f. Failing to practice within the applicable professional standard of care

   g. Failing otherwise to comply with the contract or with the Companies' rules and regulations

h. Failing to maintain site conditions that may compromise safety or lead to other concerns related to delivery of care (i.e. accessibility, appearance, adequacy of equipment).

2. A participating practitioner or organizational provider has no right to appeal the Companies' decision to terminate credentialing based on failure to comply with the following requirements:

   a. Failure to maintain active professional licensure without any actions or limitations

   b. Failure to obtain or maintain board certification

   c. Failure to maintain professional liability insurance coverage

   d. Failure to maintain continuous call coverage

   e. Failure to have active admitting hospital privileges at participating or contracted hospitals

   f. Failure to comply with the requirements of a previously approved network need exception

   g. Change in practice location when credentialing approval is based on an approved network need exception

   h. Failure to respond to any request from the Companies' Credentialing or Patient Safety team within the specified timeframe

3. Upon discovery of noncompliance with credentialing or contracting requirements, the Credentialing Department will notify the Medical Director or physician designee of the non-compliance and Provider Relations to initiate appropriate action.

4. When a credentialing action is taken based on credentialing or contracting requirements, a report may be required to the National Practitioners Data Bank (NPDB) as required by law.

B. Quality of Patient Care Issues

1. "Quality of patient care" refers to standards of practice that, in the Companies' judgment, are related to ensuring an appropriate medical outcome of treatment, including without limitation, practitioner competency, rather than to patient convenience or to other concerns. In general, whenever a credentialing action is taken based on quality of patient care, a report will be required to the National Practitioners Data Bank (NPDB) as prescribed by law.

2. Quality of Patient Care Issues related to and including, without limitation, the following:

   a. Incompetence

   b. Unethical practice

   c. Abuse of drugs and/or alcohol

   d. Loss or reduction of hospital privileges

   e. Licensing board actions related to patient care

   f. Misrepresentations to Members regarding the provision of medical services or payment

   g. Other conduct reasonably deemed to be detrimental to quality of patient care or a failure to observe quality assurance and utilization protocols

II. Medical Director and CQC Review

A. Any information that may result in a credentialing action will be immediately referred to the Medical Director or physician designee for review.

B. The Medical Director or designee shall conduct a preliminary investigation and review the case with the Providence Corporate Counsel, as appropriate.

C. Unless the Medical Director or designee exonerates the practitioner, the Medical Director or designee shall refer the matter with recommendation to the Credentials and Quality Committee (CQC) for decision.

D. Credentialing actions by the CQC are listed in Credentialing Services Policy CR 9.0 Ongoing Monitoring, Corrective Action and Intervention.

E. If the CQC recommends exoneration, the CQC's decision to exonerate will stand. In the event the CQC determines that any action other than exoneration is appropriate, the participating practitioner or organizational provider will be given written notice of the decision and the opportunity to request a hearing, if applicable.

III. Appeal Process

A. A participating practitioner or organizational provider subject to an adverse decision of the CQC on a credentialing or contracting matter may request a hearing as provided in this Section III. No appeal is available to initial credentialing applicants or when credentialing or contract is terminated for one of the reasons set out in Section I.A.2 of this policy.

B. Written notice of opportunity to request a hearing shall include:

1. That a credentialing action is proposed.

2. The reasons for the proposed action.

3. The right to request a hearing on the proposed action.

4. That practitioner or organizational provider has thirty (30) calendar days after the notification was sent to request a hearing. The request must be in writing.

5. A summary of hearing rights, including the rights to:

a. Representation by an attorney or other person of the practitioner or organizational provider's choice.

b. Select one of the three Hearing Panel members if the termination is related to quality of patient care or otherwise "with cause," provided that the nominee must be qualified by training to evaluate the issues involved, not have previously participated in the matter and not be in direct economic competition with the practitioner or organizational provider.

c. Have a record made of the proceeding, copies of which may be obtained by the practitioner or organizational provider upon payment of a reasonable charge.

d. Call, examine, and cross-examine witnesses.

e. Present evidence determined to be relevant by the Hearing Panel regardless of its admissibility in any court of law; and

f. Submit a written statement at the hearing.

6. A statement of the practitioner or organizational provider's status pending the hearing, particularly including whether Members may or may not be served without limitation or restriction pending the hearing. The standards for summary suspension are detailed in Section IV.

C. Within fifteen (15) days of a request for hearing, or such longer time as may be required based on delay in appointment of a panel member by the practitioner or organizational provider, a Hearing Panel will be appointed. The Panel is composed of three persons professionally qualified to evaluate the standards applicable to the practitioner or organizational provider, none of whom is in direct economic competition with the practitioner or organizational provider. Whenever reasonably possible, the majority of the hearing panel members will be clinical peers. A clinical peer is defined as a medical practitioner with the same professional degree or higher.

D. In the event the termination was based on quality of patient care or otherwise "with cause," two of the three Hearing Panel members will be appointed by the Companies and the third may be appointed by the practitioner or organizational provider. If the practitioner or organizational provider fails to appoint a panel

member within ten (10) days of notice, or such longer time as may be granted, the failure will constitute authorization to the Companies to appoint the third member. The Medical Director or a designee shall appoint Hearing Panel members and determine which of the Hearing Panel members shall serve as chairperson. Continued participation on the hearing panel is at the discretion of the Companies, which may remove a hearing panel member for lack of timeliness in responding to the necessary steps needed to move the process forward.

E. In the event the termination was based on credentialing or contract issues other than quality of patient care, the Companies will appoint the three members of the panel.

F. The Companies will not be held responsible for any expenses incurred by the practitioner or organizational provider, including, but not limited to, panel representation, expert witnesses, preparatory work, work-day interruption, and/or case reviewers. In particular, panel members chosen by the practitioner or organizational provider to participate on the panel are not compensated by the Companies for service on the panel.

G. Within ten (10) business days after panel members have been appointed, the hearing will be scheduled, and notification will be sent to the Hearing Panel members and the practitioner or organizational provider. Notification will include date, time, and place of the hearing (hereafter "Fair Hearing"). The Fair Hearing date should not be less than thirty (30) days after the notice without consent of the practitioner and should be scheduled in any event within sixty (60) days of the notice. The Companies will make all reasonable efforts to meet these timelines but will coordinate hearing dates with the practitioner or organizational provider.

H. The Fair Hearing will be scheduled and completed within 180 days from the date of the request for hearing. Absent waiver of this requirement by the Companies, failure of the practitioner requesting a hearing to accept a hearing date within 180 days constitutes a waiver of rights to a Fair Hearing and a voluntary acceptance of the final proposed or adverse action, which will become effective on the date specified in the notice informing the practitioner that the right to a Fair Hearing has been waived.

I. Failure to appear at a scheduled Fair Hearing, without good cause, constitutes a waiver of the right to a Fair Hearing.

J. The process for Fair Hearings will be as follows:

1. A record of the hearing will be made by electronic recording if all participants agree and/or by staff minutes.

2. The Companies will be represented by staff or by counsel, and will begin with an opening statement, followed by such testimony or other evidence as it wishes to present.

3. At the discretion of the Hearing Panel, the practitioner or organizational provider may offer an opening statement either after the Companies' opening statement or after completion of the Companies' evidence.

4. After completion of the Companies' evidence, the practitioner or organizational provider shall offer such testimony or other evidence as they wish to present.

5. The Hearing Panel in its discretion may ask any questions it wishes to ask, may permit such rebuttal as it deems useful, and may invite verbal or written closing arguments from the parties.

6. The practitioner or organizational provider will be excused so the Hearing Panel may deliberate, with or without participation by the Companies at the Panel's discretion.

K. The record will be considered closed at the end of the Fair Hearing unless the practitioner or organizational provider requests and the Hearing Panel grants additional time to submit supplementary materials or briefing, in which case the record will be considered closed upon receipt of those materials by the Hearing Panel. The Hearing Panel shall issue a written notice of the appeal decision to the Companies, copy to the practitioner or organizational provider, within ten (10) days after the record is closed. The decision shall be in writing, including a statement of the specific reason(s) for the decision.

L. In the event the Hearing Panel upholds a practitioner's appeal requesting continuation of full credentialing, the practitioner will be recredentialed without further action. In the event the Hearing Panel determines to impose conditions under which the credentialing will be upheld or denied, those conditions will be given effect without any additional hearing. In the event the Hearing Panel denies the practitioner's appeal, no further administrative appeal is provided and any required report regarding credentialing, participation, or quality of patient care will be made to the NPDB as prescribed by law.

M. Reporting to Authorities - The decision of the Hearing Panel is final unless overturned by an order of a court of competent jurisdiction. If the final determination is a reportable event, the reporting process is followed as defined in Credentialing Services policy CR 9.0 Ongoing Monitoring, Corrective Action and Intervention.

N. Reporting to Providence St. Joseph Health Entities – If the Companies determine that a practitioner is subject to an adverse credentialing decision based on quality of care concerns and the practitioner maintains privileges at any entity of Providence St. Joseph Health, the Companies retain the right to report adverse credentialing decisions to Providence St. Joseph Health. If such action is determined to be appropriate after legal review, the Providence Regional Quality Director and/or the affected Providence entities will be notified of the credentialing decision and of any other relevant information.

IV. Summary Suspension

The Medical Director or physician designee, the Chief Medical Officer, and the Chief Executive Officer each have authority to summarily suspend the credentialing status of a participating practitioner or organizational provider when it has been determined that failure to do so may result in imminent danger to the health and/or safety of any individual or to the reputation of the Companies.

Any such action will be reported to each of the individuals listed above and referred to the CQC at its next regularly scheduled meeting for a determination on whether the practitioner or organizational provider's credentialing will be terminated or otherwise

subjected to further action. The CQC may in its discretion defer a determination until its next regularly scheduled meeting but must make a determination at or before its second regularly scheduled meeting following the imposition of a summary suspension. Any decision of the CQC will be subject to appeal as provided in this policy. The CQC may decide to continue a summary suspension during the appeal process.

A summary suspension is effective immediately upon notification. The notice of suspension shall include the following:

1. An explanation of the cause of the suspension to the affected practitioner or organizational provider; and

2. Notice that the matter will be referred to the CQC at its next regularly scheduled meeting for final determination

V. Member Notification

In the event of termination, Provider Relations will be notified in order to assist Members in the transition care.

REFERENCES:

NCQA Credentialing Standards
CMS Credentialing Standards
CR 2.0 Practitioner Credentialing
CR 9.0 Ongoing Monitoring, Corrective Action and Intervention
CR 11.0 Organizational Provider Credentialing
CR 23.0 Credentialing Definitions and Acronyms

Policy and Procedure			
SUBJECT: **Organizational Providers Credentialing**		DEPARTMENT: **CR: Credentialing Services**	
ORIGINAL EFFECTIVE DATE: **09/98**		DATE(S) REVISED: **7/11; 12/11, 7/12, 8/12; 4/13; 5/14, 10/14; 6/15; 6/16, 6/17; 6/18; 6/19; 5/20; 5/21; 10/21; 5/22; 4/23; 3/24; 2/25; 2/26**	
APPROVED BY: **Medical Director**	DATE: **02/18/2026**	NUMBER: **CR 11.0**	PAGE: **1 of 12**

SCOPE:

Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Behavioral Health Facilities including mental health and substance abuse services: Inpatient, Residential, Ambulatory
Birthing Centers
Clinical Laboratories
Comprehensive Outpatient Rehabilitation Facility (CORF)
Durable Medical Equipment (DME) Prosthetic, Orthotics and Supplies (POS)
End-Stage Renal Disease Services
Free-standing Ambulatory Surgical Centers
Genetic Counseling Centers
Home Health Agencies
Hospice
Hospitals
Outpatient Diabetes Self-Management Training
Outpatient Physical Therapy and Speech Pathology Providers
Pharmacies
Portable X-Ray Suppliers
Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)
Skilled Nursing Facilities (short-term and long-term)
Telemedicine Organizational Providers

All organizational providers with which the company contracts that provide services to members and where members are directed for services rather than being directed to a specific practitioner

Fully Insured					
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid
☐ Oregon On Exchange ☐ Oregon Off Exchange ☐ Washington Off Exchange	☐ Oregon On Exchange (SHOP) ☐ Oregon Off Exchange (SHOP)	☐ Oregon ☐ Washington	☐ ASO ☐ PBM	☐ Medicare	☐ Medicaid
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS					

POLICY:

All organizational providers are required to complete initial credentialing prior to contracting. The credentialing process includes completion of an organizational provider credentialing application, verification of specific criteria with review and decision by the Credentials and Quality Committee (CQC). This assessment process is repeated at least every 3 years to the day.

Organizational Providers are required to meet and maintain compliance with credentialing criteria without limitation. Organizational Providers that fail to comply with credentialing criteria may result in the Companies' decision to terminate.

DEFINITION:
See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

PROCEDURE:

I. Credentialing Procedure

A. Credentialing receives a request from Contracting, Provider Relations, or the Pharmacy Department to contract with a new organizational provider.

B. Prior to contracting with a new organizational provider and at recredentialing, Credentialing Staff will review to ensure criteria are met. The Credentialing Department obtains all relevant documentation required in the application. The

signed application and primary source verification contained in the complete application shall not be more than 180 days old at the time of the CQC's decision. Credentialing decisions will be based on the verification of a complete Organizational Provider Application. Complete application includes, but is not limited to the following (primary source verification requirements are indicated by an asterisk *):

1. Licensure - Copy of current valid state or equivalent (business license, certificate, etc), as applicable. The Companies relies on active status enrollment of 'moderate' or 'high' risk providers in Medicare; therefore, will verify OHA licensure for 'moderate' or 'high' risk provider types.

2. Current liability insurance - The organizational provider is required to provide evidence of current professional liability coverage with liability limits at a minimum of $1,000,000 per claim and $3,000,000 aggregate, and commercial general liability coverage with liability limits at a minimum of $1,000,000 per claim and $2,000,000 aggregate.

   Organizational providers are also required to maintain insurance applicable to the organization type and in accordance with applicable state laws, including coverage for workers' compensation.

3. *Medicare or Medicaid Sanction and Exclusion – must cover most recent three-year period and includes the following:

   a. OIG - Sanctions are verified through the Cumulative Sanction Report available from the Office of Inspector General (OIG).
   b. SAM - GSA/ System Award Management parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits.
   c. Opt Out - A documented review of the Medicare opt-out list by querying the name of the organization's administrator
   d. Preclusion – A documented review of the monthly CMS Preclusion list.

4. CMS Report - Copy of last CMS inspection report, findings, and documentation submitted to explain any corrective actions necessary

5. Seclusion and Restraint Policy

6. Patient Visitation Policy (hospitals only).

7. Quality Assurance and Performance Improvement (QAPI) Policy (ASC only)

8. Surgical Site Verification Policy (ASC only)

9. Credentialing Policy - Description of credentialing, recredentialing, and clinical staff privileging program to ensure that all providers credential their practitioners

   Practitioners who provide care at the facility (such as a hospital) and only interact with members as a result of their role at the facility are credentialed by the facility (i.e. Anesthesiologists, Emergency Room providers, Hospitalists, Neonatologists, Pathologists, Radiologists and Telemedicine consultants).

10. Patient / Hospital Transfer Agreement (ASC only) - ASC must provide a copy of at least one transfer agreement with a participating hospital.

11. Accreditation – Copy of current accreditation. Recognized accrediting bodies include:

    - National Committee for Quality Assurance (NCQA)
    - The Joint Commission (TJC)
    - Det Norske Veritas Germanischer Lloyd (DNV GL)
    - Accreditation Association for Ambulatory Health Care (AAAHC)
    - Clinical Laboratory Improvement Amendments (CLIA)
    - Utilization Review Accreditation Commission (URAC)
    - American Association of Ambulatory Surgery Centers (AAASC)
    - American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
    - Commission on Accreditation of Rehabilitation Facilities (CARF)
    - Council on Accreditation (COA)
    - American Board for Certification in Orthotics, Prosthetics, and Pedorthics (ABC)
    - Commission for the Accreditation of Birth Centers (CABC)

- American College of Radiology (ACR)
- Intersocietal Accreditation Commission (IAC)
- Community Health Accreditation Program (CHAP)
- Healthcare Facilities Accreditation Program (HFAP)
- Institute for Medical Quality (IMQ)
- Accreditation Commissions for Healthcare (ACHC)
- American Osteopathic Association (AOA)
- Oregon Health Authority (OHA)
- Healthcare Quality Association on Accreditation (HQAA)

a. Findings by an accrediting body will be collected as well as evidence of corrective actions taken to resolve any cited deficiencies.

12. All Organizational Providers not accredited by a recognized accrediting body must have a process ensuring that they credential their practitioners and must meet one of the following:

    a. CMS or state survey no more than three years old may be collected from the organization or the agency stating that the organization was reviewed and passed inspection

    b. An on-site quality assessment or equivalent. The following steps will be included in the on-site review process:

        i. A date for the site visit will be scheduled with the organizational provider. If the organizational provider has satellite facilities that follow the same policies and procedures as the provider, Companies may limit the site visit to the main facility.

        ii. The organizational provider will be sent a packet, which includes the survey tool and the requirements for the on-site visit, which may include, but not limited to facility tour, staff interview, medical record review and policy review.

        iii. Following the visit, the reviewer will complete the report and submit it to the CQC for approval. If there are quality issues or other concerns identified, these issues will be discussed with a Medical

Director for a recommendation. The determination made by the Medical Director may include the following:

- no further action,
- review of medical records,
- notification/query letter to the organizational provider regarding the issues,
- third party review of stipulated cases,
- referral to the CQC
- any other appropriate action deemed necessary to determine if care is less than satisfactory.

c. If the organizational provider is in a rural area, as defined by the U.S. Census Bureau (https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html) and is not accredited, nor has a CMS site survey been conducted within the three year cycle, the on-site survey requirement will be waived.

13. *National Provider Identifier (NPI)

14. Contact Information – All organizations are required to provide current contact information including, but not limited to: current addresses, phone, fax, and e-mail address.

II. Recredentialing Process

Organizational providers are recredentialed by Credentialing Staff at least every 3 years to the day. The recredentialing process includes verification as defined in this policy and a current quality profile.

III. CQC Oversight

A. If quality issues are identified, the organizational provider will be referred to CQC for review and determination as defined in Credentialing Services policy CR 9.0 Ongoing Monitoring, Corrective Action and Intervention.

B. Failure of an organizational provider to comply with the corrective action plan may result in CQC recommending termination from panel participation. The

organizational provider has the right to appeal in accordance with Credentialing Services policy CR 10.0 Actions and Appeals Process.

C. Within thirty (30) days after the credentialing decision and recredentialing denials, the Credentialing Department sends written notification of the CQC's decision.

IV. Organizational Providers Primary Source Verification Procedure

Provider Type	Credentialing Elements	Explanation / Primary Source Verification Source*	Accrediting Body
All Organizational Provider Credentialing Criteria **Not limited to specific organization providers further defined in this document**	State License or equivalent license or certificate	Copy of document. Source may be further defined in specific organizational provider sections within this document.	NCQA / CMS
	Accreditation / State Survey	Accreditation or State Survey must be completed every 3 years unless in a rural area (total population of 2,500 persons). If neither have been completed in the last 3 years, PHP is required to perform site survey or equivalent	NCQA / CMS
	OIG	Office of Inspector General (OIG)* Two OIG verifications must be queried: 1. Administrator first and last name (Search for an Individual) 2. Facility name – separate report queried for both multiple names (Legal, DBA) (Search for a Single Entity or Search for Multiple Entities)	CMS / MAP / PHP
	SAM	System for Award Management (SAM)* Two SAM verifications must be queried: 1. Administrator first and last name. 2. Facility name – separate report queried for both multiple names (Legal, DBA)	CMS / MAP / PHP
	Preclusion	Updated Preclusion List is downloaded monthly. Document findings at the time of credentialing.	CMS / MAP / PHP
	W-9 or IRS Letter	Copy of document	PHP
	NPI – Type 2 Organizational	Verified online (can be searched either by facility name or NPI number listed on page 4 of OPCA): National Plan & Provider Enumeration System (NPPES)*	CMS / MAP / PHP
	Malpractice Insurance	Professional liability with a minimum $1,000,000 per claim and $3,000,000 aggregate; and commercial general liability with a minimum $1,000,000 per claim and $2,000,000 aggregate Two ways to verify: 1. Attested in credentialing application. 2. Verified through copy of malpractice insurance certificate, provided by facility administrator.	NCQA / CMS
	Credentialing Program or Hiring Policy	Copy of document to ensure that organizational providers credential their practitioners.	CMS / MAP / PHP
	Seclusion & Restraint Policy (CFR 438.100)	Copy of document	CMS / MAP
	Medicare Certification	Copy of document required only for organizational providers certified through Medicare. Medicare does not certify Behavioral Health or Genetic Counseling facilities in Oregon or Washington.	CMS

Provider Type	Credentialing Elements	Explanation / Primary Source Verification Source*	Accrediting Body
	NPDB	Required for all organizational providers*	PHP
Ambulatory Surgery Center (ASC)	State License	Active/Current license in good standing: - Copy - OR: Oregon Health Authority (OHA) - WA: Washington State Department of Health	NCQA / CMS
	Roster	List of all providers performing procedures, including Anesthesia	PHP
	Privileges	Copy of privileges granted at ASC	PHP
	QAPI Policy	ASC must provide a copy of their current Quality Improvement policy along with the current projects	PHP
	Transfer Agreement	ASC must provide a copy of at least one transfer agreement with a participating hospital	PHP
Behavioral Health Facilities including mental health and substance abuse services: Inpatient, Residential, Ambulatory	State License / Certificate of Approval (COA)	Oregon Outpatient/ambulatory Mental Health and Chemical Dependency Organizational Providers (excluding privately owned) are issued a Certificate of Approval (COA). - Copy - OR: Oregon Health Authority (OHA) Oregon Residential Treatment and Inpatient Organizational Providers are issued a state license - Copy - OR: Oregon Health Authority (OHA) Washington Behavioral Health Organizational Providers - Copy - WA: Washington State Department of Health COA: Provided by facility Administrator, must have COA for each provider type (Mental Health and/or Chemical Dependency) unless both types are listed on one COA. Institution for Oregon COA's is Oregon Health Authority Addictions and Mental Health Division (OHA MH/CD). Residential Treatment and Inpatient Organizational Providers License: Provided by facility Administrator, cannot be verified online.	NCQA / CMS
	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ ***(Year)*** DMAP Provider Spreadsheets	OHA

Provider Type	Credentialing Elements	Explanation / Primary Source Verification Source*	Accrediting Body
Birthing Center (BC)	State License	Active/Current license in good standing: - Copy - OR: Oregon Health Authority (OHA) - WA: Washington State Department of Health	NCQA / CMS
Clinical Laboratory	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ ***(Year)*** DMAP Provider Spreadsheets	OHA
Comprehensive Outpatient Rehabilitation Facility (CORF)	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ ***(Year)*** DMAP Provider Spreadsheets	OHA
Durable Medical Equipment (DME) Prosthetic, Orthotics and Supplies (POS)	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ ***(Year)*** DMAP Provider Spreadsheets Healthcare Quality Association on Accreditation (HQAA)	OHA
Genetic Counseling	State License	Copy of business certificate	NCQA / CMS
Home Health Agency (HHA)	State License	Active/Current license in good standing: - Copy - OR: Oregon Health Authority (OHA) - WA: Washington State Department of Health	NCQA / CMS
	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ ***(Year)*** DMAP Provider Spreadsheets	OHA

Provider Type	Credentialing Elements	Explanation / Primary Source Verification Source*	Accrediting Body
Hospital	State License	Active/Current license in good standing: - Copy - OR: Oregon Health Authority (OHA) - WA: Washington State Department of Health	NCQA / CMS
	CLIA Certificate	CLIA certificate: - Copy - Clinical Laboratory Improvement Amendments (CLIA)	CMS / PHP
	DEA Certificate	DEA certificate: - Copy - Drug Enforcement Administration National Technical Information Service (DEA NTIS)	NCQA / CMS / MAP
	Patient Visitation Policy (CFR 482.013)	Copy of document	CMS
Hospice	State License	Active/Current license in good standing: - Copy - OR: Oregon Health Authority (OHA) WA: Washington State Department of Health	NCQA / CMS
	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ ***(Year)*** DMAP Provider Spreadsheets	OHA
Outpatient Physical Therapy and Speech Pathology Provider	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ ***(Year)*** DMAP Provider Spreadsheets	OHA

Provider Type	Credentialing Elements	Explanation / Primary Source Verification Source*	Accrediting Body
Pharmacy	State License (for each Pharmacy)	Active/Current license in good standing: - Copy - OR: Oregon Board of Pharmacy - WA: Washington State Department of Health	NCQA / CMS
	DEA Certificate (for each Pharmacy)	DEA certificate: - Copy - Drug Enforcement Administration National Technical Information Service (DEA NTIS)	NCQA /CMS/MAP/ PHP
	Inspection Reports	State Board of Pharmacy Inspection Reports- most recent results	PHP
	Policies and Procedures	For the provision of birth control assessment and prescribing. Must have copy in file at each recredential	PHP
Portable X-Ray Supplier	Oregon Provider Enrollment List (Medicaid Only)	P:\OMAP\Encounter Data\Provider Information\ ***(Year)*** DMAP Provider Spreadsheets	OHA
Skilled Nursing Facility (SNF)	State License	Active/Current license in good standing: - Copy - OR: Oregon Department of Human Resources - WA: Washington State Department of Health	NCQA / CMS
	Medicare Nursing Home Compare	Required only for Skilled Nursing Facilities* Medicare.gov/nursinghomecompare	PHP

REFERENCES:

NCQA Credentialing Standards
CMS Credentialing Standards
CR 9.0 Ongoing Monitoring, Corrective Action and Intervention
CR 10.0 Actions and Appeals Process
CR 23.0 Credentialing Definitions and Acronyms

Policy and Procedure			
SUBJECT: **Exceptions (Includes Temporary Emergency Provisions)**		DEPARTMENT: **CR: Credentialing Services**	
ORIGINAL EFFECTIVE DATE: **07/10**		DATE(S) REVISED: **5/14, 11/14; 6/15; 4/16; 6/16; 1/18; 6/18; 6/19; 5/20; 5/21; 8/21; 5/22; 4/23; 3/24; 2/25; 2/26**	
APPROVED BY: **Medical Director**	DATE: **02/18/2026**	NUMBER: **CR 16.0**	PAGE: **1 of 6**

SCOPE:

Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

All practitioners

All organizational providers

Fully Insured					
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid
☐ Oregon On Exchange	☐ Oregon On Exchange (SHOP)	☐ Oregon	☐ ASO	☐ Medicare	☐ Medicaid
☐ Oregon Off Exchange	☐ Oregon Off Exchange (SHOP)	☐ Washington	☐ PBM		
☐ Washington Off Exchange					
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS					

POLICY:

The Credentialing and Quality Committee (CQC) will review all files that are considered exceptions as outlined in this policy.

In the event that an applicant is needed to fulfill a network need, Provider Relations will submit information detailing the need and request to the CQC for decision.

DEFINITION:

See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

PROCEDURE:

I. Types of Credentialing Exceptions

Credentialing Exceptions include, but not limited to the following:

A. Non-Board-Certified practitioners who do not meet grandfathering criteria

B. Current or previous malpractice claims, lawsuits, judgments, settlements, or other incidents that might indicate a quality of care or competency issue, including the following:

1. Malpractice claims with settlements of $100,000 or greater

2. Two or more malpractice claims with settlements

3. Malpractice claims that are pending disposition, dismissed or result in a judgment of no fault and/or no payment on the practitioner's behalf may be reviewed by Credentialing Leadership (Supervisor-level or above, or Medical Director) to determine if the file requires review by the CQC

4. Practitioners with malpractice claims during residency or professional training will not be considered an exception

C. Current or previous disciplinary actions by licensing boards, DEA or CDS agencies, hospitals, managed care plans, health delivery systems, facilities, medical review boards, or other administrative bodies or government agencies including Medicare and Medicaid, etc. The CQC has the sole discretion to consider any licensing board activity as a reason for suspension or termination from the Companies' network.

D. Previous misdemeanor (except non-work related, or prior to medical school/education), all felony convictions, and DUI's less than 10 years old or more than 1 DUI.

E. Any other sanction or disciplinary action indicated in the Attestation section of the practitioner's application may be reviewed by Credentialing Leadership (Supervisor-level or above, or Medical Director) to determine if the file requires review by the CQC.

F. Any violations of state or federal law or standards of ethical conduct governing the applicant's profession.

G. Practitioners who did not complete a portion of their training or transferred to another training institution for completion (i.e. medical school, internship, residency, fellowship). If the practitioners left a training program for good cause and completed their training at another facility, this will not be considered an exception. These situations may be reviewed by Credentialing Leadership (Supervisor-level or above, or Medical Director) to determine if the file requires review by the CQC.

H. Indication of need for accommodations in order to perform essential functions of the position may be reviewed by Credentialing Leadership (Supervisor-level or above, or Medical Director) to determine if the file requires review by the CQC.

I. Insufficient call coverage.

J. Insufficient admit plan and/or lack of hospital privileges.

K. Professional liability insurance (malpractice) minimum limits that do not meet credentialing criteria with the following exclusions:

1. Practitioners with Federal Tort Coverage do not require review as an exception as long as they provide a copy of the Federal Tort letter or a signed attestation that they have federal tort coverage for professional liability.

2. Practitioners with coverage through a state agency that is self–insured do not require review as an exception as long as they provide a copy of the letter from the state agency.

II. Network Need Exceptions:

Practitioners or Organizational Providers who do not meet credentialing criteria will be presented to CQC for determination when "network need" has been established and a request has been submitted by the Provider Relations Department for CQC consideration.

A. Geo-access Exceptions

Geo-access exceptions are to address a lack of specific specialty, unique subspecialty or qualifications within a defined geographic area.

B. Business Need Exceptions
Business need exceptions include practitioners practicing in a clinical setting where members do not have a choice of practitioner selection or circumstances in which the Provider Relations Manager determines that Members would be significantly impacted. Network need for business-related circumstances may include the following:

1. Practitioner relationship with a practice group that provides care in a clinical setting where the member has no choice of practitioner selection (i.e., anesthesiology, ER physician, pathology, radiology, urgent care, emergency care, immediate care).

2. Practitioner meets a business need within a group that would be unable to maintain practice (and therefore, Member access) without the practitioner.

3. Practitioner is critical to on-call schedule with other network practitioners within a given medical group.

4. Other compelling reasons proposed by Provider Relations or other Officer(s).

C. Network Need Exception Requirements

1. Practice location – Network need exceptions are specific to the location requested by Provider Relations Department. The CQC approval letter will indicate approval for network need location(s) only. Practitioners must notify the Credentialing Department of any change in practice location. If a practitioner with a network need approval changes practice locations, this information will be forwarded to Provider Relations for a new network need request that will be reviewed by CQC for determination. Termination of panel membership may occur if the practitioner no longer fulfills a network need.

2. Board Certification – The following will be obtained for non-board-certified practitioners requesting exception:

a. Primary source verification of successful completion of a board-approved residency or fellowship program in the area of specialty
b. Receive two (2) current peer reference letters from practitioners who have had direct clinical observation of the applicant within the past twelve (12) months, validating that practitioner is adequately trained in the practice specialty and has demonstrated competency in the practice specialty.
c. For initial application, applicants will be required to submit 30 hours of Category 1 CMEs from the prior year or 60 Category 1 CMEs from the previous 2 years. At recredentialing, practitioners will be required to submit 90 Category 1 CMEs within the three-year credentialing cycle or 60 Category 1 CMEs within the past 2 years.

III. Exception Review

Exceptions that have been previously approved by the CQC will not be reviewed in subsequent recredentialing cycles, unless changes or concerns are reported or discovered.

IV. Quality Improvement Waivers

A. Practitioners that qualify for board certification waivers adopted by CQC to meet quality improvement goals for access and availability are not considered exceptions and therefore are not subject to CQC case-by-case review. Such applicants may be processed as “clean” files.

B. Participating practitioners initially approved with a board certification waiver will be grandfathered to board certification requirements at the time of recredentialing regardless of the waiver’s status.

C. The following will be obtained for non-board-certified practitioners credentialed with board certification waiver:

1. Primary source verification of successful completion of an approved residency or fellowship program in the area of specialty.

2. Two (2) current peer reference letters from practitioners who have had direct clinical observation of the applicant within the past twelve (12) months and who can verify that the practitioner is currently competent in the requested specialty.

3. Thirty (30) hours of Category 1 CMEs from the prior year or 60 Category 1 CMEs from the previous 2 years. At recredentialing, practitioners will be required to submit 90 Category 1 CMEs within the three-year credentialing cycle or 60 Category 1 CMEs within the past 2 years.

V. Temporary Emergency Provisions to Exceptions Policy

Establishes exceptions for discretionary Company policy that goes beyond minimum criteria required by state and federal guidelines. The intent of the emergency provisions is to provide needed flexibility and align with state and federal policy waivers announced based on extraordinary circumstances. Temporary exceptions include:

- Exception of expired board certification
- Exception of CME requirements
- Exception of an organizational provider application without a site review
- Exception of in-state licensure when professional licensing agencies are reciprocating licensure between states allowing licensed providers to render services outside of their state of enrollment.
- Any other exceptions or accommodations published by state, federal or accrediting organizations.

The CQC may approve recredentialing applications that contain temporary emergency exceptions for one year. In subsequent re-credentialing applications, the applicant must meet all standard Company requirements, and the temporary exception will not be grandfathered.

REFERENCES:

CR 23.0 Credentialing Definitions and Acronyms and Definitions
NCQA Credentialing Standards

Policy and Procedure			
SUBJECT: **Credentialing Information Integrity**		DEPARTMENT: **CR: Credentialing Services**	
ORIGINAL EFFECTIVE DATE: **06/13**		DATE(S) REVISED: **5/14; 6/15; 6/16; 6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23; 3/24; 1/25; 2/25; 2/26**	
APPROVED BY: **Medical Director**	DATE: **02/18/2026**	NUMBER: **CR 17.0**	PAGE: **1** of **9**

SCOPE:

Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

All Practitioners
Practitioner applicants

Fully Insured					
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid
☐ Oregon On Exchange ☐ Oregon Off Exchange ☐ Washington Off Exchange	☐ Oregon On Exchange (SHOP) ☐ Oregon Off Exchange (SHOP)	☐ Oregon ☐ Washington	☐ ASO ☐ PBM	☐ Medicare	☐ Medicaid
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS					

POLICY:

The Companies have processes in place to protect the integrity of credentialing information against inappropriate documentation and updates to ensure the accuracy of the practitioner data collected during the credentialing and recredentialing processes. The Credentialing Department works fully remote; therefore, only accepts credentialing information through electronic processes. Credentialing Information Integrity is achieved by limiting access, maintaining security groups authorized to make modifications, securing access to data, auditing credentialing processes, monitoring and oversight of all modifications made to practitioner data. The Credentialing Manager is responsible and has oversight of all credentialing information integrity functions, which includes auditing.

DEFINITION:

See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

PROCEDURE:

I. Scope of Credentialing Information

Credentialing staff are responsible for maintaining and safeguarding the credentialing information used during initial and recredentialing processes and between credentialing cycles against inappropriate documentation and updates. Credentialing information for practitioners and organizational providers includes:

1. Application and attestation
2. Credentialing documents received from the source or agent
3. Documentation of credentialing activities that include:
    - Verification dates
    - Report dates
    - Credentialing decisions
    - Credentialing decision dates
    - Signature or initials of the staff reviewing or verifying information
4. Credentialing committee minutes
5. Documentation of clean file approvals
6. Credentialing checklists

II. Levels of Authorization

Levels of authorization to document and access credentialing data are set by user groups in the credentialing database. User groups are established with specific security settings to limit access and safeguard the credentialing information. In addition, access is limited to credentialing information not stored in the credentialing database, which includes CQC minutes, clean file approvals and ongoing monitoring reports stored in a secure network folder.

A. Request for Credentialing Database Access and Credentialing Network Folder

Hiring managers may request access for staff members as appropriate to the staff member's job responsibilities. When access is requested to the credentialing database, the Credentialing Manager must authorize the level of access. Levels of permissions within the credentialing database determines the ability to access, modify and release credentialing information. Access to the Credentialing folder on the Company's network also requires Credentialing Manager approval for Credentialing staff only. In addition, credentialing documents including CQC minutes, clean file approvals, and ongoing monitoring reports are password protected. The Company's password protected electronic system in conjunction with Credentialing Manager's authorization of all staff member's level of access contributes to the prevention of unauthorized access, noncompliant modifications, and release of credentialing information.

B. Staff Responsible for Performing Credentialing Activities

The following credentialing staff members or roles are granted an access level to allow for modifications to perform and document credentialing activities. This level of access allows staff to read and modify (edit, update, delete) credentialing information.

a. Credentialing Manager
b. Credentialing Coordinators
c. Credentialing Analyst (maintains access to read and modify, but is not assigned credentialing verification activities)
d. Credentialing Technicians
e. Credentialing Delegation Auditor (maintains access to read and modify, but is not assigned credentialing verification activities)

C. Read-only Access

Read-only access is authorized for but not limited to the following staff members, titles or roles:

a. Quality Management Technicians, Coordinators, RN's, Program Managers, Managers
b. Provider Relations Assistants, Representatives and Managers

c. Behavioral Health Network Assistants, Network Specialists, Contractors, Representatives and Managers
d. Providence St Joseph Health Internal Auditors

D. Credentialing database access and level of authorization is reviewed and approved on an annual basis. The Credentialing Analyst will request a review and continued authorization of staff member access from the appropriate managers. Accounts that are no longer needed or have inappropriate access will be disabled or updated as identified.

III. Tracking and Documenting Credentialing Information and Modifications

A. Types of Modifications

1. The Companies define a modification as any update, edit, deletion, or addition to credentialing information after it is initially recorded in the electronic credentialing system. Appropriate modifications include:

   a. Correction of data entry errors – both changes and deletions, including typographic errors
   b. Updates to verifications of expired credentials
   c. Auto-update of licensure and board certification expiration dates by web-crawl
   d. Deletion of information recorded in the incorrect practitioner's file
   e. Deletion of a duplicate practitioner's record
   f. Addition of a new verification between credentialing cycles, such as a new certification or license.

2. The following activities are not considered modifications:
   a. Initial credentialing of a practitioner
   b. Entry of new cycle of recredentialing primary source verification and decision
   c. Initial documentation of a credentialing or recredentialing date in the system
   d. Modifications to practitioner demographic information

3. The following are inappropriate modifications that do not meet the Companies' policy:
    a. Any modification without documentation of who, when, what, and why a modification was made
    b. Any modifications that are not specified as allowable per the terms of this policy
    c. Falsifying credentialing dates for licenses, credentialing decisions, staff verifier, and ongoing monitoring
    d. Creating credentialing documentation without performing the required activities
    e. Fraudulently altering existing documents
    f. Attributing verifications or reviews to staff who did not perform the activity
    g. Updating information by unauthorized staff

B. Documenting Modifications

The credentialing database automatically tracks who, what and when data was modified. Staff members are required to document why a modification was made in the "Notes" section within the practitioner's electronic file. Through database reporting the following data is reviewed to track and ensure compliant practices for modifying data:

- What information is modified.
- When (date and time) the information was modified to ensure that modifications are not made inappropriately after credentialing approval
- How the information was modified, specifically if data was added, edited or deleted
- Staff who made the modification
- Why the information was modified with documentation in the "Notes" section

IV. Annual Information Integrity Auditing, Documenting, and Analyzing

A. Auditing Process

Annually, the Credentialing Analyst completes the following process to identify any inappropriate modifications made as defined in Section III.A.3 of this policy.

1. Generate audit universe report from the credentialing database that includes all initially credentialed or recredentialed practitioners in the previous 12 months.

2. Randomly select 5% or 50 practitioner files, whichever is less, that includes all credentialing decisions made or due in the previous year. The practitioner electronic files will include at least 10 initial credentialing and 10 recredentialing files and will be analyzed for inappropriate documentation and updates as defined in Section III.A.3 of this policy.

B. Documenting Annual Audit

Upon completion of the annual Credentialing Information Integrity audit the Credentialing Program Manager documents the results in the audit and analysis report, which is forwarded to notify the Credentialing Manager of any findings of inappropriate modifications. Documentation includes the following:

1. Report date
2. Review date
3. The title of individuals who conducted the audit
4. Audit period
5. File audit universe size
6. Audit sample size
7. Practitioner file identifier
8. The affected credentialing information, if identified as inappropriate
9. Rationale for inappropriate documentation or update, if identified
10. Number or percent and total of inappropriate documentation and updates by type of credentialing information
11. Staff member attributed to the inappropriate modification

C. Qualitative Analysis of Information Integrity Audit

The Credentialing Manager reviews the audit and analysis report and completes a qualitative analysis to substantiate and determine the cause for any noncompliant findings. The analysis report includes a summary of the following information:

1. The credentialing information reviewed
2. Number or percent and total of inappropriate documentation and updates by type of credentialing information
3. Description of inappropriate modifications
4. Staff member attributed to the inappropriate modification
5. The cause or reason of each finding
6. Determination of noncompliance by Credentialing Manager

V. Improvement Actions

In the event noncompliance is identified in the annual auditing process, a Corrective Action Plan (CAP) will be developed to address all noncompliant findings, and a follow-up audit will be conducted to measure the effectiveness of the CAP.

A. Implementation of Corrective Action Plan
Credentialing Manger will implement a documented Corrective Action Plan (CAP) to address all noncompliant findings by identifying the reason for the finding and the actions needed to correct future noncompliance. The CAP will be presented to the Credentialing staff members involved, as appropriate. CAP may include without limitation:

1. Finding(s)
2. Date of finding(s)
3. Actions and expectations for remediation

B. Measure of Effectiveness Follow-up Audit

If noncompliance is found during the annual Credentialing Information Integrity Audit, a follow-up audit will be conducted to measure the effectiveness of any CAPs within three (3) months of the annual audit. The Credentialing Manager will conduct the follow-up audit to measure the effectiveness of the CAP. The audit process to measure the effectiveness of the CAP includes the following:

1. Credentialing Analyst will generate a report capturing all credentialing decisions made or due to be made in the audit period to include the three (3) months after the annual audit.

2. The audit report will be limited to the credentialing staff and credentialing information for which noncompliant findings were identified in the CAP.
3. The sample size will be limited to 5% or 50 files, whichever is less.
4. The Credentialing Manager will conduct a qualitative analysis and draw a conclusion of the overall effectiveness of the CAP.

C. Consequences for Inappropriate Documentation and Updates

Consequences for inappropriate documentation and updates include:

1. Education and CAP with reaudit to determine the effectiveness as described in this policy.
2. If continued noncompliance is identified, staff members will be re-educated to correct noncompliance, and the CAP will be continued with another 3-month follow-up audit.
3. If noncompliance is not corrected, continued corrective action will include steps taken up to and including termination. Steps prior to termination would include engaging Human Resource specialists to assist in completing a documented verbal warning followed by final written warning if noncompliance is not corrected.

D. Identification of fraud and misconduct will be reported by the Credentialing Manager to NCQA through the Reporting Hotline for Fraud and Misconduct, including self-identification of systemic issues affecting 5% or more of the eligible credentialing or recredentialing files (i.e. falsifying of verification dates).

VI. Credentialing Information Integrity Training

A. Annually, Credentialing Information Integrity training is conducted for Credentialing Staff who have an access level that allows modifications to practitioner data. Training will include the following, but is not limited to:

1. Appropriate and inappropriate documentation and updates as defined in this policy.
2. Auditing of staff documentation and updates in the credentialing files.

3. The process for documenting and reporting inappropriate documentation and updates to credentialing leadership.
4. The process for reporting inappropriate documentation and updates to NCQA when the organization identifies fraud and misconduct.
5. The consequences for inappropriate documentation and updates.

B. Annual training will be completed in a group setting. Documented completion of annual training will be required from staff attesting by email that they have completed and understand the training materials.

REFERENCES:

CR 23.0 Credentialing Definitions and Acronyms
NCQA Credentialing Standards

Policy and Procedure	
SUBJECT: **Medicare/Medicaid Caregiver Training**	DEPARTMENT: **CR: Credentialing Services**
ORIGINAL EFFECTIVE DATE: **10/2025**	DATE(S) REVIEWED/REVISED: **02/26**
APPROVED BY: **Medical Director 02/18/2026**	NUMBER: **CR 18.0** PAGE: **1 of 2**

SCOPE:
Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

(Note: All policies must include this standard Scope language unless an exemption is granted by the Regulatory Compliance, Risk Management and Government Affairs Department)

APPLIES TO:

Fully Insured					
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid
☐ Oregon On Exchange ☐ Oregon Off Exchange ☐ Washington Off Exchange	☐ Oregon On Exchange (SHOP) ☐ Oregon Off Exchange (SHOP)	☐ Oregon ☐ Washington	☐ ASO ☐ PBM	☐ Medicare Advantage ☐ Medicare Supplement ☐ Medicare Advantage – D-SNP	☒ Medicaid
☐ APPLIES TO ALL ABOVE LINES OF BUSINESS					

POLICY:
To ensure all network providers are properly screened, enrolled and monitored in accordance with federal and state regulations and to prevent participation of excluded providers in Medicaid managed care programs, Company provides quarterly and annual training to credentialing new hires, staff, delegated entities, and participating practitioners and organizational providers, in accordance with 42 CFR §§ 438.608(b) and 438.214(d).

DEFINITIONS:
See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

PROCEDURE:
I. Medicare/Medicaid Credentialing Compliance Training

Training is conducted to ensure compliance with provider screening and enrollment requirements, and to support ongoing monitoring for excluded providers. The following groups receive specific training as outlined below:

Policy and Procedure	
SUBJECT: **Medicare/Medicaid Caregiver Training**	DEPARTMENT: **CR: Credentialing Services**
ORIGINAL EFFECTIVE DATE: **10/2025**	DATE(S) REVIEWED/REVISED: **02/26**
APPROVED BY: **Medical Director 02/18/2026**	NUMBER: PAGE: **CR 18.0** **2 of 2**

A. Credentialing New Hires
    1. Receive HIPAA, D-SNP, Fraud Waste and Abuse training to be completed within 90 days of date of employment.
    2. Required to review credentialing policies within 30 days of hire date
    3. Trained on all practitioner credentialing criteria, as outlined in credentialing policies
B. Credentialing Staff
    1. Trained annually first quarter of each year with any new updates that have been added to credentialing policies.
    2. Any new updates that require immediate implementation, policies will be updated and staff will be trained within 30 days of the new update.
    3. Annual HIPPA, D-SNP, Fraud Waste and Abuse training third quarter of each year.
    4. Monthly internal audit of credentialing files, education /training provided as needed if a finding is identified.
C. Delegated Credentialing Organizations
    1. Receive an email copy of updated policies first quarter of each year
    2. Receive an email notification of any new updates that require immediate implementation within 30 days of the new update
    3. Annual policy, file and ongoing monitoring review with notification of opportunity for improvement, if needed.
D. Participating Providers
    1. Receive notification, upon credentialing approval, regarding how to find credentialing policies and procedures
    2. Policies are posted in provider portal
    3. Polices are posted “above the log in” for potential practitioners for review prior to approval

REFERENCES:

Healthshare Base Agreement
42 CFR §§ 438.608(b)
42 CFR §§ 438.214(d)
CR 23.0 Credentialing Definitions and Acronyms

Policy and Procedure			
SUBJECT: **Annual Review & Development of Policies & Procedures**		DEPARTMENT: **CR: Credentialing Services**	
ORIGINAL EFFECTIVE DATE: **10/15**		DATE(S) REVISED: **6/16; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23; 3/24; 2/25; 2/26**	
APPROVED BY: **Medical Director**	DATE: **02/18/2026**	NUMBER: **CR 21.0**	PAGE: **1 of 2**

SCOPE:
Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:
All practitioners
All organizational providers

Fully Insured					
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid
☐ Oregon On Exchange	☐ Oregon On Exchange (SHOP)	☐ Oregon	☐ ASO	☐ Medicare	☐ Medicaid
☐ Oregon Off Exchange	☐ Oregon Off Exchange (SHOP)	☐ Washington	☐ PBM		
☐ Washington Off Exchange					
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS					

POLICY:

Credentialing policies and procedures are maintained by the Credentialing Manager to meet or exceed the standards established by the National Committee for Quality Assurance (NCQA), the Center for Medicare and Medicaid Services (CMS), and other standards within the Companies. These policies are reviewed at least annually, revised as needed, and approved by the Credentials and Quality Committee (CQC).

DEFINITION:
See Policy and Procedure CR 23.0 Credentialing Definitions and Acronyms

PROCEDURE:

1. The Medical Director or physician designee, and/or CQC members in conjunction with the Credentialing Manager recommend revisions to credentialing policies and procedures.

2. The Credentialing Manager performs an annual review of the credentialing policies and procedures for compliance with business practices, NCQA and CMS standards, and other applicable state and federal laws.

3. The CQC holds responsibility for reviewing and approving all credentialing policies and procedures annually.

REFERENCES:
CR 23.0 Credentialing Definitions and Acronyms
NCQA Credentialing Standards
CMS Credentialing Standards

Policy and Procedure			
SUBJECT: **Credentialing Definitions and Acronyms**		DEPARTMENT: **CR: Credentialing Services**	
ORIGINAL EFFECTIVE DATE: **6/16**		DATE(S) REVISED: **6/17; 6/18; 6/19; 5/20; 5/21; 5/22; 4/23; 3/24; 2/25; 2/26**	
APPROVED BY: **Medical Director**	DATE: **02/18/2026**	NUMBER: **CR 23.0**	PAGE: **1 of 12**

SCOPE:
Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

All practitioners
All organizational providers

Fully Insured						
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid	Delegated Services to Ayin
☐ Oregon On Exchange	☐ Oregon On Exchange (SHOP)	☐ Oregon	☐ ASO	☐ Medicare	☐ Medicaid	☐ YCCO
☐ Oregon Off Exchange	☐ Oregon Off Exchange (SHOP)	☐ Washington	☐ PBM			☐ WHA
☐ Washington Off Exchange						
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS						

POLICY:

Identification of definitions and acronyms pertaining to credentialing.

PROCEDURE:

1. Action – approval, modify, deny, termination, suspension, or reduction

2. Acupuncturist – person licensed to practice acupuncture by the relevant state licensing board. Acupuncture is legally defined in Oregon as "an Oriental health care practice used to promote health and to treat neurological, organic, or functional disorders by the stimulation of specific points on the surface of the body by the insertion of needles. Acupuncture includes the treatment method of moxibustion, as well as the use of electrical, thermal, mechanical or magnetic devices, with or without needles, to stimulate acupuncture points and acupuncture medians and to induce acupuncture anesthesia or analgesia." (ORS 677.757)

3. Acute – a condition, diagnosis, or illness with a sudden onset and that is of short duration.

4. Adequate record keeping – documentation that supports the level of service billed.

5. Adverse event –includes injury or harm while a Member is receiving care from a practitioner.

6. Ambulatory Surgical Center (ASC) – a facility licensed as an ASC

7. Appeal – a request for a review of an action.

8. Applicant – a practitioner that has submitted an Oregon Practitioner Credentialing or Recredentialing Application for initial or continued participation in the Companies' network.

9. Audiologist (AuD)– a person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.

10. Behavioral Health – mental health, mental illness, addiction disorders and substance abuse disorders

11. Board Certification – designation conferred by one of the affiliated specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine (ABPM), the American Board of Oral and Maxillofacial Surgery, or The College

of Family Physicians of Canada, or Royal College of Physicians and Surgeons, Canada as applicable, upon a physician or dentist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

12. Board Certified Behavioral Analyst (BCBA) – a practitioner licensed to provide behavior-analytic services.

13. Burden on the Participating Provider – healthcare professionals who apply for or maintain participation have the burden of providing evidence that demonstrates, at the sole discretion of the Companies, that they meet the established criteria for participation.

14. Chiropractor – a person licensed to practice chiropractic by the relevant state licensing board.

15. Clinical Nurse Specialist – a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.

16. Clinical privileges or privileges – the permission granted to a physician or practitioner by a facility governing board to render specific professional, diagnostic, therapeutic, medical, surgical, or dental services in the hospital or in connection with its programs based on the following: license, education, training, experience, current competence, health status or judgment.

17. Clinical Social Worker – a person licensed to practice clinical social work pursuant to state law

18. CMS – Centers for Medicare and Medicaid Services

19. Collaboration – Consultation between the physician assistant and a physician or podiatric physician or referral by the physician assistant to a physician or podiatric physician

20. Collaboration Agreement - A written agreement that describes the manner in which the physician assistant collaborates with physicians or podiatric physicians that does not assign supervisory responsibility to or represent acceptance of legal responsibility by a physician or podiatric physician for the care provided by the physician assistant and that

is signed by the physician assistant and the physician, podiatric physician or physician assistant's employer.

21. Collaborating physician – A participating physician approved by the licensing board and holds a written agreement that describes the manner in which a physician assistant collaborates as indicated by the patient's condition, community standards of care, and the physician assistant's education, training and experience.

22. Complaint (Member Complaint) - An expression of dissatisfaction with an aspect of the Companies' operations or activities, including the actions of practitioners and organizational providers. (NCQA's definition of complaint is inclusive of the CMS definition of "grievance.")

23. Concern (Quality of Care Concern) - A concern that care provided did not meet a professionally recognized standard of health care.

24. Contracted Hospital – an Organizational Provider credentialed as a hospital and is contracted for specific services (e.g. transplant services).

25. Credentialing – the process of obtaining, verifying, and assessing the qualifications of a healthcare practitioner to provide patient care services in or for a healthcare organization.

26. Credentialing information integrity – Maintaining and safeguarding the information used in the initial credentialing and recredentialing process against inappropriate documentation and updates.

27. Credentials – documented evidence of licensure, education, training, experience, other qualifications

28. Delegation - An organization gives another entity the authority to perform certain functions on its behalf. Although the organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately.

29. Delegation Agreement– a formal written agreement between The Companies' and an entity for delegation of the entire practitioner credentialing process, which can include primary source verification and decision making.

30. Dentist – Doctor of Dental Surgery (DDS), or Doctor of Dental Medicine (DMD). A person licensed to practice dentistry pursuant to state law of the state in which he or she practices dentistry

31. Emergency Department – the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.

32. Ethnicity - A shared culture and way of life, especially reflected in language, religion and material culture products, distinct from OMB's use of the term to refer only to Hispanic ethnicity ("Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare," IOM, 2003).

33. Finding – A conclusion reached as a result of information reviewed that may indicate a quality of care concern related to a sanction, exclusion, complaint or adverse event.

34. Focused monitoring – Focused oversight of a practitioner or organizational provider when performance, conduct or quality of care concerns are identified by the CQC.

35. Fraud – an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.

36. Grandfathered exceptions – exceptions to credentialing criteria approved by prior CQC committees do not need to be reconsidered or re-opened in subsequent recredentialing cycles.

37. Grievance – See "Complaint"

38. Health Care Professionals – individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.

39. Home Health Agency – a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that is licensed by the Authority as a home health agency.

40. Home Health Services – part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy) and home health aide services

41. Hospice – a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation.

42. Hospital – a facility licensed as a general hospital that meets requirements for participation under Title XVIII of the Social Security Act.

43. License – a method of regulation by which the state grants permission to persons who meet predetermined qualifications to engage in a health profession. The qualifications are set by law and without a license the practice of the specific health professional would be unlawful.

44. Licensed Direct Entry Midwife – a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery pursuant to state law.

45. Licensed Marriage and Family Therapists (LMFT) – a practitioner trained in psychotherapy and family systems and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems pursuant to state law.

46. Licensed Massage Therapist (LMT) – a practitioner licensed to practice the manual, or hands-on, movement of soft body tissues to enhance a person's well-being pursuant to state law.

47. Licensed Professional Counselor (LPC) – a licensed practitioner trained to work with individuals, families, and groups in treating mental, behavioral, and emotional problems and disorders pursuant to state law.

48. Liability Insurance – insurance that provides payment based on legal liabilities for injuries or illness.

49. Locum Tenens – a covering practitioner who does not have an independent relationship with the Companies and is not contracted.

50. Managed Care Organization (MCO) – a contracted health delivery system providing capitated or prepaid health services. An MCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a chemical dependency organization, fully capitated health plan, dental care organization, mental health organization or physician care organization.

51. Medicaid – a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act.

52. Medical Faculty – this license allows a physician to practice medicine only to the extent that such practice is incident to and a necessary part of the applicant's duties as approved by the OMB in connection with the faculty position. This type of license is valid for one year after issuance and may be renewed as frequently as needed for a total period not to exceed four years. The four years must be consecutive.

53. Medical Services – care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating or correcting a medical problem.

54. Medicare – a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons.

55. Member Complaint – See "Complaint"

56. Military Status License – in the State of Washington. There are no restrictions on this license. The State of Washington has labeled the license as military so they can waive their fees. The only difference between "active" and "military" status is Military licenses need to be renewed annually and not bi-annually like an "active" license. The provider can practice in a civilian facility without issues.

57. Modification - Any change to a practitioner's credentialing information, within the scope of the CR system controls requirements, after it has been recorded in the system. The organization determines what is an allowable modification based on the organization's Policies and Procedures.

58. National Provider Identification (NPI) – federally directed provider number mandated for use on HIPAA covered transactions, individuals, and provider organizations.

59. Naturopathic doctor (ND)– a person licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine

60. NCQA – National Committee for Quality Assurance

61. Nurse Anesthetist (CRNA) – a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.

62. Nurse Practitioner (not limited to ARNP, NP, FNP, ANP, PNP, PACNP, PPCNP, NNP, GNP, AGNP, AGACNP, AGPCNP, PMHNP, WHNP, CNM) – a licensed independent advanced practice registered nurse who is trained to assume responsibility and accountability for the care of patients pursuant to state law.

63. Occupational Therapist (OT) – a person licensed by the State Board of Examiners for Occupational Therapy. Provides the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, the aging process, or psychological disability. The treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.

64. Oregon Health Plan (OHP) – the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations and Medicaid and CHIP services under the State Plan.

65. Organizational provider – a facility, institution or organization where members are directed for services, healthcare or items rather than being directed to a specific practitioner.

66. Optometrist (OD) – a person licensed to practice optometry pursuant to state law.

67. Participating – Practitioner or provider who is external to the Companies and are part of the Companies' networks.

68. Participating Hospital – an Organizational Provider credentialed as a hospital and is contracted for all services.

69. Patient Safety - patient safety Interventions that reduce the risk of adverse events related to exposure to medical care across a range of diagnoses or conditions.

70. Pharmacist (RPh or PharmD) – a person licensed to practice pharmacy pursuant to state law. Degrees conferred for a pharmacist are either a Bachelor of Science (BS or BS Pharm) or a Doctor Pharmacy (PharmD). The PharmD is now the only degree you can get in pharmacy. Pharmacists who graduated prior to the early 2000's have a BS Pharm. RPh is used to note a licensed pharmacist. All BS Pharms and PharmDs, if licensed are RPh.

71. Physical Therapist (PT) – a practitioner licensed by the relevant state licensing authority to practice physical therapy. Treatment comprising exercise, massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis, or treatment of human being. Physical therapy may not include radiology or electrosurgery.

72. Physician (MD/DO)– a practitioner licensed to practice medicine pursuant to state law.

73. Physician Assistant/Associate (PA or PA-C) – provides medical services under the direction, collaboration or supervision of a licensed physician according to a practice description or agreement in accordance with state requirements.
74. Podiatrist (DPM) – a person licensed to practice podiatric medicine pursuant to state law. A doctor of podiatric medicine.

75. Practitioner – a health care professional licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.

76. Primary Care Provider (PCP) – practitioner who has responsibility for supervising, coordinating and providing initial and primary care within their scope of practice.

77. Primary Source Verification (PSV) – The affirmation (verification) of a healthcare professional's reported qualifications, license, experience and competence by direct contact with the sources of the qualifying entity or an approved agent of that source, including but not limited to residency programs, licensing agencies, specialty boards,

and professional and practice-related references.

78. Professional Reference (Peer Reference) – peer of equal or higher licensure or certification that has clinical knowledge and can attest to the practitioner's professional, clinical abilities. This reference cannot include a practitioner who is subordinate (supervisee/ mentee) to the applicant.

79. Psychiatrist (MD/DO) – a practitioner licensed to provide services related to the diagnosis and treatment of mental health pursuant to state law.

80. Psychologist (PsyD) – a practitioner licensed to provide services related to the science of mind and behavior or the treatment of mental, emotional and behavioral disorders pursuant to state law.

81. Quality Improvement (QI) Implementing corrective actions, based on assessment results, aimed at addressing identified deficiencies and improving outcomes.

82. Quality of Care - The degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

83. Quality of Care Concern – See "Concern"

84. Race - A biological categorization of genetically transferred physical characteristics (e.g., skin color, eye color, hair color, bone and jaw structure).

85. Recredential – process by which a practitioner renews current hospital privileges, membership or health plan participation. Occurs at least every 36 months depending on the entities policy or applicable standards.

86. Request for hearing – a clear expression in writing by an individual or representative that the person wishes to appeal a decision or action and wishes to have the decision considered by a higher authority.

87. Rural – a geographic area that is 10 or more map miles from a population center of 30,000 people or less.

88. Sanction – an action against providers taken in cases of fraud, misuse, or abuse.

89. Social Worker (LCSW or CSW) – a person licensed by the Board of Clinical Social Workers to practice clinical social work.

90. Speech-Language Pathologist (SLP) – a person licensed by the Oregon Board of Examiners for Speech Pathology. The application of principles, methods and procedure for measuring, evaluating, predicting, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.
91. Stakeholder – Any internal department that identifies a member or practitioner quality issue. Internal departments identified as stakeholders include, Quality Improvement, Credentialing, SIU, Patient Safety, Practitioner Escalated Review Team (PERT), Provider Relations, Case Management and Appeals and Grievances.

92. Supervising Practitioner – a practitioner who is participating and approved by the relevant licensing board to act as the supervising practitioner.

93. Surgical Assistant – a person performing required assistance in surgery as permitted by rules of the Oregon Medical Board (OMB).

94. Telemedicine – the provision of health services to patients by physicians and health care practitioners from a distant site using electronic communications through a telemedicine link formal consultation, diagnosis, or treatment in which the practitioner has either total or shared responsibility for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment and services) or provides official readings of images, tracings, or specimens.

95. Termination – a sanction prohibiting a provider's participation by canceling the provider's agreement.

96. Urban – a geographic area that is less than 10 map miles from a population center of 30,000 people or more.

97. Urgent Care – health services that are medically appropriate and immediately required to prevent serious deterioration of a client's health that are a result of an unforeseen illness or injury.

98. Web crawler - A “web crawler” is software that retrieves information directly from a primary or approved source website (e.g., the state licensing or certification agency)

REFERENCES:

NCQA Credentialing Standards
CMS Credentialing Standards