Grow Healthcare Group, P.A.
CREDENTIALING PROGRAM
Policies and Procedures

POLICY VERSION: 2.6

EFFECTIVE: 05/30/2025

REVIEW: Annual

POLICY OWNER: Credentialing Director

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Credentialing Policies and Procedures

1. Credentialing Program

Grow Healthcare, P.A. ("Grow") on behalf of itself and Grow Healthcare Group, P.C., a California professional corporation ("CA PC"), Grow Healthcare Practice Group of Kansas, P.A. ("KS PA"), and Grow Healthcare Group of New Jersey, P.C. ("NJ PC") (FL PA, CA PC, KS PA, and NJ PC collectively referred to herein as the "PCs") has implemented a comprehensive credentialing program that includes credentialing, recredentialing and ongoing monitoring to confirm participating practitioners meet the established criteria to provide quality care to patients. Grow's credentialing program will maintain adherence to NCQA accreditation, Medicare (Centers for Medicare Services) standards and other regulatory credentialing standards as outlined in this policy document. Grow may delegate credentialing functions to another entity if the delegate is found to be compliant with Grow's Credentialing Policies and Procedures ("Policies and Procedures").

This policy shall be governed by and construed in accordance with the laws of the state or states in which licensed practitioners reside. Any disclosure or breach of this policy will cause immediate, irreparable harm to Grow. Any breach or threatened breach of this policy therefore may be presented to either a court of binding arbitration for enforcement by both injunction and damages.

A. Annual Policy Review

The Policies and Procedures will be reviewed at least annually and revised when necessary to remain in compliance with state and federal laws, industry accreditation and regulatory standards, and approved by the Grow Credentialing Committee ("the Committee").

The Credentialing Manager and/or designee will conduct an annual review of all Policies and Procedures. The Grow Credentialing Committee Chair ("the Chair"), the Committee members and staff will be notified of the review of the Policies and Procedures and may make recommendations regarding potential modifications. The review will address NCQA standards for credentialing and recredentialing, applicable state and federal laws and regulations, the effectiveness of the credentialing and peer review program, and any other factors related to the Credentialing Program's effectiveness.

The Chair, the Committee and staff will report their evaluations and recommendations to the Credentialing Manager. At any time, the Chair, a Committee member, or staff member may recommend or request modifications to the Policies and Procedures. Recommendations or requests must be in writing and directed to the Credentialing Manager. The Credentialing Manager will review these evaluations and recommendations and make appropriate changes. The draft changes will then be submitted to the Committee for approval. Changes to the Credentialing Policies that are not considered major or significant will be made without submission to the Committee. Any changes that would directly impact the Credentialing Program at Grow will be reviewed by the Committee prior to approval.

B. Scope of Practitioners

Grow's credentialing program applies to independent practitioners who can diagnose and have been deemed competent within the scope of services of their license, education, training and experience. Practitioners credentialed under Grow include the following: Medical Doctors (MDs) or Doctors of Osteopathic Medicine (DOs), and non-physician behavioral healthcare practitioners (psychologists, clinical social workers, counselors, nurse practitioners (NPs), marriage and family therapists, and other categories of masters-level therapists) as may be defined from time to time.[1] Grow does not utilize or credential locum tenens.

C. Practitioner Minimum Criteria for Participation

In order to be considered for participation in the Grow network, and to ensure compliance with relevant regulatory, legal, and ethical patient care standards, practitioners must meet the following criteria:

1. Valid, current licensure that grants the practitioner authority to diagnose clients as applicable in the jurisdiction in which practitioners are providing care.
2. Valid, current Drug Enforcement Agency (DEA) and controlled dangerous substances (CDS) certificates in the state where the practitioner treats patients and will be prescribing controlled substances (MDs, DOs, and NPs only). All providers who state they will not be prescribing controlled substances sign an attestation. Should a patient require controlled substances are part of their care, they will be referred to a local provider
3. Completion of appropriate training for the specialty practiced such as residency program approved by state and accreditation bodies.
4. No current sanctions or limitations on licensure. Providers with a history of licensure limitations (e.g., suspensions) must have had all restrictions removed for at least one year before applying for credentialing.
5. Must not appear on any Federal or State Sanctions or Exclusions as outlined in the "Primary Source Verification Process" Section.
6. Malpractice coverage amounts must meet state limits based on the practitioner type. If state limits are not specified, amounts must meet $1 million/$3 million. No shared limits will be accepted.
7. No unprofessional conduct as reported to the NPDB or state medical board that may have or has the potential to impact patient care. The Committee reserves the right to review any reports of unprofessional conduct and determine whether it will disqualify the applicant.
8. Practitioners must not have unsatisfactory liability claims history including but not limited to lawsuits, arbitration, mediation, settlements or judgements. An unsatisfactory liability claims history may include but not be limited to, multiple claims related to the same or similar service, settlements of $100,000 for non-prescribing practitioners and $250,000 for prescribing practitioners for any single case in the past 10 years.
9. No liability claims, judgments, or settlements for sexual misconduct.
10. Practitioners must not have any current licensure probation, reduction or restriction of duties or privileges, or any such liability claims, cases or actions pending, by which in the view of the

[1] CR 1, Element A, factor 1 (the organization specifies the types of practitioners it credentials).

Committee would raise concerns about the future professional performance, conduct and competency of care.

These criteria are based on the NCQA standards and requirements from the payors with which Grow partners.

D. Directories

Grow with the assistance of the management services organization, Grow Care, Inc. (the "MSO"), ensures that information provided in member materials and practitioner directories is consistent with the information obtained during the credentialing process. Verification of fellowship required if communicated to members.[2] Directories, both internal and external, will be updated with new information as appropriate and on a regular basis.

2. Credentialing Committee Structure

The Committee supports the mission of the Credentialing Policies and Procedures by evaluating each potential practitioner for participation in the Grow network and ensuring quality within the network that aligns with relevant regulatory, legal, and ethical standards. The Committee is a multi-disciplinary committee composed of the Credentialing Chair ("the Chair") and both primary care and specialty practitioners, which participate in Grow's network.[3] The Committee members may be MDs, DOs or NPs who are board certified in Psychiatry, Mental Health, or other specialties as determined to be appropriate by the Committee. The Committee also includes licensed behavioral health providers/counselors or therapists or other advanced practice professionals. This Committee may also include ad-hoc practitioners to provide clinical experience and guidance, as necessary if particular specialty expertise is required.[4] Administrative support staff are non-voting members with the purpose of facilitating meetings and execution of the Credentialing Program. The Committee shall be composed of at least six members selected by the Chair. The term of each member shall be three years, renewable by the Credentials Committee indefinitely. A quorum of four voting members must be present (in person or electronically) to take any action. The Chair only votes in the event of a tie. The Committee upholds the highest standards for monitoring credentialing, recredentialing, ongoing monitoring and participation within the Grow network.

[2] CR 1, Element A, factor 12 (Credentialing Policies and Procedures describe the organization's process for ensuring that information provided in member materials and practitioner directories is consistent with the information obtained during the credentialing process).
[3] CR 1, Element A, factor 9 (The medical director or other designated physician's direct responsibility and participation in the credentialing program.)
[4] CR 2, Element A, factor 1 (The Credentialing Committee is a peer-review body with members from the types of practitioners participating in the organization's network. The organization may have separate review bodies for each practitioner type).

A. Non-Discrimination

Grow is committed to providing the highest quality of care that aligns with relevant regulatory, legal, and ethical standards. To ensure there is no discrimination during the credentialing and recredentialing processes, Grow takes actions that may include, but are not limited to: [5]

1. Prevention
    a. Maintaining a heterogeneous Committee membership.
    b. A commitment to diversity, equity and inclusion.
    c. Requiring the Chair and the Committee to sign an affirmative statement to make decisions in a nondiscriminatory manner.
    d. All voting Committee members must attest in writing "as a member of the Committee decision making process will ensure that credentialing and recredentialing is conducted in a non-discriminatory manner. The formal selection and retention criteria by the Committee are not based on any protected characteristic or trait, including but not limited to age, gender, race, religion, creed, sexual orientation, gender identity ethnic/national identity, population of patients served, payer acceptance, patient's insurance coverage, or physician disability (after any necessary reasonable accommodations)." [6]
2. Monitoring[7]
    a. Conducts annual audits of practitioner files to assess any indication of discrimination throughout the credentialing process.
    b. Practitioner complaints are evaluated at least semi-annually to determine and address any alleging discrimination.

B. Credentialing Chair & Committee Responsibilities

The Committee meets monthly, or as needed to make timely decisions through teleconferencing or in-person. All meetings will be documented through formal meeting minutes to include but not limited to recorded attendance, recorded absences, thoughtful discussion and considerations, documented decisions and a final signature by the Chair or a designee when formally approved at the next scheduled meeting.[8]

The Committee has responsibilities in the following areas:

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[5] CR 1, Element A, factor 7 (Nondiscriminatory credentialing and recredentialing):
- Specify the process for preventing discriminatory practices
- Specify how the organization monitors the credentialing and recredentialing processes for discriminatory practices, at least annually

[6] CR 1, Element A, factor 7 (State that the organization does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient's insurance coverage (e.g., Medicaid) in which the practitioner specializes).

[7] CR 1, Element A, factor 7 (Specify how the organization monitors the credentialing and recredentialing processes for discriminatory practices, at least annually).

[8] CR 2, Element A, factor 2 (The Credentialing Committee: Reviews the credentials of practitioners who do not meet the organization's criteria for participation in the network; Gives thoughtful consideration to credentialing information; Documents discussions about credentialing in meeting minutes; Meetings and decisions may take place in real-time, virtual meetings. As well as; CR 1, Element A, Factor 3 and 4 (Decision-making criteria and process).

1. Reviews individual credentialing files, performs peer review, and has full authority to make credentialing and recredentialing decisions regarding the approval/disapproval for practitioner participation in the PCs.
2. Reviews and provides input into Grow's credentialing, monitoring, peer review, and recredentialing standards as defined in the Credentialing Program's policies.
3. Reviews Quality reporting provided by Grow's Quality department for accessing complaints and adverse events.
4. Reviews sanctions, complaints and other adverse events found during ongoing monitoring based on the organization's criteria and makes recommendations about actions.[9]
5. Oversees delegated credentialing activities through the review of performance reports and recommends corrective actions that should be taken when delegate performance does not meet expectations.

The Credentialing Chair has responsibility in the following areas:

1. Reviews and evaluates any issues or sanctions of network physicians
2. Annually evaluates Policies and Procedures, or periodically when necessary
3. Make all required reports to NPDB, state medical boards, other state professional boards, and health plans
4. Reviews credentialing and recredentialing clean files as outlined in the "Clean File Process."
6. Assist in the development of corrective action plans and/or regulatory compliance as needed
7. Participates and monitors the development and performance of the Credentialing Program
8. Coordinates with contracted practitioners on quality initiatives and credentialing activities, as applicable
9. Monitors implementation of and the performance of the Credentialing Program and Quality Improvement processes related to quality-of-care concerns

3: Practitioner Rights and Notifications

A. Practitioner Rights

Practitioners applying for participation or completing a recredentialing application have the right to review information submitted in support of their application except for peer review and NPDB queries, the right to correct erroneous information submitted by them and the right to request status of their application. Grow notifies practitioners of the rights described in this policy using a variety of avenues, such as the credentialing application cover letter, practitioner handbook or manual, website, letters to practitioners, or other information distributed to practitioners.

[9] CR 1, Element A, Factor 6 (Criteria for ongoing monitoring notifications to the Credentialing Committee).

a. Right to Review Information[10]

1. Upon request, practitioners have the right to review information obtained from outside sources and that is used in the credentialing process.
    a. Evaluation may include information obtained from outside primary sources (such as malpractice insurance carriers or state licensing boards, etc.).
    b. The review does not include:
        i. NPDB reports (due to OIG civil monetary penalties for violation of confidentiality)
        ii. References or recommendations
        iii. Other peer-review protected information.
    c. Grow is not required to reveal the source of information if the information is not obtained to meet credentialing verification requirements or if disclosure is prohibited by law.
    d. Practitioners may review the information at the Grow offices or receive copies of the information in a secure and confidential manner, such as secure fax, secure email, or certified mail.

b. Right to Correct Erroneous Information

Practitioners have the right to correct erroneous information collected during the credentialing and / or recredentialing process. This may include, but is not limited to, actions on a license, malpractice claims history, or board certification. If credentialing information obtained from other sources varies substantially from that supplied by the practitioner, the Credentialing Department notifies the practitioner by phone call, fax, email or certified letter as soon as possible after receipt of the conflicting information.

1. If the notification is made by:[11]
    a. Phone call – document the date of the call, person contacted, and the name or initials of the Grow staff member are recorded in the file.
    b. Fax - a copy of the fax confirmation report is dated, signed, or initialed by the Grow staff member and placed in the file.
    c. Email - a copy of the email will be saved in the practitioner's file.
    d. Certified letter - a copy of the letter and the certified return receipt is placed in the file.
2. The notification advises the practitioner of the nature of the discrepancy and asks the practitioner to submit a response to clarify or correct the information. The response must be submitted within ten working days of the notification.[12] Failure to respond may result

[10] CR 1, Element B, factor 1 (The organization notifies practitioners of their right to review information obtained from outside sources (e.g., malpractice insurance carriers, state licensing boards) to support their credentialing application. The organization is not required to make available: references; recommendations; peer-review protected information).
[11] CR 1, Element B, factor 2 (The organization notifies practitioners of their right to correct erroneous information and: the time frame for making corrections; the format for submitting corrections; where to submit corrections).
[12] CR 1, Element A, factor 8 (Credentialing Policies and Procedures describe the organization's process for notifying practitioners when credentialing information obtained from other sources varies substantially from that provided by the practitioner).

in the application being discontinued without hearing and appeal rights. The response must:

a. Be submitted in writing (via mail, email, or fax) to the Credentialing Department.
b. Include supporting documentation if available.

3. Upon documented receipt of corrected information, response is placed in the practitioner's credentialing file for review by the Chair, and the Committee. Grow is not required to reveal the source of information that was not obtained to meet verification requirements or if federal or state law prohibits disclosure.[13]
4. Any file with corrected information may be considered a Red Flag file.

c. Right to be Informed of Application Status[14]

Upon request, practitioners have the right to be informed of the status of their application. In response to such an application status request, one of the following statuses is provided by email, telephone or fax:

1. Application required from practitioner.
2. Primary source verification of credentials is in process.
3. Awaiting additional information from the practitioner. The practitioner is also advised that additional information is required.
4. All information has been received and the application is in process.
5. Application is scheduled to be presented to the Committee.
6. Application has been approved and a notification letter has been sent to the practitioner.
7. The Committee makes decisions pending additional information from practitioners. The practitioner is also told what additional information is needed.
8. Application has been denied and a notification letter has been sent to the practitioner.
9. Application has been withdrawn.

Credentialing Department staff records the date of the call, caller's name, and the name or initials of the staff member who spoke with the practitioner.

B. Incomplete Application Notifications and Follow-ups

During credentialing or recredentialing, a practitioner's credentialing application may be considered incomplete or require further investigation. Grow will notify the practitioner in order to provide direction for continuation of the credentialing process. Subject to applicable law, an application being deemed incomplete or requiring further investigation may result from:

1. Refusal to complete the credentialing or recredentialing Application and/or Attestation
2. Falsification of information supplied on the Application and Attestation
3. Criminal conviction or indictment, including a plea or verdict of guilty, or a conviction following a plea of nolo contendere

[13] CR 1, Element B, factor 2 (The organization is not required to reveal the source of information that was not obtained to meet verification requirements or if federal or state law prohibits disclosure).
[14] CR 1, Element B, factor 3 (The organization notifies practitioners of: their right to be informed of the status of their application, upon request; the information it is allowed to share with practitioners; its process for responding to requests for application status).

4. Documentation of inappropriate utilization of medical resources, either excessive or inadequate
5. Documentation of substantiated quality problems
6. Repeated and substantiated complaints from patients, institutions or other peers or allied health care practitioners
7. Concerns from information discovered in the credentialing/recredentialing process
8. Reported events from credentialing continuous monitoring

C. Determination Notifications

The applicant for credentialing or recredentialing is notified within five days of the Committee decision via letter delivered by email.[15] Where state or local requirements mandate alternate delivery methods and/or time frames, state or local requirements will be followed. In the case that an applicant is denied for appointment or reappointment, the reason for denial is sent to the practitioner and included is written notification of applicant's right to an appeal hearing, the time frame to request a hearing, and a copy of the fair hearing procedures. The practitioner may request an appeal within thirty days of notification.

4. Initial Credentialing Application Process

All applicants must meet the minimum criteria before being credentialed. Once an application is submitted, the Credentialing Manager or a designee will review it to determine if it is complete. Once completion is confirmed, the Credentialing Manager or a designee will timestamp the receipt of the completed application (e.g., a checklist notation) for each file, in which the credentialing process will begin. Grow will verify receipt and inform the applicant whether the application is complete within 7 working days from the application submission date. After the "Primary Source Verification Process" Section is conducted as described below, the file will be audited. A checklist must be present, signed/initialed, and dated to show that primary source verifications have been completed.. The checklist will describe each verification completed, the source that was used, the unique electronic signature of the user who completed the verification and the date the verification was completed. [16] Files will then be presented to the Committee as described in the "Final Review and Determination Process."

The initial credentialing decision is to be completed, if feasible, within 30 days after receiving a completed credentialing application. Any applications that cannot be completed in that time frame must contain a clear explanation of the basis for the delay and a plan to complete the application. Practitioners are only credentialed in states where they meet all "Practitioner Minimum Criteria for Participation."

[15] CR 1, Element A, Factor 9 (Credentialing policies and procedures specify that the organization's time frame for notifying applicants of initial credentialing decisions and recredentialing denials does not exceed 30 calendar days from the Credentialing Committee's decision. The organization is not required to notify practitioners regarding recredentialing approvals).
[16] CR 1, Element A, Factor 13 (Process for documenting information and activities in credentialing files.)

A. Application Contents

Applicants must submit a completed CAQH application and/or state mandated application as outlined in *Credentialing Policies & Procedures State Amendments*. The application shall include the following Personal / Practice information:

1. Applicant's full name
2. Degree
3. Social Security number
4. Specialty
5. Office(s) address and phone number, if applicable
6. Home street address and phone number
7. Cell phone number and practitioner email address
8. Date of birth
9. Practitioner race, ethnicity and languages (other than English) in which fluent[17]

The application will also include all necessary information to fulfill the required "Primary Source Verification Process" Section.

a. Attestation

The application will also include an attestation signed by the applicant confirming correctness and completeness. The signature date must be within 120 days of the Committee decision. If the application and attestation must be updated, only the practitioner may attest to the update.
If the applicant answers "yes" to any questions, the applicant must provide written details, and a copy of any judgment, adverse or favorable decisions, if applicable.

Practitioners must disclose all information pertaining to[18]:

1. **Licensure or registration:** Currently pending challenges to any licensure or registration and all prior challenges and the manner in which they were resolved, including through the voluntary relinquishment of such licensure or registration or probation.[19]
2. **Hospital Privileges and Other Affiliations:** Voluntary or involuntary termination of professional or medical staff membership or limitation, reduction, or loss of clinical privileges at a hospital or other health care delivery system or facility or any investigation or pending action which may lead to limitation, reduction, or termination.
3. **Education, Training and Certification:** Probation, discipline, reprimand, suspension, or resignation during clinical education or training.
4. **Sanctions:**
    a. Participation in Medicare, Medicaid or other Governmental Programs, other sanctions, or investigations or any pending actions.

[17] CR 3, Element C, factor 6 Applications for credentialing shall include the Practitioner race, ethnicity and language
[18] Grow requires these disclosures to ensure compliance with regulatory, legal, and ethical standards, and as needed to complete a CAQH application for enrollment with health plans.
[19] CR 3, Element C, factor 3 (At initial credentialing, practitioners attest to any loss of license since their initial licensure. At recredentialing, practitioners attest to any loss of licensure since the last credentialing cycle).

   b. National Practitioner Data Bank ("NPDB") or any state medical board reports related to the practitioner
5. **Malpractice Claims History and Professional Liability:**
   a. Involvement in pending professional liability actions and those that resulted in final judgment or settlement
   b. History of Professional Claims Resulting in a settlement
6. **Felony Convictions or Drug Use:**
   a. History of felony charges or convictions, loss or limitation of privileges or disciplinary activity
   b. Current use of illegal drugs or use of legal drugs without a prescription from a physician or authorized practitioner
7. **Ability to Perform Requested Professional Activities:** Any accommodations or limitations that may affect their ability to perform their professional responsibilities

b. Release from Liability

1. The submitted application shall imply consent for verification of data submitted and authorize Grow and its agents or employees to consult with members of the Medical Staff(s) or Administration of other hospitals with which the applicant is/has been associated and/or with persons who may have information on applicant's competence, character, and ethical qualifications.
2. The applicant is responsible for producing adequate information for proper evaluation of character, competence, and other qualifications and for resolving any doubts about such qualifications.
3. The submitted application implies consent for the inspection of all records and documents that may be submitted (either by the US Post Office or electronically) to evaluate applicant's professional and ethical qualifications for membership.
4. The application also releases from any liability any individuals who, for the purposes of credentialing, provide information to Grow in good faith and without malice concerning the applicant's competence, conduct, ethics, character. and other qualifications related to appointment and clinical privileges, including otherwise privileged or confidential information.
5. The applicant consents to the disclosure to other hospitals, medical associations, licensing boards, NPDB and/or other entities to which disclosure is mandated by law information regarding applicant's professional or ethical standing.
6. The applicant acknowledges their obligation to abide by the provisions of the applicable Grow Policies and Procedures if she/he is approved.
7. Applicant authorizes Grow to release information to third parties as required by law and regulation (for audit and verification purposes).
8. All items verified via oral, written, or internet means must be dated & initialed/signed by appropriate staff to provide evidence of review. Neither stamp initials nor pencil is acceptable. By making application, the practitioner releases and indemnifies Grow and the MSO and their employees, assigns, agents, affiliates, attorneys, and others from any

liability, cause of action, or damages, or other claim incurred as a result of their application or membership in the Grow network.

B. Primary Source Verification Process[20]:

All primary source verifications are completed within 120 calendar days of the Credentialing Committee's decision. [21]

1. **NPI Number:** The applicant will supply their Type 1 NPI Number with a taxonomy code that matches the practitioner's specialty. Grow will confirm NPI number is accurate and the taxonomy code matches the practitioner's specialty by querying the NPPES NPI registry.
2. **Professional Licensure and/or Certification:** Applicant will supply current and past state license(s) with status. License(s) for the state(s) where the practitioner is applying to practice must be unrestricted, and any prior actions must be resolved. Licenses, state sanctions and limits on scope of practice will be verified using one of the following methods:
    a. Verification of licensing specific to the state(s) and license(s) held by the practitioner
    b. State and federal sanctions (if applicable)[22]
        i. Grow verifies the most recent five-year period available through any of the following sources:
            1. Physicians: Appropriate state agencies and/or Federation of State Medical Boards (FSMB).
            2. Other nonphysician health care professionals: State licensure, certification board, and/or appropriate state agency.
3. **Drug Enforcement Administration (applicable for MDs, DOs, and NPs)[23]:** Applicants will supply their Drug Enforcement Administration (DEA) registration with all schedules or an explanation why all schedules are not included. Providers that do not prescribe controlled substances and do not have DEA will sign an attestation listing the name of a designated alternate prescriber, that will be included in the credentialing packet. Providers that do hold an active DEA registration will be verified using one of the following methods:

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[20] CR 1, Element A, factor 2 (Credentialing policies and procedures describe the sources the organization uses to verify credentialing information…)

[21] CR 3, Element A, Factor 1, Factor 2, Factor 4, Factor 5 and Factor 6 (The organization verifies that the practitioner has a valid and current license to practice at the time of the credentialing decision. The organization verifies licenses in all states where the practitioner provides care to members. The organization must verify the license directly from the state licensing or certification agency or its website. License, Board certification, Work history and Malpractice History are verified within 120 days of the committee's decision.)

[22] CR 3, Element B, factor 1 (The organization verifies state sanctions, restrictions on licensure and limitations on scope of practice in all states where the practitioner provides care to members. The organization may obtain verification from the NPDB for all practitioner types listed below: Physicians; . . . .Other nonphysician health care professionals.).

[23] CR 3, Element A, factor 2 This factor applies to practitioners who are qualified to write prescriptions. The organization verifies that the practitioner's Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members. Attestation listing the name of the designated alternate prescriber will be obtained for those that do not hold a DEA or CDS. Acceptable verification sources: DEA or CDS agency, DEA or CDS certificate, or a photocopy of the certificate, documented visual inspection of the original DEA or CDS certificate or confirmation from the American Medical Association (AMA) Physician Masterfile (DEA only).

a. DEA number via internet website: http://www.deanumber.com
b. DEA Office of Diversion Control via internet website: https://www.deadiversion.usdoj.gov/
c. DEA certificate, or a photocopy of the certificate
d. Documented visual inspection of the original DEA certificate.
e. Confirmation from the American Medical Association (AMA) Physician Masterfile

4. **Controlled Dangerous Substance Certificate (if applicable):** Applicant will supply Controlled Dangerous Substance (CDS) certificate. Providers that do not prescribe controlled substances will sign an attestation listing the name of a designated alternate prescriber that will be included in the credentialing packet. CDS will be verified utilizing one of the following methods:
    a. CDS verification website for the specific state where the CDS is held
    b. CDS certificate, or a photocopy of the certificate
    c. Documented visual inspection of the original CDS certificate.
    d. Confirmation from the state pharmaceutical licensing agency, where applicable. [24]
5. **Board Certification (applicable for MDs, DOs, and NPs)[25]:**
    a. Applicant will supply identification of Board Certification (e.g., American Board of Medical Specialties, American Osteopathic Association, American Nursing Credentialing Center, American Association of Nurse Practitioners), the date(s) of certification, the expiration date on the certificate(s), and any MOC documentation.
    b. When an applicant states he/she is board-certified, Grow verifies current certification status and documents the verification date and expiration date of certification. Practitioner Board Certification will be verified using one of the following:
        i. Verification through ABMS Solutions/CertiFACTS
        ii. Verification through the AMA website (for MDs) www.ama-assn.org
        iii. Verification through the AOA website (for DOs) https://www.doprofiles.org
        iv. Additional AMA recognized medical specialty boards (available on the AMA website) may be accessed
6. **Education and Training[26]:** Applicant shall supply information the following information on where they attended College or University, Postgraduate Education, and Residency (if applicable): institution name, address, degree, major or specialty, dates attended, program completion.

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[24] CR 3, Element A, factor 2 This factor applies to practitioners who are qualified to write prescriptions. The organization verifies that the practitioner's Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members. Attestation listing the name of the designated alternate prescriber will be obtained for those that do not hold a DEA or CDS. Acceptable verification sources: DEA or CDS agency, DEA or CDS certificate, or a photocopy of the certificate, documented visual inspection of the original DEA or CDS certificate or confirmation from the American Medical Association (AMA) Physician Masterfile (DEA only).

[25] CR3, Element A, factor 4 (NCQA does not require board certification; however, the organization verifies the current certification status of practitioners who state that they are board certified.)

[26] CR 3, Element A, factor 3 (The organization verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate:1.Board certification.2.Residency.3.Graduation from medical or professional school.The organization uses any of the following to verify education and training:The primary source. The state licensing agency, specialty board or registry, if it performs primary source verification.)

a. Education and Training is verified by the highest of the following levels of education and training obtained by the practitioner:
    i. Board Certification
    ii. Residency
    iii. Graduation from medical or professional school
b. Education and training will be verified using one of the following methods:
    i. Internet on-line site via education training Web (if applicable)
    ii. AMA Profile https://profiles.ama-assn.org or AOA Profile https://www.doprofiles.org
    iii. National Student clearinghouse for all non-MD/DO behavioral health practitioners
    iv. The primary source such as documentation directly from the education institution if National Student Clearinghouse is not available
    v. The state licensing agency, specialty board, or registry of primary source verification is performed.
        - Grow will obtain written confirmation at least annually or provide a printed, dated screenshot from the website that the approved source performs primary source verification, or
        - provide evidence of the state statute requiring the licensing board to obtain verification of education and training directly from the institution.

7. **Professional References**: Applicant will supply complete addresses and phone numbers of two professional peers practicing in the same or similar specialty who have current and direct knowledge of applicant's qualifications, clinical competency, professional conduct, character and health status.
8. **Professional Work History**[27]: Applicants will supply at least five years of professional work history, starting with the present, including office practice, teaching appointments, military, public health service and employment. The work history will be documented in month/year format using any one of the following sources:
    a. Listed on Practitioner Application
    b. A separate written statement of work history. If CV is included for consideration, it must include month and date in the format
    c. Written (or oral) verification from past employers
    d. Internet on-line (if applicable)
    e. Gaps exceeding six months must be explained in writing from the practitioner including time, context and outcome (where permitted by applicable law).
9. **Professional Liability:** Applicant will supply a Certificate of Insurance for malpractice coverage with minimum limits in the amounts of $1/$3 million unless different amounts are required by the state of licensure. The provided Certificate must be current as of the date when the practitioner signed the attestation. Grow will ensure proof of medical malpractice insurance for the applicant

[27] CR 3 Element A, factor 5 (Employment dates. The organization obtains a minimum of the most recent 5 years of work history as a health professional through the practitioner's application or CV. If the practitioner has fewer than 5 years of work history, the time frame starts at the initial licensure date… Gaps in work history. If a gap in employment exceeds 6 months, the practitioner clarifies the gap verbally or in writing…if the gap in employment exceeds 1 year, the practitioner clarifies the gap in writing and the organization documents its review.)

appointed and approved by the Credentialing Committee. Medical Malpractice face sheet will be placed in credentialing file and will list coverage amounts as required by the state or carrier, and dates effective.

10. **Malpractice Claims History:**[28] Malpractice history of minimum of past five years is queried using the NPDB (https://www.npdb.hrsa.gov/). Malpractice claims will be monitored on an ongoing basis through the NPDB as described in "Ongoing Monitoring of Sanctions, Complaints and Adverse Events."
11. **Hospital Affiliations or Privileges (if applicable):** Applicant will supply any hospital affiliations or privileges.
12. **National Practitioner Data Bank (NPDB):** Grow will query the NPDB (https://www.npdb.hrsa.gov/) for verification of adverse actions taken by any State Medical Boards, insurance companies, hospitals, and any other reported entities. All practitioners will be enrolled in NPDB continuous query for ongoing monitoring as described in "Ongoing Monitoring of Sanctions, Complaints and Adverse Events."
13. **Medicare, Medicaid and Government Sanctions and Exclusions:**[29] The practitioner must confirm that they are able to participate in Medicare, Medicaid or other Governmental Programs and that they have no other sanctions, investigations or any pending actions. Grow will perform the queries below in order to confirm the practitioner's ability to participate, and all queries will be monitored on an ongoing basis as described in "Ongoing Monitoring of Sanctions, Complaints and Adverse Events":[30]
    a. The Office of Inspector General (OIG) Website http://exclusions.oig.hhs.gov/ to include List of Excluded Individuals and Entities(LEIE)
    b. EPLS (Excluded Parties List System)/SAM
    c. Social Security Administration Death Master File (SSA DMF) https://dmf.ntis.gov/
    d. CMS Medicare OPT-OUT Website
    e. Office of Foreign Asset Control (OFAC)
    f. CMS Preclusion Listing
    g. National Practitioner Data Bank (NPDB)
    h. All published state Medicaid Exclusion lists (state-specific websites) as outlined in the Policies & Procedures State Amendments

5. Recredentialing Process

All approved practitioners must be recredentialed within 36 months[31] from the original date of credentialing or on a more frequent basis if required by third party payors. Grow may extend the 36-month timeframe for a re-credentialing file for 60 calendar days due to certain circumstances.

[28] CR 3, Element A, factor 6 (The organization obtains confirmation of the past five years of malpractice settlements from the malpractice carrier or queries the National Practitioner Databank (NPDB). The five-year period may include residency or fellowship years. The organization is not required to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship).
[29] CR 3, Element B, factor 1 and 2. (Review Medicare and Medicaid sanctions, as well as, an additional verification source such as NPDB.)
[30] CR 5, Element A, Factor 1 and 2 (Outlining Medicare and Medicaid sanctions, as well as, Medicare and Medicaid exclusions utilized during the ongoing monitoring process.)
[31] CR 4, Element A (The organization formally credentials its practitioners at least every 36 months).

Documentation of extension will be kept in the practitioners file. If the practitioner does not respond to the recredentialing application by the end of the 35-month period, a non responder notice will be sent. If the application is not returned within the additional 30 days beyond the 35-month time frame the practitioner is sent a termination notice for non-response. Grow may extend a practitioner's recredentialing cycle time beyond 36 months if the practitioner is on an active military assignment, on medical leave, sabbatical or other good cause.[32]

The practitioner will receive a Recredentialing Application 90 days to the 3-year anniversary that requires the same applicant contents as the Initial Credentialing Application. The practitioner completes and returns the application and attestation. The credentialing staff will have 7 days to review the application for completeness. Once the recredentialing application is deemed complete, the credentialing staff proceeds to perform the "Primary Source Verification Process" with the exception of work history and education completion. A checklist must be present, signed/initialed, and dated to show the file has been audited. The checklist will describe each verification completed, the source that was used, the unique electronic signature of the user who completed the verification and the date the verification was completed. [33] Files will then be presented to the Committee as described in the "Final Review and Determination Process."

Any current practitioner not returning their recredentialing application will be deemed to have their appointment expired and will be considered terminated from the network at the end of the month in which the 36-month time frame occurs. The practitioner will be sent a letter notifying them of their termination from the network with instructions for re-applying to the network if desired. This termination will be considered administrative in nature and shall not entitle the practitioner to the hearing rights set forth in this policy.

A. Gaps in Participation in Network

Any suspension of practitioner privileges for more than 30 days requires network termination and full initial credentialing for the practitioner. If Grow suspends the practitioner's privileges, it may reinstate the practitioner within 30 calendar days of the suspension and not perform initial credentialing. If Grow terminates the practitioner for any reason, initial credentialing is performed.

B. Recredentialing Quality of Patient Care Monitoring

The credentialing staff will review and file data from patient satisfaction surveys, substantiated complaints/grievances, quality information provided by Grow Clinical Excellence department from the practitioner file and notes if any issues should have the Chair review:

1. Any quality, patient satisfaction surveys, and substantiated patient complaints provided by participating health plans.
2. If quality of patient care information is received, it is documented and reviewed in the practitioners re-credentialing file.

[32] CR 4, Element A (The organization may extend a practitioner's recredentialing cycle time frame (beyond 36 months) if the practitioner is: on active military assignment, medical leave (e.g., maternity leave), or on sabbatical).
[33] CR 1, Element A, Factor 13 (Process for documenting information and activities in credentialing files.)

3. If no quality of patient care information is found, indication is documented on the practitioner checklist or in the practitioner's recrediting file.

6. Final Review and Determination Process[34]

A. Credentialing Determinations

During the process, the Committee may elect to use one of the three credentialing status definitions. The three status definitions are:

1. Approved – practitioner successfully met criteria established by Grow
2. Denied – practitioner has failed to meet criteria required to participate or continue as a practitioner in the PCs If denied, practitioners will have the hearing and appeal rights set forth under Appeals.
3. Pend – Potential Issues – Committee needs more information from the practitioner or other sources in order to make a determination and will be brought back to a future committee meeting for final decision.

B. Clean File Process[35]

Grow has established a clean file process for reviewing practitioner credentialing and recredentialing files with no significant issues or findings.

The following will be considered a clean file when the practitioner has otherwise met the minimum criteria for participation:

1. Dismissed liability claims, sanctions, or licensing board complaints, investigations, reports, or actions, or an isolated complaint or report of reprimand, investigation, or corrective action from a professional affiliation or place of employment that were isolated in nature within a 5-year timeframe.
2. Paid liability claims from over 10 years ago with a payout less than $50,000 for practitioners and did not result in loss of life.
3. A health-related issue that does not require an accommodation
4. An isolated misdemeanor that took place over 10 years ago
5. A felony conviction that was not violent or sexual in nature that took place over 15 years ago
6. Resolved CE Credit Fines from over 10 years ago
7. Failing a board exam, one or more times, if passed on subsequent attempts

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[34] CR 1, Element A, factors 3, 4: Decision-making criteria and process - The organization:

- Credentials practitioners before they provide care to members.
- Has a process for making credentialing decisions, and defines the criteria it requires to reach a credentialing decision. Criteria are designed to assess a practitioner's ability to deliver care.
- Determines which practitioners may participate in its network.

[35] CR 1, Element A. factor 5 (The process for managing credentialing files that meet the organization's established criteria.)

The Chair will review clean files on a monthly or as needed basis and sign-off on the files.[36] The Committee will review all approved clean files monthly in the Committee meetings.

C. Red Flag File Process

All files that do not meet the criteria outlined in the "Clean File Process" will be considered Red Flag files and must be reviewed by the Committee.[37] These files cannot be expedited. The Committee will consider the adverse information in all Red Flag Files and vote to make a determination on each file, as outlined in "Credentialing Determinations," based on the "Practitioner Minimum Criteria for Participation." There will be a 1 year waiting period before practitioners may reapply if denied network participation.

7. Appeals [38]

In compliance with the NCQA Standards and federal and state mandates, Grow provides practitioners an appeal process when a professional review action has been taken to deny, suspend or terminate participation in the Grow Network. All hearing proceedings will be kept confidential unless required by law to release elements of the hearing.

A. Written Notification of Proposed Action

1. The practitioner is notified in writing that a professional review action has been proposed against him/her. The notification must include the reason for the action, a summary of rights, and an overview of the appeal and hearing process.
2. The practitioner's request must be made within 30 calendar days of the date of notification.

B. Written Notification of Hearing

1. If the affected practitioner requests a hearing, a written notification of the charges to be heard is sent to the practitioner. The notification must state the place, time, and date of the hearing.
2. The date of the hearing is not less than 30 calendar days after the date of the notice and not more than 90 days after, unless a longer period of time is agreed to by the parties.
3. The notification includes a list of the witnesses, if any, that are expected to testify at the hearing on behalf of the Grow professional review body.
4. The practitioner is also informed that the practitioner has the right to be represented by an attorney or another person of their choice.

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[36] CR 2, Element A, factor 3 (For files that meet the organization's credentialing criteria, the organization: Submits all practitioner files to the Credentialing Committee for review, or has a process for medical director or qualified physician review and approve clean files).
[37] CR 2, Element A, factor 2 (Reviews credentials for practitioners who do not meet established thresholds; Gives thoughtful consideration to credentialing information; Documents discussions about credentialing in meeting minutes). As well as; CR 1, Element A, Factor 5 (Managing files that meet/do not meet criteria).
[38] CR 6, Element A, Factor 1 and 2 (Notification to authorities and practitioner appeal rights.)

C. Hearing Panel Procedure

1. The hearing is held before a hearing panel. The Medical Director appoints a hearing panel composed of an odd number, at least three of the practitioner's peers who are not in direct economic competition with the practitioner involved or who participated in the decision. The majority of hearing panel members are peers of the affected clinician. Knowledge of the matter does not exclude a practitioner from serving on the panel.
2. The Medical Director designates an individual to serve as the Presiding Officer at the hearing.
    a. The Presiding Officer oversees the entire hearing process and is responsible for assuring that all participants have a reasonable opportunity to be heard and to present oral and documentary evidence, and that decorum is maintained throughout the hearing.
    b. The Presiding Officer may be legal counsel to Grow, but does not act as the prosecuting officer or as an advocate for either side at the hearing.
    c. The Presiding Officer may participate in the private deliberations of the hearing panel and may be a legal advisor to the panel but may not vote on the panel’s recommendations.
    d. The Presiding Officer has the sole authority and discretion to rule on all questions such as those pertaining to discovery, procedure, and the admissibility of evidence.
3. The affected practitioner is required to personally participate in the hearing. All hearings will be held via a web-based meeting. The right to the hearing may be forfeited if the practitioner fails, without good cause to appear and proceed. The practitioner has the right to be represented by an attorney or another person of the applicant's choice. Grow or the MSO will not have an attorney if the practitioner does not have an attorney.
4. Both parties have the right to:
    a. Have a recording made of the proceedings and to obtain a copy of that record upon payment of any reasonable charges associated with the preparation of the record.
    b. Call, examine, and cross-examine witnesses.
    c. Present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law.
    d. Submit a written statement at the close of the hearing.
5. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law.
6. The practitioner has the burden of proving by a preponderance of the evidence, that the adverse action or recommendation is arbitrary and capricious.
7. The Quality Liaison in conjunction with the Medical Director has the initial obligation to present evidence in support of its decision.
8. The practitioner is responsible for supporting, by a preponderance of the evidence, his/her challenge that the adverse action or recommendation was arbitrary and capricious.
9. New or additional matters or evidence not raised or presented during the original consideration to the quality investigation may be introduced at the hearing only at the discretion of the Hearing Officer and only if it can show that it could not have been discovered in time for the Committee’s review. The Committee shall provide a written substantive description of the matter or evidence to the Hearing Officer and the other party at least three days prior to the scheduled date of the review.

D. Post Hearing

1. Within fifteen days after final adjournment of the hearing, the hearing panel makes a written report of its findings and recommendations, including a statement of the basis for the recommendations.
2. A copy of the hearing panel's findings and recommendations are sent to Grow and the affected practitioner.
3. If the hearing panel's result is favorable to the practitioner, it is effective immediately.
4. Within fifteen days of Grow's review and action, the affected practitioner is sent written notification of Grow's decision, including a statement of the basis for the decision.

8. Reporting Responsibilities[39]

Grow will report adverse findings of practitioners affiliated with the organization in accordance with the requirements set forth in the NPDB Guidebook, State Medical Boards or other state professional boards, Medicare, Medicaid, health plans or appropriate authorities. An adverse action is an action against a practitioner's clinical privileges or medical staff membership in a healthcare organization. Professional review action, as defined by the NPDB, professional review action is an action or recommendation of a health care entity:

1. Taken in the course of professional review activity;
2. Based on the professional competence or professional conduct of an individual physician or other health care practitioner which affects or could affect adversely the health or welfare of a patient or patients; and
3. Which adversely affects or may adversely affect the clinical privileges of the physician or other health care practitioner.

A. NPDB Reporting

Grow complies with its obligations under the federal Health Care Quality Improvement Act to make appropriate and timely reports to the NPDB and State Boards of Medicine and other state professional boards of professional review actions taken with respect to practitioners' Network privileges. Violation of such service expectations may result in disciplinary action up to and including suspension and/or termination from Grow's network that do not implicate the fair hearing procedures and that are not reportable to the NPDB or State Boards of Medicine or other state professional boards as adverse privileged actions. Grow will report the following when based on the competence or professional conduct of a practitioner that could adversely affect the health or welfare of a patient or patients:

1. Final action to deny or revoke a practitioner's application for appointment or reappointment to the network after hearing rights have been exhausted or waived.
2. Restriction or suspension for a period of more than 30 days of network privileges granted to a practitioner.
3. Acceptance of the surrender of a practitioner's network privileges while the Practitioner is under investigation for possible incompetence or improper professional conduct.

[39] CR 6, Element A, Factor 1 and 2 (Notification to authorities and practitioner appeal rights.)

Such reports will be made to the NPDB and applicable State Board of Medicine or other state professional boards within 15 days of the date of the action or event triggering the reporting obligation in accordance with the procedures set forth in the NPDB Guidebook or applicable laws.

Grow will report as required by federal and state law.

a. Malpractice Payments

Grow will make a report to the NPDB within 15 days of making a payment on behalf of a practitioner in settlement of, or in satisfaction in whole or in part of, a written claim or judgment for medical malpractice against that practitioner. A reportable payment includes a refund of professional fees only if it results from a written complaint or demand for damages based on the Practitioner's provision of, or failure to provide, healthcare services. Courtesy adjustments initiated by Grow are not reportable.

1. **Reporting to NPDB** – Credentialing Department Staff will use the Data Bank Integrated Querying and Reporting Service (IQRS) web-application within fifteen calendar days of an adverse action (the day following the event is considered day one) will do the following:
    a. Completes the intake form of the report
    b. Completes the submission by clicking the Submit to Databank option and a Report Submission Complete page appears on the screen.
    c. Prints the Report Verification Document (RVD).
    d. Verifies the information on the RVD and files the RVD in the practitioner's credentialing file.
    e. Mails a printed copy of the RVD to the appropriate state licensing board.
    f. Grow may also elect to send an electronic version of the report to the appropriate state board through the Databank system, provided that state board has agreed to accept electronic Notices of Action.
    g. Note: The Databank mails a copy of the processed report to the practitioner named in the report.

B. New York State Office of Professional Medical Conduct (OPMC)

OPMC investigates professional discipline issues involving physicians, physician assistants, and specialist assistants. OPMC is responsible for investigating all complaints of misconduct, coordinating disciplinary hearings that may result from an investigation, monitoring physicians whose licenses have been restored after temporary license surrender, and monitoring physicians, physician assistants, and specialist assistants placed on probation as a result of disciplinary action.

1. **Reporting to the OPMC** – the Medical Director, or designee will within fifteen calendar days of action will:
    a. Notifies the OPMC of actions that may constitute "Professional misconduct" under the New York State Education Law (the day following the event is "Day One") using the OPMC telephone number 1-518-402-0836.

   b. Provides the OPMC with the following information:
      i. Grow address and phone number.
      ii. Name of the affected practitioner.
      iii. Names of affected patients.
      iv. Details of the issues, including when and where events occurred.
2. Answers any questions the OPMC staff may have.
3. Ensures Grow cooperates with the OPMC on any following investigation.

C. To State Medical Boards, and Health Plan

1. To the extent individual state laws require reporting of Practitioners to Medical Boards or other state authorities that are different from the standards imposed by Grow will make such reports in accordance with state law.
2. Grow will comply with any applicable reporting obligations imposed by health plans with which it has a contract.
3. Submitting reports to the NPDB, State Medical Boards, and notification to health plans is the responsibility of the Credentialing Department.

9. Confidentiality

Grow treats all information collected, developed, or presented as part of the credentialing and peer review process, including Personally Identifiable Information (PII), as confidential, protected or privileged peer review information and has established mechanisms to promote confidentiality. All documentation and information related to credentialing purposes is only distributed only on a need-to-know basis. Files may be released for peer review conducted in good faith as required by law or as agreed to in the initial or recredentialing application or agreement. Access to credentialing information is restricted to those individuals deemed necessary to attain the objectives of Grow Healthcare, P.A.'s Credentialing Program. Grow uses safeguarding mechanisms in accordance with these Policies and Procedures including but not limited to "Security & Credentialing System Controls Oversight" to protect the confidentiality of its credentialing information.[40]

Personnel authorized to access credentialing files will sign a Confidentiality Agreement upon within the first 30 days of their contract and annually thereafter. Authorized personnel are as follows:

- Credentialing Department Employees
- The Committee & the Chair
- Grow Legal Counsel
- Board of Governors if applicable
- Any personnel associated with a contracted delegating entity for the purpose of required audits.

Any Grow practitioner, or such practitioner's designated legal representative, shall have access to the practitioner's own file upon written request but must be viewed in the presence of authorized Grow staff

[40] CR1, Element A, factor 10 (Credentialing policies and procedures describe the organization's process for ensuring confidentiality of the information collected during the credentialing process and the procedures it uses to keep this information confidential).

or a Committee member. Any other request for access to a practitioner's credentialing file will be reviewed by the Committee on a case by case basis.

A. Confidentiality/Conflict of Interest

1. All credentialing decisions and actions shall be kept confidential
2. Records and information generated in connection with and/or a result of professional review activities shall be kept confidential
3. Committee members are subject to any confidentiality and conflict of interest policies. Breach of confidentiality may result in disciplinary actions to include removal from the Committee

B. Release of Credentialing Information to Third Parties

1. Grow obtains the practitioner's authorization before credentialing information is released, unless otherwise permitted or required by law.
2. Credentialing information may be released internally or externally to third parties as set forth in the practitioner agreements for purposes of payer enrollment only with the consent of the Chair or a designee to which the practitioner has given Grow Healthcare, P.A. written consent to release such information.

C. Provisions for Paper and Electronic Information and Credentialing Staff

1. Security mechanisms include for electronic files, a protected computer infrastructure with password controls.
2. All credentialing information, including minutes of the Committee, are kept on a secure network drive. Only authorized employees have access to this network drive. Credentialing information includes, but may not be limited to:
    a. Information supplied by an applicant in the application, as well as other non-publicly available information.
    b. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up.
        i. The credentialing database has "Edit" or "Read only" user security rights used to control who can make changes to credentialing information. The Audit Trail provides history of user activities including who, when and what field was changed or added. The Credentialing Supervisor generates the User History report from the Audit Trail functionality at least on an annual basis and review employee activities such as accessing files not assigned to the user, identifying any patterns of unusual behavior including deletion or changes to verification and other information without documented explanation or authorization for the Supervisor or Manager.
        ii. The Policies and Procedures and minutes of the Grow Credentialing Committee shall be open to review by state and federal regulating agencies and accrediting bodies to the extent permitted by law.

iii. Authorized staff of participating health plans, agencies with regulatory or accreditation functions, or other parties who have the legal right to review such information are provided access to requested information in compliance with all applicable laws and regulations.

3. Credentialing Staff Orientation
    a. All new employees who join Grow's credentialing staff undergo orientation training on the protection of credentialing information within 30 days of employment.
    b. Credentialing staff training:
        i. Includes Grow's confidentiality policies and procedures, including the confidentiality of credentialing information.
        ii. Includes orientation to the roles and responsibilities of the Credentialing Department, including the handling of credentialing information.
        iii. Includes an explanation of the rationale for protecting the security and confidentiality of credentialing information.
        iv. Includes an explanation of the security of credentialing information, such as, secure network drives, authorization levels, security policies, password protection, etc.
4. Credentialing Staff Confidentiality Obligations
    a. Grow requires that all employees adhere to Grow Policies and Procedures regarding confidentiality and security of credentialing materials
    b. Credentialing staff shall sign a Confidentiality Statements at time of employment and annually thereafter affirming they will:
        i. Protect any confidential information they handle during and after their employment.
        ii. Not share credentialing information to which they have access.
        iii. Abide by Grow's confidentiality and security Policies and Procedures.
        iv. Include the following statement: "as a member of the Credentialing Committee decision making process will ensure that credentialing and recredentialing is conducted in a non-discriminatory manner. The formal selection and retention criteria by the committee do not discriminate against practitioners based upon age, gender, race, religion, creed, sexual orientation, gender identity ethnic/national identity, population of patients served, served or physician impairment (after any necessary reasonable accommodations)."
5. Disposal of Confidential Credentialing Information will occur no earlier than ten years or as prescribed by state and federal laws.

D. Use and Disclosure of PHI

As further described in Grow's Notice of Privacy Practices, Grow may use and disclose PHI in the following ways:

1. Treatment, Payment and Health Care Operations. Grow is permitted to use and disclose PHI for purposes of (a) treatment, (b) payment and (c) health care operations.
2. Payment. Grow may use and disclose PHI to health insurers or health plans in connection with the processing and payment of claims and other charges.

3. Health Care Operations. Grow may use and disclose PHI in connection with its health care operations, such as conducting quality assessment and improvement activities, including outcomes evaluations and development of clinical guidelines. Grow may engage third parties to provide various services for Grow in the event any such third party must have access to member's PHI in order to perform its services, Grow will require that third party to enter an agreement that binds the third party to the use and disclosure restrictions outlined in this Policy.
4. Authorization. Grow is permitted to use and disclose PHI upon written member authorization, to the extent such use or disclosure is consistent with member authorization. The member may revoke any such authorization at any time.
5. Applicable Law. This policy shall be governed by and construed in accordance with the laws of the state or states in which licensed practitioners reside.
6. Enforceability. Any disclosure or breach of this policy will cause immediate, irreparable harm to Grow Any breach or threatened breach of this policy therefore may be presented to either a court of binding arbitration for enforcement by both injunction and damages.

10. Credentialing Information Integrity Oversight

Grow will protect all credentialing information as outlined in the Policies and Procedures. Grow ensures protection of each of the following types of credentialing information:

1. The practitioner application and attestation.
2. Credentialing documents received from the source or agent.
3. Documentation of credentialing activities:
    a. Verification dates.
    b. Report dates (e.g., sanctions, complaints, identified adverse events).
    c. Credentialing decisions.
    d. Credentialing decision dates.
    e. Signature or initials of the verifier or reviewer.
4. Credentialing Committee minutes.
5. Documentation of clean file approval, if applicable.
6. Credentialing checklist, if used.[41]

Grow will also ensure that delegates collecting information on its behalf have measures in place that meet the intent of the NCQA credentialing information integrity functions, including auditing. .

A. Primary Source Verification Information[42]

Primary source verification (PSV) is received via the internet, email, fax, and postal mail from approved sources. PSV is stored in the secure credentialing database and reviewed by the Credentialing Staff. The Credentialing Staff will have access to the database and a tracking log is generated with name and date of access. Staff will ensure the method by which the information was received is documented as follows:

1. Via the internet – the URL must appear on the verification page

[41] CR 8, Element A, Factor 1 (Policies and procedures specify protection of each of the following types of credentialing information.)
[42] CR 1, Element C, factor 1 (Describes how primary source verification information is received, dated and stored).

2. Via Fax – the receiving fax information must appear on the verification page
3. Email – email information must appear on the verification page
4. Postal mail services – signature and date is considered reviewed
5. Uploaded from CVO database

Once uploaded into the secure database, all paper copies will be shredded. Grow does not house PSV data in any format outside of the credentialing database.

B. Tracking Modification[43]

Grow or the delegate are not to remove or delete verification information. If a modification is needed, the following actions are taken:[44]

1. When credentialing information is modified in the credentialing database, the authorized employee's name and the date it was modified appears in the credentialing database.
2. The modification records show the date, time, and name of the person who modified a record, as well as how the information was modified and why the information was modified. The modification record is maintained as part of the credentialing file.
3. Modifications to records are typically related to updating dates as information expires or adding additional information. Occasionally a correction to erroneous or manual error needs to be made to a current record which is only allowable by Authorized personnel.

C. Authorization to Modify Information

Security access levels for trained authorized employees are managed through the credentialing database and audited by the Credentialing Manager who supplies the authorized user with an overview of Organization audits of staff documentation and updates in credentialing files. The overview of this training will include the process for documenting and reporting inappropriate documentation and updates to: the organization's designated individual(s) when identified, NCQA, when the organization identifies fraud and misconduct, and the consequences for inappropriate documentation and updates. [45] The security levels dictate the level of access the authorized employee is responsible for documenting credentialing activities and can modify, edit, update, and delete credentialing information.

1. Security Access Levels:
    a. Credentialing Director, Credentialing Senior Manager, Credentialing Managers, Credentialing Leads, and Credentialing Specialists- Read/Write; authorized to modify information following the requirements in the Tracking Modifications section
    b. Credentialing Assistants - Read only, not authorized to make modifications. [46]

[43] CR 1, Element C, factor 2 (Describes how modified information is tracked and dated from its initial verification).
[44] CR 1, Element D, factor 1 (Identifying all modifications to credentialing and recredentialing information that did not meet the organization's Policies and Procedures for modifications).
[45] CR 8, Element B, Factor 2 (Organization audits of staff, documenting and reporting information integrity issues.)
[46] CR 8, Element A, Factor 2 (Policies and procedures specify the titles of staff responsible for performing credentialing activities).

Credentialing Staff will be trained on appropriate and inappropriate modifications during their onboarding process and annually thereafter as outlined below. Annual training of staff consists of a thorough overview of how to effectively utilize and leverage our CVO's functionality; as Grow utilizes the CVO for credentialing purposes and ongoing maintenance. Upon completion of annual training the credentialing staff will sign and date an attestation. [47] The credentialing software allows for audit trails to be pulled on information that was updated which provides the time and date stamp, as well as, the authorized employee who conducted the update for routine expirables and certification renewal review. When updates are made to errors or duplicate profiles these will be documented in the Notes section of the credentialing software to include a description of what information was updated and why. [48]

Circumstances When Modification is Appropriate:

1. Updates to expired licensure or other documents
2. Changes/Updates to education, training, or privileges
3. To correct any entry errors
4. Duplicate profiles
5. Documents to append to practitioner profile

Scenarios where credentialing updates are inappropriate:

1. Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates).
2. Creating documents without performing the required activities (e.g., photocopying a prior credential and updating information as a new credential).
3. Fraudulently altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).
4. Attributing verification or review to an individual who did not perform the activity.
5. Updates to information by unauthorized individuals.
6. Deletions or removal of practitioner files or documentation unless it is a duplication.
    a. In some situations, information may need to be deleted when an error is made. An instance where deletion may occur is when the authorized employee uploads the incorrect PSV information to a file. The authorized employee may have access to delete that image and replace it with the correct verification which will be documented in the notes section of the credentialing software.

Consequences for inappropriate documentation or updates to the credentialing information may include but not limited to:

1. Staff member put on a corrective action plan
2. Auditing credentialing files processed by staff member
3. Re-education/ training on Credentialing Information Integrity

[47] CR 8, Element B, Factor 1 (The organization trains credentialing staff on inappropriate documentation and updates to credentialing information) and CR 8, Element D, Factor 1 (Implements corrective actions to address all inappropriate documentation and updates found.)
[48] CR 8, Element A, Factor 3 (Describing the organization's actions as credentialing information is updated.)

4. Disciplinary action including demotion, transfer, leave without pay, or termination of employment. [49]

D. Security of Information

The Credentialing Manager controls access and level of access for all authorized users to protect the confidentiality and accuracy of data when collecting from primary sources and NCQA approved sources.

1. Hard Copy Data
    a. Any printed confidential/sensitive document or file is stored out of sight and not accessible to anyone who does not have a business need to view the contents. All practitioner files and information, when not in process and during non-work hours, are stored in locked cabinets. Generally, all written information is changed to digital format and the hard copy destroyed.
2. Data
    a. The credentialing database is password protected and each user has their own unique login identification which allows for tracking of data in the database. Authorized users are prohibited from allowing others to access systems or credentialing information with their account, password, or unique ID information. Users are required to utilize strong passwords and ensure user credentials are not visible in the office environment. Staff is discouraged from writing down passwords. Users must update their passwords when asked by staff or when their password has been compromised. Employees will only be assigned access to the credentialing database based on job role Electronic and only the Credentialing Manager has the authority to delete any records.
    b. When a credentialing staff member with access to the database terminates or moves to another department, the Credentialing Manager shall disable the user access within twenty-four hours and notify the IT Department to ensure the employee's security is updated and access is removed.
    c. Authorized Information Release
    d. With their oversight, the Credentialing Manager may authorize the release of Credentialing information in the following circumstances:
        i. Requests from attorneys, the Chair, organizational executives
        ii. Requests from regulatory or accrediting agencies
        iii. Third-party organizations such as health plans with whom Grow is contracted with

E. Credentialing Information Integrity Audit Process

Grow will complete audits of the credentialing information used in the credentialing process for the inappropriate documentation and updates will be conducted on an annual basis. Grow audits 5 percent or 50 of its credentialing files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10

[49] CR 8, Element A, Factor 4 and 5 (Overview of scenarios where updates to credentialing information are considered inappropriate to the organization and remediation/consequences for the employee.) As well as, CR 8, Element D, Factor 1 (Implement corrective actions).

practitioners were credentialed or recredentialed since the last annual audit, Grow audits the universe of files rather than a sample.[50]

1. Falsifying credentialing dates (e.g., licensure dates, credentialing decision dates, staff verifier dates, ongoing monitoring dates).
2. Creating documents without performing the required activities.
3. Fraudulently altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).
4. Attributing verification or review to an individual who did not perform the activity.
5. Updates to information by unauthorized individuals. [51]Grow monitors and performs audits of the credentialing system at least annually as follows. [52]

Grow monitors all noncompliant modifications, under the oversight of the Credentialing Manager, in which the Credentials Verification Organization (CVO) tracks and reports all modifications to Grow, at least annually. Grow analyzes modifications that do not meet its established Policies and Procedures, when applicable as further described below. The monitoring will be to ensure employees did not access, modify, or delete any information they were not authorized to, and that any modification or deletion was in accordance with its policy.

Audits performed will be documented on the Annual CR Information Integrity Assessment Reporting Tool. [53] The tool conducts qualitative analysis of each instance of inappropriate documentation and update identified in the audit (factor 1) to determine the cause.

The organization's auditing and analysis report also includes:

1. Titles of credentialing staff involved in the qualitative analysis.
2. The cause of each finding.

Results of the annual audit of Integrity of Credentialing Information are presented to the Committee for review and development of any action plans, under the oversight of the Credentialing Manager. Any modifications found to not meet the established policy requirements, will be reported, documented, tracked, and analyzed.[54] When deficiencies are identified, the following quarterly monitoring process will be adhered to until modifications are made that meet policy:[55]

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[50] CR 8, Element C, factor 1 and 2 (Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. The organization uses one of the following methods to audit the files:

5 percent or 50 of its files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.)

[51] CR 8, Element C, Factor 1 (Audits for inappropriate documentation and updates to credentialing information.)

[52]

[53] CR 8, Element C, Factor 1 and 2 (Audits for inappropriate documentation and updates to credentialing information.)

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[55]

1. If any unauthorized or inappropriate modifications are found in Grow's Integrity of Credentialing Information Oversight report, Grow documents these findings and implements quarterly monitoring of its processes.[56]
2. Grow will conduct a follow up audit on the effectiveness of the CAP that will be documented on the Integrity of Credentialing tool. CAP is satisfied when Grow demonstrates compliance for three consecutive quarters.[57]

The Credentialing Manager or designee will perform audits as outlined in "Delegation" to ensure any PSV handled on behalf of Grow is following appropriate methods to ensure the protection of this data.

11. Ongoing Monitoring of Sanctions, Complaints and Adverse Events

All practitioners regardless of product participation are subject to monthly monitoring for license expirables, license sanctions and limitations reported to NPDB, internal or payor complaints and adverse events, as well as all Medicare, Medicaid and Government Sanctions and Exclusions listed in the "Primary Source Verification Process". [58]The Application Authorization completed by practitioners in connection with the credentialing process provides Grow with the authority to access and review certain information regarding participating practitioners as part of its ongoing monitoring.

Should a practitioner appear on an ongoing monitoring report for any reason; in addition, our clinical team will conduct ongoing reviews of provider performance and service quality. If any quality concerns including complaints that may arise, the clinical team will assess the issue and provide a detailed report with findings and corrective outcome.[59] The Credentialing Committee will take appropriate action after considering the nature of the sanction or pending investigation and the practitioner will be afforded hearing rights, if applicable. Ongoing monitoring is completed on a monthly basis and reports are reviewed within 30 days of discovery. [60]The ongoing monitoring reports include name of board, date of query, date of report, and signature/initials of staff. [61]For those entities that do not publish sanction reports on a set schedule, Grow individually reviews sanction reports every month.
All monitoring shall be reviewed as follows:

1. Reports are compared against the current active practitioner network on a monthly basis.
2. The reviewer will document review via timestamp and initials or date and initials in a monthly log that will be submitted to the Committee at each monthly meeting. These reports and summary logs will be maintained indefinitely for documentation, tracking, and quality review.
3. Practitioners that are verified as actively excluded from a federal or state program, including but not limited to Medicare and Medicaid, are terminated from Grow's network.

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[56]CR 1, Element A, 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 8, Element A, Factor 5 (Unauthorized or inappropriate modifications and actions taken if found). CR 1, Element D, factor 3 (Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters).
[57] CR 8, Element D, Factor 2 (Measure of effectiveness follow up audit).
[58] CR 5, Element A, factor 1, 2, 3, and 5 (Updates to Ongoing Monitoring)
[59] CR 5, Element A, Factor 4 (Outlining and reviewing complaints)
[60] CR 5, Element A, Factor 1 (Medicare/Medicaid Sanctions)
[61] CR 5, Element B (Appropriate interventions)

4. The Credentialing Committee is informed of terminations at the next meeting.
5. Practitioner receives written notification of termination in e-mail or via standard mail within 7 days of reviewing the discovery and effective immediately and effective immediately.

A. License Sanctions and Limitations[62]

Grow will monitor for licensure expiration to ensure the provider holds an active license at all times to ensure compliance standards are met.[63] State Medical and Behavioral Health Boards are reviewed via NPDB Continuous Query, which all practitioners are enrolled in at initial credentialing as described in Primary Source Verification Process. If an undisclosed adverse event is identified, it is routed immediately to the Chair for a quality review, and additionally presented to the Committee for review as to whether the practitioner's privileges will be restricted, suspended, or revoked. All reports will be reviewed within 30 days[64] of publication or alert.

1. The Chair makes the determination as to whether the practitioner will remain active in the Grow network pending the Committee decision or if the practitioner's consultation privileges will be suspended immediately pending the Committee decision (a provisional measure that will be reportable to the NPDB if it lasts in excess of thirty days.)
2. The practitioner is notified via email of the event and requested to provide additional information. If no response from the practitioner is received within thirty calendar days from the first request, the practitioner will be placed on temporary administrative suspension. A total of three attempts to obtain the information from the practitioner, over the course of thirty days will be made. If the practitioner has not responded after the third attempt, the practitioner will be brought back to the next committee for a vote on permanent termination from the Grow network.
3. After investigation, the practitioner is presented at the subsequent Committee meeting for a final decision as to whether the applicant's privileges will be restricted, suspended or revoked. Upon decision, the practitioner is afforded hearing rights in accordance with the procedures outlined in Appeals.
4. If the adverse event is related to a malpractice claim exceeding one million dollars, the practitioner is immediately administratively suspended pending the subsequent Committee final decision.

B. Adverse Events/Complaints Tracking Monitoring

To ensure compliant and ethical care, Grow continuously monitors for complaints and adverse events monthly.[65] Complaints, quality or adverse events that are identified as potential quality of care issues are referred to Quality Liaison for appropriate investigation and evaluation. Adverse events include injury or harm while a member is receiving care from a practitioner. [66] Grow will forward, when appropriate, complaints to the applicable Health Plan upon receipt if not delegated for site quality complaints.

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[62] CR 5, Element A, factor 2 (Sources for sanctions and limitations on licensure).
[63] CR 5, Element A, Factor 3 (Review of licensure expiration).
[64] CR 5, Element A, factor 3 (The organization reviews information within 30 calendar days of its release by the reporting entity).
[65]
[66] CR 5, Element A, Factor 5, (Monthly review of adverse events).

Clinical Complaints are defined as any complaint related to the quality, timeliness, appropriateness of the diagnosis, treatment and outcomes, general visit issues or medication concerns, raising a question about the competence or professional conduct of a practitioner that could adversely affect the health or welfare of patients. Clinical Complaints are received from patients, member representatives or clients, and are investigated and resolved in a similar process as the peer review program. Clinical Complaints may include Adverse Events. Adverse Events are events resulting in unintended physical injury resulting from or contributed to by the medical care provided (including the absence of indicated medical treatment), that requires additional monitoring, treatment, or hospitalization, or that results in death. Adverse Events may be reported by patient complaint(s), Grow staff, and other Grow practitioners. All Adverse Events are evaluated and acted on when reported. This is a continuous reporting process performed throughout the year. Grow investigates practitioner-specific member complaints upon their receipt and evaluates the practitioner's history of complaints, if applicable; and evaluates the history of complaints for all practitioners at least every month.[67]

Service Complaints are complaints related to the service quality, visit access or contracted practitioner dissatisfaction that is not based on conduct that could adversely affect the health or welfare of a patient or patients.[68] Service Complaints are received from patients, member representatives, clients or any entity and are investigated and resolved in a similar process as through further investigation.

Case review results and instances of poor quality, when appropriate, are communicated to the Credentialing Department to ensure integration with practitioner re-credentialing processes. Complaints are reported for consideration when there are three or more valid complaints for a practitioner during the recredentialing process. All peer review findings will be held in confidence and will not be disclosed.

1. **Review Process**: Quality Liaison will conduct case investigations into service complaints or potential quality of care upon receipt. All quality of care and service complaints and practitioner's history of complaints after investigation are reviewed by a peer reviewer and/or Clinical Director.
2. **Committee Review**: After any necessary review the findings are then submitted to the Quality Committee for review, tracking and trending along with investigation findings.
3. **Data**: Cumulative complaint data is analyzed on a quarterly basis, at a minimum, to identify specific trends or patterns of care at the practitioner level that may suggest a need for improvement.
4. **Confidentiality of Peer Review Information**: All data and information acquired by the Quality Committee will be held in confidence and will not be disclosed to anyone except to the extent necessary to carry out the purposes of the Quality Committee duties.
5. **Record Maintenance**: All documentation concerning specific quality of care concerns, cumulative reporting and analysis, and associated improvement initiatives are filed as confidential protected files in the Quality Management department. Records are archived for a period of ten years. After ten years, records will be destroyed in compliance with methods that maintain confidentiality of the information.

[67] CR 5, Element B(Investigating, addressing, and implementation of interventions for complaints).
[68]

C. Actions against Practitioners

1. To ensure compliant and ethical patient care, the Quality Committee reviews participation of practitioners whose conduct could adversely affect members' health or welfare to determine whether a practitioner meets Grow's quality standards.
2. The Committee may confer with a practitioner regarding how to provide patient care that aligns with relevant regulatory, legal, and ethical standards before terminating the practitioner from Grow's network.
3. Grow may report its actions to the appropriate authorities and agencies as required under applicable laws.

12. Site Visits

Complaints from individual patients regarding clinicians are reviewed upon occurrence as outlined in Adverse Events/Complaints Tracking Monitoring. If the nature of the complaint relates to any of the clinician's office environment (e.g., physical accessibility and safety or any of the six elements that are part of evaluating the clinician office quality), and the complaint is substantiated after investigation, a site visit is conducted within 60 days.

The eight elements used to evaluate clinician office quality are:

1. Physical Accessibility & Safety
2. Physical Appearance
3. Adequacy of the Clinical Records Filing System
4. Maintenance of Confidentiality
5. Availability of Appointments
6. Adequacy of Clinical Record Keeping Practices.
7. Adequacy of Waiting Room Space
8. Adequacy of Examining Room Space

Any deficiency must be corrected by the clinician within 90 days or risk denial for ongoing participation in the practice. The clinician is also expected to provide a corrective action plan for any substantiated complaints or deficiencies identified in the site review. Effectiveness of actions is evaluated at least every 6 months until deficient offices meet thresholds. Follow-up visits for offices that had subsequent deficiencies will be documented.

13. Delegation

In compliance with the NCQA Standards and Guidelines for Accreditation in Credentialing and federal and state mandates, Grow has defined the components within the delegation agreement and the formal processes Grow uses to oversee any CVO with whom it has agreements to perform credentialing activities on its behalf. Grow maintains ultimate responsibility for all credentialing activities and decision making. The Credentialing Department is responsible for policy compliance, implementation and administration

and conducts precontractual and at least annual audits of credentialing files, Policies and Procedures of CVO against NCQA standards to ensure compliance.

A. Delegation Agreement Requirements

1. The delegation agreement is a mutually agreed upon[69] document that describes the responsibilities of Grow and the delegate, the delegated activities, the process by which Grow evaluates the delegate's performance, and the remedies, including the termination of the delegation, available to Grow if the delegate does not fulfill its obligations.
2. Following a satisfactory precontractual assessment, (approval of delegation) the delegation agreement is fully executed.
3. The following must be included in all delegation agreements:
    a. The responsibilities of Grow and the delegate, to clarify which party is responsible for conducting which aspects of credentialing.[70]
    b. Adherence to CMS requirements as applicable.
    c. Grow will retain decision making authority for approval and denial of practitioners.[71]
    d. What information is reported about delegated activities; how, and to whom, information is reported, and, the frequency (at least semi-annually) of reports. Grow will evaluate those reports at least semiannually. Grow will semi-annually receive and evaluate regular reports from all delegates, even NCQA-Accredited delegates. [72]
    e. The process for monitoring and evaluating the delegate's performance, including[73]
        i. a description of the delegate's credentialing system and security controls in place to protect data from unauthorized modification;
        ii. a description of how the delegate monitors its credentialing system security controls at least annually, in compliance with the delegation agreement and its Policies and Procedures;
        iii. a description of how Grow monitors the delegate's credentialing system controls at least annually.
    f. The methodology Grow will use to evaluate the delegate's performance against NCQA standards for the delegated activities on an ongoing basis, at least annually.[74] For NCQA-certified CVOs, they may consist of verification of the delegate's continued certification.

[69] CR 9, Element A, factor 1 (Is mutually agreed upon).
[70] CR 9, Element A, factor 2 (Describes the delegated activities and the responsibilities of the organization and the delegated entity).
[71] CR 9, Element A, 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).
[72] CR 9, Element A, factor 3 (Requires at least semiannual reporting by the delegated entity to the organization); CR 8, Element C, factor 4 (Semiannually evaluates regular reports, as specified in Element A).
[73] CR 9, Element A, factor 4 (Describes the process by which the organization evaluates the delegated entity's performance).
[74] CR 9, Element C, factor 3 (Annually evaluates delegate performance against NCQA standards for delegated activities).

g. Remedies, including up to termination of the delegation, available to Grow if the delegate has not performed satisfactorily.[75]
h. Mutual agreement to the delegation agreement requires signatures by both parties.

B. Pre-delegation Audit Assessment[76]

Grow Healthcare, P.A. verifies that the prospective delegate has established Policies and Procedures and has sufficient and appropriately qualified staff to perform the function(s). The assessment and audit process may include:

1. Assessment of the delegate's Policies and Procedures.
2. Interviews with the delegate's supervisory staff regarding the delegate's credentialing resources.
    a. Credentialing database software system
    b. Ratio of staff to number of practitioners verified
    c. Staff credentialing experience and knowledge
    d. Initial and ongoing training for staff
3. The document assessment may be on-site, via remote viewing, or as a desktop audit if the prospective delegate is willing to provide all necessary documentation.
    a. The prospective delegate must provide the following Policies and Procedures:
        i. Scope of verification activities, including practitioner type and credentials.
        ii. Process for ensuring that time-sensitive information is no more than 120 calendar-days old, where specified, when reported to clients.
        iii. Responsibilities of staff in completing verification activities.
        iv. Methods used to access and verify credentials information.
        v. Sources used to obtain and verify credentials information, including Medicare Opt-Out.
        vi. Process for compiling and reporting information to clients.
        vii. Procedures for resolving client complaints in a timely manner
        viii. Process for internal continuous quality improvement to maintain the accuracy and completeness of credentials reports or files.
        ix. Mechanisms in place for protection and recovery of data
        x. Mechanisms in place for security of data
        xi. Process for ongoing monitoring that includes discovering and reporting Medicare/Medicaid sanctions, state sanctions or limitations on licensure, and Medicare Opt-Out
        xii. Provisions for periodic review, update and approval of policies.
    b. The documentation is evaluated against NCQA standards, state and regulatory requirements.
4. Results of the pre-delegation assessment are reported to the Grow management, which makes the final delegation decision.

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[75] CR 9, Element A, factor 6 (Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement).
[76] CR 9, Element B, Predelegation Evaluation (For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began).

C. Annual and Ongoing Monitoring of Delegate

Grow assesses the delegate's ability to continue to perform the delegated credentialing functions outlined in the agreement. This assessment is conducted at least annually.[77]Assessments will include following:

1. Grow audits 5 percent or 50 of its credentialing files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, Grow audits the universe of files rather than a sample.[78]
2. The methodology Grow will use to evaluate the delegate's performance against NCQA standards for the delegated activities on an ongoing basis.[79]
3. Grow Healthcare, P.A. requests and reviews the Policies and Procedures as listed above in the Pre-Delegation Assessments section as well as any additional information, if any, that may be required by NCQA, state and federal bodies, including but not limited to language regarding security controls to protect against unauthorized modification, monitoring security controls, and how the findings of the monitoring are reported.[80]
4. Delegate supervisory staff are interviewed to identify any significant changes in credentialing resources or process changes since the last audit.
5. Areas for improvement outside of a formal corrective action

Additionally, the delegate monitors their credentialing information integrity to protect data from unauthorized modification and monitors its own compliance with the delegate's policies, including annual review of all modifications made during the look-back period.

1. The delegate reports their compliance and monitoring activities to Grow annually and may utilize the Credentialing Integrity Audit Tool template for this purpose.
2. For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, Grow is to follow up on opportunities for improvement, if applicable.[81]

D. Corrective Actions and Termination of Delegation

When significant deficiency in performance is identified, Grow may request the delegate implement a corrective action plan (CAP).

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[77] CR 9, Element D, Factor 2 (Annually reviews its delegate's credentialing Policies and Procedures).

[78] CR 9, Element D, Factor 2 (Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect). The organization uses one of the following methods to audit the files:

- 5 percent or 50 of its files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.
- The NCQA "8/30 methodology" available at https://www.ncqa.org/programs/health-plans/policy-accreditation-and-certification/

[79] CR 9, Element C, factor 3 (Annually evaluates delegate performance against NCQA standards for delegated activities).

[80] CR 9, Element C Factor 5 (Annually audits each delegate's credentialing files for inappropriate documentation and inappropriate updates to credentialing information.)

[81] CR 9, Element D (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).

1. The Credentialing Department notifies the delegate when a CAP must be submitted due to performance that does not meet Grow policy, or is below NCQA standards or regulatory requirements. [82]
2. The steps for corrective action include:
    a. The delegate is informed that the corrective action is due in an appropriate timeframe commensurate with the seriousness of the deficiency, but at a maximum of 30 days.
    b. The delegate prepares and submits a written CAP detailing the actions necessary to correct the deficiencies, including a timetable for each step and any required status reports.
    c. The Credentialing Department reviews the CAP and sends a written communication to the delegate indicating approval or disapproval of the proposed CAP within 30 business days of receipt of the proposal.
        i. If the CAP is not approved, the written communication specifies the reason and indicates further actions required to make the CAP acceptable to Grow
    d. If accepted, the delegate implements the CAP and the Credentialing Department oversees full compliance of the remediation of the CAP. This may result in progress reports from the CVO or additional auditing may be conducted.
    e. Grow attempts to assist the delegate to succeed in performing the delegated function(s). However, in cases where the delegate is significantly out of compliance and the service quality is at risk, Grow may invoke immediate withdrawal of the delegated relationship without benefit of a CAP attempt.
3. If any unauthorized or inappropriate modifications are found in the delegate's Credentialing Integrity Audit report, Grow documents these findings and implements quarterly monitoring of the delegate.[83]
4. Grow will conduct a follow up audit on the effectiveness of the CAP that will be documented on the Integrity of Credentialing tool. CAP is satisfied when Grow demonstrates compliance for three consecutive quarters..[84]

14. References

1. NCQA Standards and Guidelines for Accreditation in Credentialing
2. 42 CFR § 422.204
3. Medicare Managed Care Manual Chapter 6 – Relationships with Practitioners, Section 60.3

[82] CR 9, Element C, Factor 6 (Implements corrective actions to address inappropriate documentation and inappropriate updates found in factor 5, for each delegate)

[83] CR 9, Element C, factor 7 (Conducts an audit of the effectiveness of corrective actions (factor 6) on the findings for each delegate 3–6 months after completion of the annual audit for factor 5.
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[84] CR 9, Element C, factor 6 and 7 (Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters).

15. Approvals

Signed by:
Patrice Rotolo
9155AC0EDD314BD...

05/30/2025

Credentialing Program Co- Chair Signature | Approval Date

DocuSigned by:
Tommy Saathoff
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05/30/2025

Credentialing Program Co- Chair Signature | Approval Date