DIVERSUS
HEALTH

CREDENTIALING POLICIES AND PROCEDURES MANUAL

Diversus Health, Health Services

Our most important value is to make a positive difference in the lives of those we serve.

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1. Credentialing Program

The credentialing process enables Diversus Health to appropriately employ quality psychiatrists and other licensed/certified behavioral health providers to provide behavioral healthcare and ensures that all providers are properly trained, qualified, and accessible to participate within Diversus Health's service areas. Diversus Health does not make credentialing/recredentialing decisions based on an applicant's race, gender, age, ethnicity, nationality, sexual orientation, types of service, patients, or provider specialties.

This Credentialing Program Manual outlines the standards, processes and policies used for employment/assignment of providers. Diversus Health may deny, restrict, terminate, or take other disciplinary actions in accordance with this Credentialing Manual or the due process policy.

This Credentialing Policy Manual, along with the due process policy, may be changed at the discretion of the Credentialing Committee. Any change in legal, regulatory, or accreditation requirements will be automatically incorporated into this manual as of the requirement effective date. Changes will be effective for all new and existing providers from the effective date of the change.

Diversus Health's Chief Medical Officer (CMO) and the Credentialing Committee will review all Diversus Health's credentialing/recredentialing policies and procedures annually.

1.1 Scope:

- Diversus Health Credentialing Committee
- Diversus Health Leadership and sub-committees
- Diversus Health Services Credentialing Staff
- Diversus Health CMO/Medical Director/Designated Physician Alternate
- Diversus Health Quality Control

1.2 Credentialing Program Goals and Objectives:

- Ensures credentialing/re-credentialing process is conducted in manner that is non – discriminatory.
- Ensures credentialing/re-credentialing verification process does not exceed the specified time limit of 180 days and is completed within 60 days of receipt of a completed application.
- Ensures provider re-credentialing cycles occurs at least every 24 months.
- Ensure compliance with industry standards for credentialing and re-credentialing.
- Ensures compliance with all federal, state, and applicable accreditation requirements.
- Ensure confidentiality of all applications received.
- Ensures all providers are credentialed prior to treating members.

1.3 Credentialing Department Staff:

Under the direction of the CMO and the Credentialing Committee, the Credentialing Manager is responsible for the development, effective coordination, and maintenance of the Credentialing Program. The Credentialing Manager oversees the Credentialing staff's day-to-day activities of the department, including initial and re-credentialing processing, provider updates and audit preparation.

The CMO interacts with the Credentialing Department by chairing the Credentialing Committee, participating in the development and review of credentialing policies and procedures, and by reviewing credentialing/re-credentialing files.

2. Credentialing Committee

Diversus Health's Credentialing Committee is a forum of employed staff that provide comments and recommendations on standards of care for the credentialing/re-credentialing of providers. The leadership of the Credentialing Committee will consist of designated representatives of related provider disciplines employed with Diversus Health as needed. The CMO shall serve as the Chairperson and actively participate in the Credentialing Committee activities.

General membership is comprised of **5 permanent members/1 alternate participating provider** representatives from clinical disciplines including psychiatry, nursing, behavioral health, and substance use counseling. 75% of membership constitutes quorum – 1 of which must be the Chairperson or designated physician alternate; only 1 member may be absent. (Exhibit A)

The Credentialing Committee meets at least every 4 months to review staffing and clean files approved by CMO or as needed to review provider files that require committee review and approval. Meetings are conducted with a pre-determined agenda, with the minutes of each meeting maintained on file for review and are signed by the CMO. The Credentialing Committee must report its recommendations and findings through the minutes as applicable. Members of committee or their designated alternate have 1 vote. A simple majority is required for approval by committee.

All members are expected to attend meetings on a regular basis. When attendance falls below 75%, the Credentialing Committee determines possible actions up to and including replacement of the member.

2.1 The Credentialing Committee serves a two-fold goal:

- To serve as a Peer Review Committee to address concerns or identified problems relating to quality-of-care issues.
- To review credentials and approve/deny providers for participation in Diversus Health's network and review the credentialing/re-credentialing policies and procedures.

2.2 Roles and Responsibilities of the Credentialing Committee Include:

- Provide oversight of the credentialing/recredentialing process.
- Implement the development, maintenance and/or revision of policies and procedures, protocols and workflows related to the credentialing/re-credentialing process as set forth by the Credentialing Committee.
- Ensures established credentialing/re-credentialing criteria comply with requirements of accreditation organizations; federal, state, and local guidelines, payor specific requirements; and Diversus Health's standards.
- Review all provider credentials that are subject to Credentialing Committee oversights and make recommendations as to acceptance/denial of an application for inclusion in the network. This includes a thorough review of any application based on failure to meet established credentialing criteria.
- Enforce decisions made by the Credentialing Committee for provider appeal of sanctions regarding quality-of-care, issues and non-compliance issues when not reported by an external source.
- Ensure implementation of established policies and procedures for review of quality information in the recredentialing process.
- Ensure providers continue to meet credentialing/recredentialing criteria and remain in good standing with the appropriate state agency, state licensing agency or certification board and the National Practitioner Data Bank (NPDB).
- Ensure all providers practice within the scope of their defined job duties.

3. Credentialing Guidelines:

Diversus Health's Credentialing Department, Credentialing Committee and CMO ensure all licensed healthcare providers meet credentialing/re-credentialing and performance standards for employment/assignment with Diversus Health. Providers must maintain a valid, unrestricted Colorado State professional license at all times. Providers must notify Diversus Health's Credentialing Department of any complaints submitted to state/local/federal agencies as well as any arrest for misdemeanor or felony charges within 48 hours of notification of complaint or arrest.

All employed/contracted healthcare providers must be credentialed prior to treating and billing for Diversus Health members and within 60 days of receipt of a completed application for credentialing.

3.1 Types of Providers Credentialed:

- Psychiatrists and other physicians
- Addiction Medicine Specialists
- Psychologist who are state licensed
- Master's level counselors who are state licensed
- Master's level social workers who are state licensed
- Master's level advanced practice nurses who are state licensed
- Physician Assistants who are state licensed
- Registered Nurses who are state licensed
- Other behavioral healthcare/substance use specialists, who are licensed/certified or registered by the State of Colorado to practice independently.
- Locum Tenens/Contracted providers

3.2 Verification Sources:

The following documents should be current and maintained in the credentialing file in MODIO along with other documents required by the National Committee for Quality Assurance (NCQA), Joint Commission and other federal, state or contract requirement:

- Provider's Colorado Professional License and any other state license active within the last 5 years (Active and unrestricted)
- Clinical privileges in good standing; as applicable.
- Valid DEA with Colorado Practice Address. If provider does not have a DEA or a DEA with a Colorado Practice address, he/she must send, in writing, who will prescribe for the provider until he/she obtains Colorado DEA.
- Graduation from graduate clinical school and completion of post-graduate training, if appliable. (e.g., Internship, residency, or fellowship). Per contractual agreements, if terminal degree is not obtained from a regionally

accredited institution/program, provider will not be added to applicable payor panels.

- o Work History (e.g., Curriculum Vitae, resume, application).
- o Proof of current and adequate malpractice insurance with minimum covers (1 Million/3 Million) as determined by NCQA. If provider is employed with Diversus health, the insurance policy is provided by Diversus Health's group policy.
- o Professional liability claims history (e.g., NPDB query and application)
- o Initial/Re-Credentialing State Application, including statement with applicable laws, and signed by the applicant attesting to the following:
  - ▪ Inability to perform essential function of the position, with or without reasonable accommodations.
  - ▪ Absence of illegal drug use.
  - ▪ History of loss of license and/or felony conviction(s).
  - ▪ History of loss or limitation of privileges or disciplinary activity.
  - ▪ Accuracy and Completeness of application.
- o Board Certification/eligibility in designated specialty for Physicians, Advanced Practice Nurses and Physician Assistants is required. Diversus Health verified current certification status of providers certification. Per contractual agreements, if provider is not board certified and have successfully completed an approved residency, provider will not be added to applicable payor panels.
- o National Provider Plan and Enumeration (NPPES)
- o National Practitioner Data Bank query report (NPDB) and
- o Medicare/Medicaid Sanction report (OIG, SAM and EPLS via Lexis Nexis report)
- o Medicare Opt out report

3.3 Decision Making Criteria and Process:

The CMO and the Credentialing Committee hold the responsibility for reviewing Diversus Health's credentialing/re-credentialing activities.

All providers employed/contracted with Diversus Health must be approved by the CMO and/or the Credentialing Committee.

- o Clean Files - The CMO, acting as the Chairperson of the Credentialing Committee, may approve all "clean "files after the approval from the department Director(s).
- o Files that do not meet Credentialing Criteria -The Credentialing Committee reviews the file(s) and decides to approve/deny the provider application. The Credentialing Committee may not approve providers with a pending investigation under review by any state licensing agency.
- o All credentialing approvals/initial denials are completed within 60 calendar days of receipt of a completed application.

3.4 Managing Files that Meet Criteria:

Credentials/Peer Review files are treated as confidential and kept electronically in SharePoint and MODIO with restricted access to the Credentialing staff only. The files are protected from discovery by applicable Federal/State law. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes consistent with applicable Federal/State law and Diversus Health Policy. The Peer Review/Credentials file is open to review by Federal/State Agencies as applicable.

Queries are run monthly to determine which providers licenses, board certification, DEA and malpractice insurance will expire for that month. Primary source verification is obtained, and the provider's credentialing file is updated.

The following documents will be current and maintained in the provider's credentialing file:

- Current Colorado Professional State License
- Verification of hospital privileges in good standing as applicable. If MD/DO has no privileges, a plan of admission/coverage will be completed and uploaded into the file.
- Valid DEA certificate, if applicable
- Verification of education/training
- Verification of board certification/eligibility, if applicable.
- Work history, including gap history.
- Current, adequate professional liability insurance.
- Professional liability claims history.
- Application including a statement consistent with applicable laws, signed by the applicant regarding any reasons for inability to perform essential function of the position, with or without reasonable accommodations; lack of illegal drug use; history of loss of license, and/or felony conviction(s); history of loss or limitation of privileges or disciplinary activity and attestation to accuracy and completeness of application.
- Sanction Activity – NPDB, Lexis Nexis and Medicare Opt out report.

In addition to the above listed, each file contains a signed and dated checklist that includes:

- The source used.
- The date of verification and report date (if applicable)
- Signature or initials of person who verified the information.

3.5 Credentialing Files are considered "clean" when the following criteria are met:

- Application and attestation are complete, signed and dated.
- All required documentation is present in the file.
- All information requiring verification has been verified within the specified time limits.
- The documentation and verification reveal:
  - Active license to practice with no limitations or sanction.
  - Active DEA, if applicable
  - Adequate education/training/board certification, if applicable.
  - Continuous applicable work history without a gap of more than 6 months without documentation.
  - No malpractice claims history within the past ten years.
  - No reason for inability to perform job duties.
  - Absence of illegal drug use.
  - No history of loss of license/felony or misdemeanor convictions.
  - No history of loss/limitation of privileges or disciplinary action.
  - Current/adequate malpractice coverage.
  - Attestation to correctness and completeness of application.
  - No State sanctions or restrictions on licensure
  - No Medicare/Medicaid Sanctions (See section 7).
  - Hospital admitting privileges or alternate admitting process for Diversus Health members.

3.6 Re-Credentialing Files are considered "clean" when the following criteria are met:

- Application and attestation are complete, signed and dated.
- All required documentation is present in the file.
- All information requiring verification has been verified within the specific time frames.
- The re-credentialing cycle has been completed within 24 months of the previous credentialing cycle.
- The documentation and verification reveal:
  - Active license to practice with no limitations or sanction.
  - Active DEA, if applicable
  - Continued Board certification, if applicable.
  - No malpractice claims history since last credentialing cycle.
  - No reason for inability to perform job duties.
  - Absence of illegal drug use.
  - No history of loss of license/felony or misdemeanor convictions.
  - No history of loss/limitation of privileges or disciplinary action.
  - Attestation to correctness and completeness of application.
  - Current/adequate malpractice coverage
  - No State sanctions or restrictions on licensure

- No Medicare/Medicaid Sanctions (See section 7).
- Hospital admitting privileges or alternate admitting process for Diversus Health members.
- Performance monitoring (e.g., member grievances, adverse events, competency assessments, etc.) The threshold for complaints/grievances is 3 complaints/grievances (related to clinical or behavioral) within 1 year except when related to quality-of -care issues or state/federal/regulatory/legal issues.
  - All complaints related to quality-of-care, state/federal/regulatory/legal issues are reviewed by the Quality and Compliance Department at the time of occurrence and forwarded to the Credentialing Committee for review and discussion.
  - When performance review data or complaint threshold does not meet established criteria, the Credentialing Committee will review and make recommendations for performance improvement via focused/ongoing evaluations up to and including termination.

3.7 Non-Discriminatory Credentialing and Re-Credentialing:

Credentialing and re-recredentialing decisions are made solely based on the results of the verification process. Annually, the Credentialing Committee members sign an affirmation confirming that the credentialing and re-credentialing decisions are not made based on an applicant's race, ethnicity/national identity, gender, age, sexual orientation, or area in which provider specializes. Applicant's demographic information is not provided to the Credentialing Committee.

The Credentialing Manger conducts audits on ALL initial/re-credentialing files prior to submission to CMO and the Credentialing Committee as well as ALL complaints regarding discriminatory credentialing decisions.

All Credentialing/Re-Credentialing applications are logged, and their status (Approved/Denied) recorded. Annually, the Credentialing Manager reviews a summary report. The purpose of this report is to review all denials; and assess whether discrimination played a role in any case. The CMO and/or the Credentialing Manager is responsible for identifying trends in discrimination, and the Credentialing Committee is responsible for ensuring that a plan of corrective action has been implemented and followed.

3.8 Discrepancies in Credentialing Information

If verification information obtained by the credentialing staff substantially differs from that supplied by the provider, the credentialing staff will contact the provider to have them either correct or explain the differences. If changes are made, a new application/attestation signature is required by the provider. If the changes include required Primary Source Verification (PSV) documents, new PSV documents are obtained, and the most current dated PSV documents are used in the credentialing/re-credentialing application.

Providers have the right to correct erroneous information submitted during the application process; corrections must be submitted in writing to the Credentialing Department within 10 calendar days of the notification. Once corrections have been made, the provider is required to resign the attestation of correctness and completeness.

3.9 Notification of Decision and Status

Diversus Health's Credentialing staff notifies applicants of all credentialing/re-credentialing decisions and statuses electronically via email or MODIO/DocuSign:

- Receipt of credentialing applications - confirmed through MODIO/DocuSign ***immediately*** via the confirmation notice supplied by MODIO/DocuSign. The Certificate of Completion created during each DocuSign signing process provides a permanent audit trail of each sender, signer, approver, or receipt of the form.
- Incomplete application - applicant is notified within 7 calendar days of review of application describing what information is needed to complete the application.
- Notification of Approval/Denial - Provider is notified within 7 calendar days of credentialing approval/denial decision via official approval/denial letter.

3.10 Provider Directory Listings

Diversus Health does not list individual providers in provider directories. Diversus Health is listed in the directories with the locations of each practice site. Members are required to call into the Contact Center for scheduling and will be assigned an initial provider based on location and availability of providers at that location.

3.11 Provider Rights and Confidentiality

See attached Provider Right and Confidentiality statement provided to all applicants. Applicant must attest to receiving the information at initial application and a copy of the signed form is kept in the applicants credentialing file. (Exhibit D)

3.12 Providers Termination and Reinstatement

If a provider's employment/contract is terminated and later reinstated, the provider must be initially credentialed prior to reinstatement if there is a break in service of more than 30 days. Diversus Health's Credentialing staff re-verifies credentials that are no longer within the re-verification time limits (credentials that will not be in effect when the CMO or Credentialing Committee make the credentialing decision).

4. Credentialing Verification

Diversus Health verifies the following items within the specified time limits. (Exhibit B)

4.1 Current and valid Colorado license to practice:

- Verification time limit = 180 calendar days; license must be in effect at the time of decision
- Diversus Health confirms the provider holds a valid, current, unrestricted Colorado license. Verification must come directly from the Colorado Department of Regulatory Agencies (DORA) online verification system.

4.2 DEA, if provider prescribes controlled substance:

- Verification time limit: Prior to credentialing decision.
- If a provider has a pending DEA certificate application, the provider must be provisionally credentialed. To award a provisionally credentialed status, Diversus Health must obtain documented evidence that another provider within Diversus Health, who holds a valid Colorado DEA certificate, will write all prescriptions for controlled substances until the applicant has a valid Colorado DEA certificate.
- Diversus Health obtains a copy of the Colorado DEA certificate and/or verification from the DEA Validation Website.

4.3 Education and Training:

- Verification time limit: Prior to credentialing decision. Re-verification during re- credentialing is not required.
- Diversus Health verifies the highest degree of the following 3 levels of education and training obtained by the provider as appropriate:
  - Board Certification
  - Completion of Residency
  - Graduation from Medical/Professional School.
- Diversus Health uses any of the following to verify education and training:
  - Sealed Transcripts
  - PSV from Colorado Department of Regulatory Agencies (DORA). Diversus Health obtains letters annually from DORA specifying they perform PSV on education/training prior to licensing.

  - Education Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.
  - For providers who are not board certified, Diversus Health verifies the highest level of education.

4.4 Board Certification Status:

- Verification time limit = 180 calendar days.
- Board certification/board eligibility is required for MD/DO, Advanced Practice Nurses and Physician Assistants. For board eligibility, providers must be board certified within one (1) year of employment. A signed acknowledgement letter will be maintained in Human Resources.
- Diversus Health documents the expiration date of board certification within MODIO. If a provider has "Lifetime" certification and there is no expiration date for re-certification, Diversus Health verified the board certification is current and documents the date of verification.
- Diversus Health uses any of the following to verify board certification:
  - American Board of Psychiatry and Neurology (ABPN)
  - American Nurse Credentialing Center (ANCC)
  - National Board of Certified Counselors (NBCC)
  - National Commission of Certification of Physician Assistants (NCCPA)
  - Other specialty boards as applicable.

4.5 Work History:

- Verification time limit = 180 calendar days.
- Diversus Health verifies provider work history through provider's application, resume, or CV. If the provider has fewer than five (5) years of work history, the time frame starts at the initial licensure date.
- If a gap in employment exceeds 30 days, the provider must clarify the gap in writing or verbally. Diversus Health documents verbal clarification in the provider's credentialing file by notating the name of the individual who provided the clarification, organization, title, email, phone number and date the clarification was made.
- If the gap in employment exceeds 6 months, Diversus Health will request the provider to supply a letter stating the reason for the gap and explanation of activities verifying ongoing education/training used to upkeep skills and knowledge.

4.6 Malpractice History:

- Verification time limit = 180 calendar days.
- Diversus Health obtains written confirmation of the past 5 years of history of malpractice settlements by querying the NPDB.

5. Sanction Information

Diversus Health verifies the following sanction information for credentialing/re-credentialing and monthly:

- Verification time limit: 180 calendar days (initial/re-recredentialing).
- State Sanctions, restrictions on licensure or limitation on scope of practice via the Colorado Department of Regulatory Agencies (DORA) and/or the National Practitioner Data Bank (NPDB).
- Medicare/Medicaid Sanctions by querying the US Office of Inspector General in the Department of Human Services (OIG), System of Award Management (SAM), and the Office of Foreign Assets Control (OFAC) to confirm that the applicant has not been excluded from participation in Medicare/Medicaid or involved in any terrorists' activities via LexisNexis Bridger.
- Medicare Opt Out providers by querying Novitas Solutions Medicare Opt out report to confirm no new additions are credentialed providers with Diversus Health.

6. Credentialing Application

Diversus Health uses the Colorado Healthcare Professional Credentials Application (CHCPA) via MODIO and Council for Affordable Quality Healthcare (CAQH).

Upon receipt of the application, the credentialing staff verifies that the application is complete and accurate with required DocuSign electronic signatures via MODIO/DocuSign Certificate of Completion. Applications will not complete without the required attestation and signatures and will not be forwarded to the credentialing staff. The following documents must be submitted along with the application:

- Colorado Healthcare Professional Credentials Application (CHCPA)
- Copies of all Medical/Professional licensure for past 5 years (Colorado and any other state).
- Copy of current DEA registration, if applicable. DEA must be registered in Colorado and at 115 S Parkside Drive, Colorado Springs, CO 80910).
- Verification of current professional liability insurance coverage, if applicable. If employed by Diversus Health, professional liability will be provided by Diversus Health for services provided during employment with Diversus Health.
- Copy of Board certification, if applicable (ABPN, ANCC, NCCPA, NBCC etc.)
- Copy of current, valid, government issued photo ID (Driver's license, passport, etc.)
- Copy of diploma, residency, internship, and fellowship certificates, if applicable.

- Current CV/Resume (MM/YY format) of last 10 years work history; employment gaps more than 30 days please supply written explanation of gap and how you kept skills and knowledge.
- Copies of EFCMG to include test date and certification number, foreign graduates only
- Case logs for past 24 months (or letter on letterhead stating number/types of services provided in past 24 months), if applicable.
- CAQH Attestation and Release – wet signed and uploaded
- PHYSICIAN ASSISTANT's ONLY ----- Verification of Primary Physician Supervisor Registration
- LPC's ONLY ----- Copy of NCE/NCMHCE exam verification
- MD/DO/APN/PA ONLY – Streamline Healthcare Solutions Signature form. Signatures must be in ink, signed three times (one in each box) and uploaded. No digital signatures accepted
- MD/DO's ONLY – Physician admitting plan for hospital admitting privileges outside of Diversus Health.
- CAQH/NPPES/PECOS/Medicaid Designation Authorization form
- Signed Provider Rights
- Signed employee indemnification form
- Completed Delegated Credentialing Provider Information form

Diversus Health and NCQA do not require receipt of the attestation before beginning the credentialing verification process/ queries required. However, the attestation must be received (signed and dated) before the credentialing decision is made.

If the signed attestation exceeds the time limit before the credentialing decision, the provider must attest the information on the application remains correct and complete but is not required to submit another application. Diversus Health will send a copy of the completed application with the new attestation form when it requests the provider to update the attestation.

6.1 Diversus Health's credentialing application includes at a minimum the following responses:

- **Ability to perform essential functions of the position.**
  - When this statement is marked "NO" in the attestation, provider must submit in writing the reason for their inability to perform the essential functions of the position.
  - The CMO will review the credentialing file, conduct further investigation, and submit recommendations for the next steps to the Credentialing Committee.
  - The Credentialing Committee will make the final decision in the credentialing process.

- **<u>Practice impaired by physical or mental condition including chemical dependency or substance use.</u>**
    - When this statement is marked “Yes” in the attestation, the CMO will review the credentialing file, conduct further investigation, and will submit recommendations for the next steps to the Credentialing Committee
    - The Credentialing Committee will make the final decision in the credentialing process.
- **<u>History of loss of license.</u>**
    - At initial credentialing, provider attests to any loss of licensure since their initial licensure. At re-credentialing, the provider attests to any loss of licensure since the last credentialing cycle.
    - When this statement is marked “Yes” in the attestation, the CMO will review the credentialing/re-credentialing file, conduct further investigation, and will submit recommendations for the next steps to the Credentialing Committee.
    - The Credentialing Committee will make the final decision in the credentialing process.
- **<u>History of felony/misdemeanor charges/convictions.</u>**
    - At Initial credentialing, provider attests to any felony/misdemeanor charges/convictions since their initial licensure. At re-credentialing, the provider attests to any felony/misdemeanor charges/convictions since the last credentialing cycle.
    - When this statement is marked “Yes” in the attestation, the CMO will review the credentialing file, conduct further investigation, and will submit recommendations for the next steps to the Credentialing Committee.
    - The Credentialing Committee will make the final decision in the credentialing process.
- **<u>Limitations of privileges or disciplinary actions.</u>**
    - At Initial credentialing, provider attests to any felony/misdemeanor charges/convictions since their initial licensure. At re-credentialing, the provider attests to any felony/misdemeanor charges/convictions since the last credentialing cycle.
    - When this statement is marked “Yes” in the attestation, the CMO will review the credentialing file, conduct further investigation, and will submit recommendations for the next steps to the Credentialing Committee.
    - The Credentialing Committee will make the final decision in the credentialing process.

- **Current Malpractice Coverage:**

    - Provider submits a copy of the most current certificate of insurance and malpractice liability coverage. A group policy for staff providers is provided by Diversus Health.
    - For providers with Federal Tort Coverage, the file includes a copy of the Federal Tort letter or an attestation from the provider of Federal Tort Coverage.
    - Coverage must be in effect at the time of credentialing decision.

7. Ongoing Monitoring and Intervention

Diversus Health continuously monitors providers between credentialing cycles and takes appropriate actions when it identifies occurrences of poor quality of member care and services.

Providers with an expired clinical license to practice are terminated or suspended at the sole discretion of the CMO and/or the Credentialing Committee.

In addition, Diversus Health monitors the Colorado Department of Regulatory Agencies (DORA) for any licensure actions, stipulations, terminations, suspensions, etc. Any findings are forwarded to the Credentialing Committee for review. The Credentialing Committee may act up to and including termination based on severity of action.

On a monthly basis, the Credentialing staff queries the NPDB, Lexis Nexis (OIG, SAM and OFAC) and the Medicare Opt Out report. Search findings are forwarded to the CMO/Credentialing Committee. With approval from the CMO/Credentialing Committee providers with sanctions by the OIG, OFAC, or SAM are immediately terminated from Diversus Health.

On a monthly basis, the Credentialing staff review member/payor complaints, grievances, and potential quality issues for trends on dissatisfaction with the quality of care received from the providers. Please refer to the Provider Appeal and Fair Hearing process for details on how these cases are handled. (Exhibit E)

8. Notification to Authorities and Provider Appeal Rights

Diversus Health uses objective evidence and patient-care considerations when deciding the course of action for providers who do not meet quality standards. Diversus Health's CMO/Credentialing Committee notifies authorities as appropriate of providers termination or suspension as applicable. Diversus Health's Provider Appeal and Fair Hearing policy and procedures (Exhibit E) describes the process for handling quality of care issues and related decisions.

9. Delegation of Credentialing Functions

It is the policy of Diversus Health to **NOT** delegate credentialing functions. The only consideration for delegation of PSV is with DORA. The Credentialing staff obtains letters annually attesting to the PSV of education and training at the time of licensure. Diversus Health uses the PSV of licensure in DORA for PSV of education/training verification.

10. Confidentiality, Storage of Records, Systems of Control

All personnel of Diversus Health shall respect the confidentiality of the Provider Credentialing Records. This requirement of confidentiality extends not only to the information contained in the electronic provider's credentialing file but also the Credentialing Committee meeting minutes, oral discussions, deliberations, and proceedings that occur at all meetings at which credentialing, peer review and performance improvement activities are discussed, including but not limited to the Credentialing staff department, network, and committee meetings.

The following items shall be considered confidential materials:

- All credentialing files of Diversus Health providers and applicants.
- All Credentialing Committee meeting, network and department minutes and related documents AND
- All general files maintained in the Credentialing Department

10.1 Disclosure and/or Requests for Information

- Disclosure of the above noted material for official business/credentialing functions will only be permitted if there is a specific reason and need to know that is acceptable to the Credentialing Manager, CMO, and/or the Credentialing Committee.
- Access to the above noted materials by persons performing official business/credentialing functions shall be permitted only to the extent necessary to perform said functions upon the approval of the Credentialing Manager, CMO, or Credentialing Committee.
- Employee's and applicants shall be permitted access to only the information that was provided directly by the employee or applicant. Access by an employee or applicant to any other information contained in the credential's file shall be granted only after legal consultation and upon the approval of the Credentialing Manager, CMO, and or the Credentialing Committee.
- Disclosures of any of the above noted materials to outside agencies shall be permitted only when required by las or regulation or upon the request of the individual provider and only with the approval of the Credentialing Manager, CMO or the Credentialing Committee.
- Routine requests for credentials information from other hospitals or healthcare organizations, which pertain to the credentialing process, shall

be answered from information contained in the credentials file of the provider upon receipt of a written request, which contains a statement signed by the provider, releasing from liability all those providing such information. If a provider has not encountered disciplinary or peer review problems, the Credentialing Manager or designee may release information contained in his/her credentials file in response to a request from another healthcare organization or its medical staff. All such requests shall be answered in writing by the Credentialing Manager or designee or through affiliation verification requests.

- If a provider has encountered disciplinary or peer review problems, no information shall be released until the copy of the signed released from requesting organization is deemed satisfactory from legal counsel. All responses to such inquiries shall be reviewed and concurred by the CMO and legal counsel shall be consulted.
- All subpoenas pertaining to credentialing files shall be referred to the Credentialing Manager, who will consult with legal counsel regarding an appropriate response.

10.2 Location and Security:

All credentialing records shall be maintained under the care and custody of the Diversus Health's Credentialing Department staff. The office where the credentialing records are stored shall be kept locked, except when an authorized representative or credentialing professional supervises access. Records stored electronically shall be protected by unique individual passwords issued, permissions, and read/write controls, as administered by the Credentialing Manager. When staff members leave, the Credentialing Manager will deactivate all logins immediately.

All members of the Credentialing staff and Credentialing Committee will sign the approved Confidentiality and Non-Discrimination agreement.

10.3 Authorized Representatives:

Access to the below authorized representatives shall only be to the extent necessary to perform their function in their respective roles:

Authorized representatives shall be:

- Credentialing Manager/Credentialing Department Staff
- Credentialing Committee
- CMO/Medical Director/Designated Physician Alternate
- Director of Human Resources

10.4 Access to Records:
An individual permitted access under this section will be afforded a reasonable opportunity to inspect the records and to make notes regarding the requested records in the presence of an authorized representative or Credentialing staff. In no case shall an individual remove or make copies of any records without express permission.

10.4.1 Access by Non-Diversus Health individuals performing official functions:

A. Files leaving the credentialing office will always be accompanied by a Credentialing staff member.
B. The following individuals may access credentialing records to the extent described:
    - Representative of the following regulatory or accreditation agencies may access credentialing information to fulfill their responsibilities when approved by the Credentialing Manager/staff, CMO/ or Credentialing Committee:
        - Centers for Medicare and Medicaid Services
        - Colorado Department of Public Health and Environment
        - Colorado Department of Human Services, Office of Behavioral Health
        - Payers with which Diversus Health has a delegated credentialing agreement in place and only for the purpose of annual delegation audits.
        - Joint Commission
C. An individual provider may review his/her credentials file under the following circumstances:
    - Review of the files is accomplished in the presence of a Credentialing staff, Credentialing Committee, or the CMO.
    - The provider understands he/she may not remove any items or other documents from the file.
    - The provider understands that he/she may add an explanatory note or other documents to the file.
    - The provider understands that he/she may not review confidential letters, references, or the NPDB reports received during the initial credentialing or any subsequent interval.
    - No items may be photocopied without express written permission of the Credentialing Manager.

10.5 Confidentiality of Credentialing Information and Systems Control:

Credentialing information is considered confidential and held in strict confidence. Credentialing files, Committee minutes, any discussions/deliberations or other meetings discussing credentialing, peer review, and performance improvement documentation are kept in a secure SharePoint drive and/or MODIO. Access to electronic credentialing information (i.e., credentialing, sanction, SharePoint and MODIO) are protected by permissions granted by the Credentialing Manager, using unique individual passwords to limited staff as required for business purposes.

- Peer review files are highly confidential and are kept separate from the credentialing files.
- Credentialing files are prohibited from release to outside parties without prior approval from legal counsel with the exception for auditing purposes from a delegated contracted payor

Primary source verifications (PSV) are stored in electronic file in PDF format with the verification date and name or initials added into the credentialing system by the user. This process adds the unique electronic identifiers of the authorized user, the date of the verification, the verification source, and the date of the report as applicable.

Modifications are permitted only by an authorized user prior to the final Committee/CMO review and are tracked in the historical data within the automated credentialing system. Authorized users include the credentialing staff working to prepare the credentialing file.
Authorized changes only occur when:

- Updated information is required if such verification information expired during the credentialing review.
- A request from the CMO, Credentialing Manager or the Credentialing Committee needing clarification or additional documentation/information.
- Notification from the provider regarding clarification of information/documentation.
- Unauthorized modifications are prohibited and monitored by the Credentialing Manager.

The Credentialing Manager oversees staff audits of credentialing files for each authorized credentialing staff:

- Weekly random audits to ensure adherence to the policies, procedures, and accuracy of the credentials file.
- Monthly random audits to ensure compliance of policies, procedures, accreditation standards, and state specific requirements as well as to identify any restrictions of the system/process.
- All credentialing files prior to and after approval/denial to ensure no discrimination was used in the process and ensure no unauthorized modifications were done.

11. Review and Approval of Credentialing Policies

All policies and procedures must be reviewed and approved by the Credentialing Committee. Annually thereafter, each policy and procedure will be reviewed by the Credentialing Committee. Apart from technical corrections made by the Credentialing Manager related to reorganization, renumbering, punctuation, spelling or grammar related changes, or changes in legal, regulatory or accreditation requirements, all policy amendments require Credentialing Committee review and approval.

Approval:

____

CMO/Medical Director/Designated Physician Alternate Date:
Credentialing Committee Chair

Effective 8/9/2010

Revision: 7/25/2011; 5/15/2012; 4/16/2013; 8/8/2014; 7/10/2015; 8/9/2016; 9/1/2017; 5/24/2018; 3/9/2019; 3/4/2020; 12/15/2020; 9/7/2021

EXHIBIT B: CREDENTIALING/RECREDENTIALING VERIFICATION SOURCES AND TIMELINES

The noted Sources and Methods will be used to verify applicable credentialing elements

Credential	Source	Method(s)	Time Frame for Verification
Licensure*	State Licensing Board	Aggregate Report or online query	Within 180 calendar days of credentialing decision and monthly
DEA*	US Dept of Justice, DEA Diversion Control site online verification and/or DEA Certification Card	DEA card and/or online verification	Within 180 calendar day of credentialing decision
Training (Residency)	State Licensing Agency or Board Certification Agency	Online verification	Within 180 days of credentialing decision
Education (Highest)	State Licensing Agency or directly with school. Colorado Department of Regulatory Agency	Online verification or official transcripts	Within 180 days of credentialing decision
Board Certification	ABPN or Specialty Board	Online verification	Within 180 days of credentialing decision
Malpractice Coverage*	Declaration page as applicable	Declaration page	Within 180 days of credentialing decision
Malpractice Claims History and other reportable actions	NPDB	Online query NPDB; Continuous Query	Within 180 days of credentialing decision; Renewed annually
Application (work history)	Provider CV, Resume, Application	Form	Within 180 days of credentialing decision
History of Licensure loss, sanctions, or felony convictions	NPDB and/or State Licensing Board, Application attestation, Background Check	Online query, application	Within 180 days of credentialing decision and Monthly
Medicare/Medicaid Sanctions	NPDB/OIG/SAM	LexisNexis query	Within 180 days of credentialing decision and Monthly
Hospital Privileges in good standing*	Primary Hospital	Letter or online query	Within 180 days of credentialing decision

**Must be current at time of credentialing decision.*

A. The Credentialing Staff utilize the following process to conduct primary source verification (PSV):

State and/or professional licensure – The Credentialing staff verifies the license within 180 calendar days of the credentialing decision via a telephone call, letter to the state licensing agency, or via internet query for professional licensure verification. A copy of the license is included in the provider file that is current on the date of the credentialing decision. Credentialing staff checks the adverse action report from the Colorado Department of Regulatory Agency at initial credentialing, recredentialing and monthly.

Hospital Privileges – The Credentialing staff verify primary hospital privileges via telephone, letter or via internet query to the current hospital affiliation (applicable only as indicated).

DEA Certificate – The Credentialing staff verifies the DEA certificate within 180 days calendar days of the credentialing decision via hard copy of the certificate that is current on the date of the credentialing decision or via entry in the U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Division (DEA).

Education and residency training - At the time of initial credentialing, the Credentialing staff verifies education/training via telephone, letter from the University/Institution requesting verification of terminal degree and completion date. Credentialing staff verifies the school accreditation status and ensures providers are paneled appropriately for those payors that require accreditation of school. Verification may also be obtained from the appropriate State Licensing Agency. **(Diversus Health must obtain written confirmation, at least annually, from the State Licensing Agency that it performs primary source verification of education and training).**

Board Certification – The Credentialing staff verifies board certification within 180 calendar days of the credentialing decision via the specialty board or internet query if applicable. Credentialing staff panels provider per board certification requirement of each payor.

Malpractice Claims History - The Credentialing staff queries the NPDB within 180 calendar days of the credentialing decision to verify if sanctions or convictions have been enacted against the provider from licensure boards, Medicare, or Medicaid concerning fraudulent activity, professional misconduct, or criminal offenses.

Specialized Training – The Credentialing staff verifies training via telephone call or internet query to the organization requesting verification of completion of any special training the provider received.

Medicare/Medicaid Sanctions – The Credentialing Staff queries the NPDB and the OIG within 180 calendar days of the credentialing decision to verify any Medicare/Medicaid sanctions, for the most recent three (3) year period available. All Medicare/Medicaid sanctions are verified through LexisNexis Bridger at initial, recredentialing and monthly.

Sanctions or limitations on licensure – The Credentialing staff verifies any sanctions or limitations on the license within 180 calendar days of the credentialing decision, for the most recent five (5) year period via the NPDB and state licensing board website(s) at time of initial credentialing, recredentialing and monthly.

Medicare Opt Out – The Credentialing staff queries the appropriate web site to verify whether the provider has opted out of Medicare within 180 calendar days from credentialing decision and monthly.

System of Award Management (SAM). Office of Inspector General (OIG) and Office of Foreign Assets Control (OFAC) – The Credentialing staff queries the SAM. OIG and OFAC databases within 180 calendar days of initial credentialing, recredentialing and monthly to verify any Federal sanctions through LexisNexis Bridger.

B. When PSV is performed utilizing the internet Diversus Health must obtain written confirmation directly from the source that attests to the accuracy and timeliness of the information available on the website.

C. The Credentialing staff also verify the following:

   a. Work History - The Credentialing staff reviews at a minimum, five (5) years of work history on the provider's CV, Resume, or application within one (1) years of the initial credentialing decision. Any gap in work history greater than 30 days must be reviewed and clarified in writing and documented appropriately.

   b. Malpractice Insurance Coverage – The Credentialing staff collects a professional malpractice face sheet from the provider, as applicable, and confirms that the effective dates and amounts of coverage are current and acceptable on the date of the credentialing decision.

D. The Credentialing staff completes the PSV and maintains it in the provider's file along with all Professional Reference Verification documentation.

Provider Rights and Confidentiality

Provider Rights

A. All providers are treated equally to ensure that credentialing and recredentialing is conducted in a non-discriminatory manner. Credentialing decisions are based on qualifications and training, without regard to race, ethnicity, religion, gender, age, sexual orientation, or other types of legal and ethical procedures or provider specialties.

B. Providers have the right to review the information submitted in support of their credentialing/recredentialing application. Additionally, the provider has the right to:

   a. Providers have the right to review information obtained by Diversus Health for the purpose of evaluation their credentialing/recredentialing application. This includes non-privileged information obtained from any outside source (e.g., state licensing boards, malpractice insurance carriers), but does not extend to the review of information regarding references or recommendations protected by laws from disclosure. Providers may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at:

      Diversus Health
      ATTN: Credentialing Manager
      1795 Jetwing Drive,
      Colorado Springs, CO 80916

   b. The Credentialing Department will notify the provider within 72 hours of the date and time when such information will be available to review.

   c. Providers have the right to be informed of the status of their credentialing/re-credentialing application at any time. The provider may request this information by sending a written request by letter, mail, email, or fax to the Credentialing Department.

d. Providers will be notified by the Credentialing Department, via written or electronic format, of their credentialing status:

- Receipt of credentialing applications - confirmed ***immediately*** via
- the MODIO/DocuSign. The Certificate of Completion created during each DocuSign signing process provides a permanent audit trail of each sender, signer, approver, and receipt of the application.

- Incomplete, applicants- applicant is notified within 7 calendars days of review of application describing what is needed to complete the application.

- Notification of Approval/Denial – Provider is notified within 7 calendar days of the credentialing approval/denial decision via official approval/denial letter.

e. Providers will be notified in writing via a certified letter, email, or fax when information obtained by primary source varies substantially from the information provided on the providers application. Examples of information at substantial variance includes reports of providers malpractice claims history, actions taken against a provider's license/certification, suspension or termination of hospital privileges or board certification expiration when one or more of the examples have not been self-reported by the provider on his/her application. Provider will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

f. If a provider believes that erroneous information has been supplied to Diversus Health by primary sources, the provider may correct such information by submitting written notification to the Credentialing Department. Provider must submit a written notice, via certified letter, fax, or email along with a detailed explanation within 48 hours of Diversus Health's notification to the provider of the discrepancy or within 24 hours of the provider's review of his/her credentials file to the Credentialing Department at:

Diversus Health
ATTN: Credentialing Manager
1795 Jetwing Drive,
Colorado Springs, CO 80916

g. Upon receipt of the notification from the provider, Diversus health will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to providers credentials file. The provider will be notified in writing via certified letter, email, or fax that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with the provider notification, the Credentialing Department will so notify the provider via certified letter, email, or fax. The provider may then provide proof of correction by the primary source body to Diversus Health Credentialing Department via certified letter at the address listed above within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

C. Providers have the responsibility to produce adequate information for proper evaluation of professional competence, character, ethics, and other qualifications and resolving any doubt about such qualifications to the satisfaction of the Credentialing Department and/Credentialing Committee. Applicants must supply all information to satisfy the definition of a complete application within 10 days of receiving an application packet. Failure to do so without good cause will result in their application being nullified. Providers may submit corrections to their application in writing, via mail, email, or fax.

Confidentiality Process

A. Diversus Health will exercise due care with provider specific information by keeping all providers files in MODIO and SharePoint with individual unique username/passwords provided by Credentialing Manager.

B. Diversus Health Staff will not disclose provider confidential or protected information to parties outside of the organization unless required by law, in which case Diversus Health Legal Counsel will be involved.

C. Direct access to provider files is limited to Credentialing Department Staff only.

D. Diversus Health employees who are members of the Credentialing Committee and Legal Counsel will have access to provider files via a Credentialing Department Staff member.

E. Diversus Health Credentialing Committee Minutes do not identify providers by name.

F. All Diversus Health employees sign a confidentiality statement upon hire.

G. Diversus Health Credentialing Department will maintain the complete file of all providers for a minimum of ten (10) years following termination for Diversus Health. Files are kept electronically on a secure folder and in MODIO. Terminated provider files will be maintained at Diversus Health in the Credentialing Department electronically for two (2) years following termination. Files of providers who have not been with Diversus Health for more than 2 years will be sent to Archives Folder for confidential storage with a destroy date of 10 years.

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Signature/Date

EXHIBIT C: DEFINITIONS

MODIO – Diversus Health's credentialing software application

Clean File – File submitted to the CMO/Medical Director/Designated Physician Alternate, who acts on behalf of the Credentialing Committee with recommendations for approval for a provider who meets all the credentialing standards and complies with contractual obligations.

CMO - (Chief Medical Officer/Medical Director/Designated Physician Alternate) - With direct credentialing responsibility as designated by Diversus Health's Credentialing Committee must possess(es) the scope and authority to determine that file is clean and to sign off on it as completed, clean, and approved.

Provider/Practitioner – A professional who provides behavioral health services and required to be licensed/certified as defined by law.

Credentialing/Recredentialing – The process by which the organization (Diversus Health) authorizes, contracts with, or employs providers/practitioners who are licensed/certified to practice independently to provide services to its members. Eligibility is determined by the extent to which applicants meet objective, non – discriminatory defined requirements for education, licensure, professional standing, service availability and accessibility, and performance with managed care organizations utilization and quality management requirements. Processes include those for initial credentialing of new providers, newly licensed providers and recredentialing process for on-going providers. Recredentialing cycle is every twenty-four (24) months.

Non – Discriminatory – Not based on applicant's race, ethnic/national identity, gender, age, sexual orientation, or the type of procedure or patient in which the provider specializes.

Providers/Practitioners subject to the credentialing process with Diversus Health

- MD/DO: Psychiatrist or another physician
- Addiction Medicine
- Doctoral or master's level state certified/licensed behavioral health provider
- CNS/NP – Nationally or state certified/licensed
- Physician Assistants
- Registered Nurse
- Other providers licensed, certified, or registered to practice independently.

Primary Source Verification (PSV) – the process by which an organization validates credentialing information from the organization that originally conferred or issued the credentialing element to the provider.

National Practitioner Data Bank (NPDB) – A Federally mandated agency that is the repository of information about settled malpractice claims and adverse events, sanctions, or restrictions

against the practice privileges of a physician or other healthcare provider.

List of Excluded Individuals/Entities (LEIE) – Office of Inspector General (OIG) database that provides information to the healthcare industry, patients, and the public regarding individuals and entities currently excluded from participation with Medicare, Medicaid, and all Federal HealthCare programs.

Excluded Parties Lists System (EPLS) – System of Award Management (SAM) database that provides information to the healthcare industry, patients, and the public, regarding individuals and entities currently excluded from participation with Medicare, Medicaid, and all Federal HealthCare Programs due to non – healthcare related issues.

Office of Foreign Assets Control (OFAC) – U.S. Department of Treasury's agency that enforces the mandatory screening of all employee's, vendors, and providers against the database that provides information to the public regarding individuals and entities involved with terrorists and terrorist activities.

Appeal – A formal written request by a provider/practitioner, organizational provider, and/or program for reconsideration of a credentialing or sanctioning decision.

Fair Hearing – A hearing conducted impartially in accordance with due process of law of which the provider has a reasonable notice as to the time, place, and issues/charges, for which he/she has had a reasonable opportunity to prepare, at which he/she is permitted to have the assistance of a lawyer, and during which he/she has the right to present witnesses and proof and to argue that a decision be made in accordance with the law and evidence.

Quality of Care Issues – Any issue that decreases the likelihood of desired outcomes and is inconsistent with current professional knowledge. Example of quality-of-care issues may include, but are not limited to:

- Any major deviation from established structures, policies, and procedures that may be viewed as contributing to unexpected outcomes.
    - Treatment and/or discharge planning issues
    - Medication management issues
    - Access to appropriate treatment
    - Inappropriate or unprofessional behavior
    - Over- and under- utilization
    - Quality of care indicators
    - Clinical guideline adherence
    - Fraud and abuse
    - Adverse incidents

Exhibit E: Provider Appeals and Fair Hearing Policy

Policy: It is the policy of Diversus Health that providers, organizational providers, and programs have the right to formally appeal the decisions of the Credentialing Committee. All appeals and supporting documentation must be submitted in writing by the provider or their legal counsel within 30 calendar days of the date of notification from the Credentialing Committee. Diversus Health complies with all applicable state and federal regulations related to the provider/ provider appeal process.

Purpose:

To ensure a process is available to providers, organizational provider sand/or programs to appeal decisions made by the Diversus Health Credentialing Committee concerning acceptance into the network, corrective and/or disciplinary actions.

Scope:

A. Diversus Health Credentialing Committee
B. Diversus Health Credentialing Manager
C. Diversus Health Leadership
D. Diversus Health Board of Directors

Definitions:

A. Appeal- A formal written request by a provider, organizational provider, and/or program for reconsideration of a credentialing or sanctioning decision.

B. Fair Hearing - a hearing conducted impartially in accordance with due process of law of which the provider has reasonable notice as to the time, place, and issues or charges, for which he/she has had a reasonable opportunity to prepare, at which he/she is permitted to have the assistance of a lawyer, and during which he/she has a right to present witnesses and proof and to argue that a decision be made in accordance with the law and the evidence.

C. CMO – Chief Medical Officer/Medical Director/Designated Physician Alternate.

Responsibilities:

A. CMO – Takes appeals to Credentialing Committee and relays decisions back to the provider.

B. CMO – Sends notification to provider of recommendation for adverse action

Procedures:

A. Following an adverse action or a recommendation for adverse action, the CMO or designee will provide written notice to the affected provider. To appeal, the provider musts end within 30 days of receiving notice, a written request for a hearing and a statement explaining the basis for contesting the adverse action.

B. When a provider / provider submits a written request for an appeal, the appeal letter and date of receipt is documented in the applicable credentialing tracking system by the Credentialing Manager. The appeal letter and any supporting documentation received is placed in the provider / provider's file and queued to the CMO for review. The CMO adds the appeal request to the agenda of the next regularly scheduled meeting of the committee.

C. During its regularly scheduled meeting, the Credentialing Committee reviews the provider/provider's appeal and any supporting documentation received. The Credentialing Committee must determine to: (1) support the original decision, (2) overturn the original decision; or (3) forward appeal to the Diversus Health Board of Directors for review and final determination. The CMO notifies the provider/ provider of the decision and the specific reason for the decision of the Credentialing Committee and/or Diversus Health Board of Directors in writing, via certified mail, within 14 calendar days of the decision. A representative of the Credentialing Committee will present provider/provider file, Credentialing Committee decision and provider appeal to the Diversus Health Board of Directors for final decision.

D. The decisions of the Credentialing Committee/Diversus Health Board of Directors relative to provider / provider appeals are final unless the issue is related to competence and/or professional conduct. A Fair Hearing is offered to qualifying providers within 30 calendar days from the date of notification of the Credentialing Committee/Diversus Health Board of Directors' decision. If required by law, the CMO or designee will report the final action to the appropriate state licensing board and the NPDB, the HIPDB, or both. Diversus Health will also send a copy of the final report to the provider.

E. Providers may request a second level of appeal or a Fair Hearing when the Credentialing Committee denies credentialing, recredentialing, issues an action or terminates a provider based on issues related to competence or professional conduct.

F. A request for a Fair Hearing must be made within 30 calendar days of the date of the Credentialing Committee's notification.

G. The provider will receive written notice of the place, time and date of the Fair Hearing, which date shall not be less than 30 calendar days and no later than 90 calendar days after the date the request for appeal is received from the provider. Additionally, the provider will receive an explanation of the hearing procedures, and a list of witnesses, if any, expected to testify on behalf of Diversus Health.

H. The CMO/designated alternate of Diversus Health will identify peer reviewers who will participate as the Fair Hearing panel, assuring representation of the discipline of the provider requesting the appeal. These peers will not have any economic interest adverse to the provider, nor will they have participated in the decisions of Credentialing Committee.

I. One member of the Fair Hearing panel will be selected to act as the hearing officer and will preside over the Fair Hearing.

J. Both Diversus Health and the provider will make reasonable efforts to establish a mutually agreed upon date for the hearing.

K. Both Diversus Health and the provider have the right to legal representation at the Fair Hearing.

L. The provider will receive a written recommendation from the panel within 15 business days after the Fair Hearing. The Fair Hearing process as set forth above is subject to applicable state and federal law.

M. Provider / provider may also file an appeal with the appropriate state agency if they Disagree with the Provider Appeal Committee's decision

N. Though Diversus Health can resolve most provider credentialing and quality issues through consultation and education, occasionally further action is necessary to ensure quality service delivery and protection of clients. The Credentialing Committee may impose provider actions for issues related to client complaints/grievances, quality of care or violations of state and federal laws and regulations. Diversus Health will comply with all applicable local, state, and federal reporting requirements regarding professional competence and conduct to ensure the highest quality of care for our clients. A provider has the right to appeal any action through the Credentialing Committee/Fair Hearing Appeals Process set forth above. The following is a list of actions available to the Credentialing Committee and the Provider Appeals Committee.

(a) Consultation-A call is placed to notify the provider of the alleged action or incident. The provider will be provided with an explanation of possible sanctions if corrective actions are not taken. The call will be documented to include the date and subject for consultation. A copy of the consultation will be placed in the provider's file.

(b) Written Warning - A written notice is sent to the provider notifying him/her of the alleged action or incident. Possible sanctions if corrective actions are not taken, will be explained. A copy of the letter is retained in the provider's file; Corrective action will be monitored as necessary.

(c)) Second Warning/Monitoring-At the discretion of the CMO/designated alternate, a second written notice may be sent to the provider and a copy of such letter shall remain in Diversus Health file. Additionally, the provider may be placed on monitoring when data indicates nonconformance with standards. and, if Diversus Health determines it is in the client's best interest, Diversus Health may elect to suspend provider. The provider will be given written notice via facsimile and certified mail of the issues for which he/she is being suspended. A copy of the letter is placed in the provider's file.

(d)) Automatic Termination: Providers will be immediately terminated upon the happening of any of the following events:

(i) Loss of License. The provider license issued by the state is revoked, suspended, surrendered, or not renewed.

(ii) Conviction of Fraud

(iii) Limited Ability to Practice. Final disciplinary action by a governmental agency or licensing board that impairs the professional ability

Related policies/sources:

Attachment1– Provider Appeals and Fair Hearing Notice

Effective date: 08/09/16 Review Date December 15, 2020

Approved by: Policy Review Committee

Sponsor: VP, Human Resources

CREDENTIALING APPEALS PROCESS FOR PROVIDERS

Right of Appeal

If Diversus Health's Credentialing Committee ultimately determines not to approve the applicant's credentialing file, the file is referred to the CMO to draft communication to notify the applicant of the decision, including the reason(s) for such decision. The notification is furnished to the applicant within thirty (30) calendar days of the credentialing decision unless a shorter time period is required by applicable law. Providers denied initial credentialing do not have the right to appeal. They may resubmit their application for consideration after two (2) years. Providers denied during recredentialing have the right to appeal the decision in writing in accordance with Divers Health's Policy (Provider Appeals and Fair Hearing Policy). Appeal rights are only afforded to employed staff at Diversus Health. The provider will be notified of the denial and provided a copy of the appeals process upon denial from the Credentialing Committee.

If the Credentialing Committee denies your credentialing application, approves continued employment with conditions, or terminates your employment, and such action constitutes a "disciplinary action" as defined in Diversus Health's Credentialing Policy Manual, you are entitled to appeal the disciplinary action. A disciplinary action is an adverse action taken by Diversus Health's Credentialing Committee, up to and including termination from Diversus Health, based on a Credentialing Committee determination that the provider does not meet credentialing criteria related to the competence or professional conduct of the provider (i.e., quality of care or service). Examples include, but are not limited to:

a. Denial or termination due to the volume or nature of malpractice suits against the provider.
b. Quality or quantity of adverse clinical events generated during a provider's employment with Diversus Health.

Providers have no right of appeal if denial is for:

a. Initial Credentialing denial.
b. Locum Tenens or another temporary agency.
c. An "Adverse Administrative Action" – an adverse action taken by the Credentialing Committee against a provider, up to and including termination from Diversus Health, that is not related to the Committee's assessment of your competence or professional conduct. Examples include, but are not limited to:
    a. Loss of licensure
    b. Loss of Board Certification/Eligibility
    c. Conviction of fraud
    d. Actions taken by State or Federal Program that limit ability to practice.

Notice

If the Credentialing Committee takes a disciplinary action, the provider will be notified in writing (by signature-requested delivery) within thirty (30) calendar days following the date of the action. The notice will contain a summary of the reasons for the disciplinary action and a detailed description of the appeal process.

Provider Request for Appeal

You may request an appeal in writing by sending a letter to the Diversus Health's Credentialing Committee Chairperson postmarked no more than thirty (30) calendar days following your receipt of Diversus Health's notice of disciplinary action. Diversus Health will not accept provider appeals after the thirty (30) calendar day period. You have a right to be represented in appeal by another person of your choice (including an attorney). Your appeal should include any supporting documentation you wish to submit.

When we receive a timely appeal, we will send you an acknowledgement letter. The Credentialing Committee Chairperson will arrange for your case to be sent back to the Credentialing Committee for reconsideration. If no appeal request is received by the filing deadline, the Credentialing Committee's action is final.

Credentialing Committee Reconsideration

Upon timely receipt of an appeal request, the Credentialing Committee will review the appeal and reconsider its original decision. Upon reconsideration, if the Committee overturns its original decision, you will be notified in writing. If the Committee upholds its original decision or modifies it such that another type or level of disciplinary action is taken, you will be notified in writing that an Appeal Panel will be assembled to review the appeal, the date and time of the Appeal Panel hearing, whether you are invited to attend the hearing, and other administrative details.

Appeals Panel Hearing and Notice

The Appeals Panel is a peer review committee that is appointed by Diversus Health to hear the appeal. The hearing will occur no earlier than 30 calendar days and no later than 90 calendar days following the Diversus Health's receipt of your appeal request, unless otherwise determined by Diversus Health Credentialling Committee. The hearing shall consist, at minimum, of the Panel's review of the written submissions by Diversus Health and the provider, but may, at Diversus Health's sole discretion, allow for presentation of live testimony by Diversus Health and/or the provider. The Panel is empowered to uphold, modify, or overturn the Credentialing Committee's decision. The Appeals Panel's decision is final.

You will be notified of the decision of the Appeals Panel, and the reason therefore, no later than 15 calendar days from the date of the hearing.

Re-Application following Denial or Termination

In the event initial credentialing is denied, or if a provider is terminated from the network, Diversus Health will not reconsider his/her application for credentialing for 2 years following the effective date of denial or termination, unless the Credentialing Committee, in its sole discretion, deems a shorter period to be appropriate.

EXHIBIT F – CREDENTIALING POLICIES REFERENCING NCQA STANDARDS

Standard	Element	Section	Page	Exhibit
CR1: Credentialing Policies	A: Provider Credentialing Guidelines	3	5	
CR1: Credentialing Policies	B: Provider Rights	3	10	D
CR1: Credentialing Policies	C: Credentialing System Controls	10	17	
CR2: Credentialing Committee	A: Credentialing Committee	2	3	A
CR3: Credentialing Verification	A: Verification of Credentials	4	11	B
CR3: Credentialing Verification	B: Sanction Information	5	13	
CR3: Credentialing Verification	C: Credentialing Application	6	13	
CR4: Recredentialing Cycle Length	A: Recredentialing Cycle Length	3	8	
CR5: Ongoing Monitoring	A: Ongoing Monitoring and Interventions	7	16	
CR6: Notification to Authorities and Practitioner Appeal Rights	A: Actions Against Practitioners	8	16	E
CR8: Delegation of CR		9	17	

Initial/Recredentialing Checklist

Credentialing Type:

Initial Credentialing **Recredentialing (Required every two years)**

Non - Licensed to Licensed

Provider Name:

Provider Start Date:

Provider Type:

LPC	**APN (CNS/NP)**
LMFT	**PA**
LCSW	**MD/DO**
LAC	**CACII/CACIII**
PSY	**RN**

Other:

Verification Start Date:

Initial Approval Date:

Prior Approval Date:

Letter of Notification Sent:

180 days PSV date calculator date from: (www.timeanddate.com/date/dateadd)

Date of verification: *Date of Approval:*

Completed by: **Date Completed:**

Committee/CMO/Medical Director Approved Date:

Committee/CMO/Medical Director Denial Date:

DORA (Colorado Department of Regulatory Agency completes PSV of Education, training, board certification. Diversus Health Services obtains letters from DORA annually indicating PSV completed.

Diversus Health Services Credentialing

Provider ID:

Provider Degree/License Type:

Provider Practice Location:

Provider Start Date:

I have reviewed the applicant's credentialing file and attest that the applicant meets minimum requirements and the required information has been verified as set forth in Diversus Health Services's Credentialing Policy and Procedures.

(Signature, Credentialing Specialist) Date:

I have reviewed the applicants credentialing file and make the following recommendation.

Approve (Clean Files only) Date:

Deny (Must be reviewed by AspenPointe Credentialing Committee)

Signature CMO/Medical Director/Designated Alternate Date:

Credentialing Committee Decision

(***** Credentialing Committee Meeting Minutes available upon request as applicable*****)

Approve no conditions
Approve with conditions
Deny

DORA (Colorado Department of Regulatory Agency completes PSV of Education, training, board certification. Diversus Health Services obtains letters from DORA annually indicating PSV completed.

Credentialing Manager Audit/Approval

ITEM	PSV TIME FRAME	REVIEW DATE	INITIALS OF VERIFIER	REPORT DATE (IF APPLICABLE)	SOURCE USED
CO Application to include Disclosure/Clinical Privileges	180 Days from date of signature				CO Application: Attestation Questions: Click each box answering the corresponding question: Reason for Inability Lack of Drug Use Loss of License Felony Convictions Loss of limits to Privileges Attestation Signature Date:
Colorado License Verification: License Number: License Expiration: Other/Additional:	180 days				DORA Wallet Copy Received Previous adverse actions Current adverse actions (LPC's only:) Prior to 1/1/2017 After 1/1/2017 NCE NCMHCE
Out of State licenses (past 5 years): State(s): Number(s): Expiration date(s):	180 days				State board of licensing online verification. Additional license/expiration date:

Current DEA (registered in CO) DEA Number: Expiration Date: Schedule 2 2N 3 3N 4 5 Suboxone waiver Y N Suboxone Licensed State: Date Certified: Certified for how many patients:	180 days				Copy of Current DEA Certificate Address listed on DEA: SAMHSA Website Copy of Current DEA Certificate with X Waiver number.
Current Malpractice COI AP Policy Number: Effective Date: Expiration Date: Policy Amounts: 1Mill/3Mill Personal Policy Number Effective Date Expiration Date Policy Amounts:	Effective at time of credentialing				Copy of COI(s)

ASPEN POINTE

Board Certification (If Applicable) Specialty(is) Board: APBN ANCC NCCPA NBCC Other: Effective Date: Expiration Date: Lifetime Meeting MOC Board Eligible: Y N Eligibility Expiration Date:	180 days				Online verification from Board website or letter from Board.
Education/Training – confirm that the highest of the three levels of education has been appropriately verified (Not required for recredentialing) Graduate/Medical School Residency Board Certification, if applicable ECFMG: Y N Graduate Diploma Y N	180 day				DORA Official Transcripts Board Certification Website AMA profile Accredited: Y N Accrediting body: EFCMG Certificate Number: Date Issued:

Work History – CV/Resume Gap Y N *must contain current 5-year work history – more than 30 days gap requires written explanation: please send work gap form to provider to complete*	180 days				Copy of current CV/Resume Dates must be in MM/YY format For recredentialing obtain attestation by provider that CV/Resume has not changed since last credentialing cycle.
Government Issued Photo ID (not required for recredentialing)	Prior to Approval				Copy of Government Issued Photo ID Form of ID: Driver’s License Visa/Passport Military ID State: Issue Date: Expiration Date:
NPDB – Continuous Query	180 days				Copy of NPDB report Current Adverse actions found: Y N Past Adverse actions found Y N Malpractice claims > 10 years Y N
Medicare/Medicaid Sanctions – OIG, OFAC, SAM)	180 days				LexisNexis report Actions found: Y N
Medicare opt Out	180 days				Novita’s Solutions Report Is provider listed on the opt out report: Y N
Background Check Verification	180 days				Paycom report: Issues found Y N

Peer References (Three for Initial; Two for Recredentialing)	180 days				Paycom Report Letters from reference subject Dates references completed: 1 2 3
Hospital Privileges: Admitting Consulting Other:	180 days				Copies of letters from applicable hospitals. If no privileges: Admitting Action Plan Form Y N
NPI Verification: NPI Number: NPI State: Enumeration Date:	180 days				NPPES Website
Competency (Recredentialing only): CME Competency Assessment Case logs Supervisor Assessment Complaints/Concerns:					Relias/Personal CME transcripts Competency Assessment Case Logs from SmartCare Supervisor Form Grievance report/Smart Care

Job Description Present: Y N Minimum Requirements Met Y N					Copy of Job Description
Comments/Additional Information:					
24 Hour Coverage	N/A	N/A	N/A	N/A	Crisis Center Available 24/7/365

Concerns to be discussed at Committee (if applicable):