Subject:	CHI Texas Health Networks Credentialing Policies & Procedures		
Date Approved:	April 12, 2017	Date Amended:	June 13, 2018 August 8, 2018 January 9, 2019

PURPOSE:
To establish mechanisms for gathering relevant data that will serve as the basis for decisions regarding credentialing of physicians and other health care Providers for the purpose of determining their professional qualifications and competency for appointment and reappointment as participating Providers in CHI Texas Health Network (CIN) and contracted health care services agreements.

DEFINITION(S):

Applicant
An individual who has submitted an application for appointment or reappointment to the CIN requesting to be approved for participation or continued participation in the CIN. In accordance with NCQA and the Texas Department of Insurance (TDI), credentialing is not required for Providers who practice exclusively within a hospital setting, also known as hospital-based providers.

Board-Eligible
A description for a physician who has completed the requirements for admission to a medical specialty board examination, but has not passed that examination. Each medical specialty board has the right to define this period.

Chapter
A standing committee of CIN, established by the Board, which will be responsible for overseeing clinical integration efforts in certain regional service areas within the State of Texas. Each Chapter will be composed of such providers, and have the purposes, duties and obligations, as set forth by the Board in "Chapter Committee Charters".

Chief Medical Officer
Means the board certified Participating Physician licensed to practice medicine in the State of Texas who is a member of the Credentialing Committee and is responsible for the duties as identified in the Credentialing Policies and Procedures.

Compliance and Performance Improvement Committee (CPIC)
A multispecialty committee of three or more Providers appointed by the Board, which is authorized to recommend and oversee processes, pathways, bundles of care and services to ensure clinical integration.

Credentialing Committee
A multispecialty subcommittee of the Network Performance and Membership Standards Committee consisting of three or more Providers, which is authorized to use a peer review process to evaluate the qualifications and competence of all Applicants.

Credentialing Elements
Means those items discovered, including Primary Source verification and supporting documents, in the credentialing process by the CVO and/or submitted by the Applicant that are reviewed by the Chief Medical Officer, Credentialing Committee or Governing Authority to determine an Applicant's eligibility to participate in the Organization's Provider Panel.

Delegating Entity
An entity that has an executed agreement with The CIN that entitles The CIN to perform the credentialing functions for the providers who fall under the agreement.

Division Board (Board)
The governing body of the CIN, as described in the CIN's Operating Agreement and other organizational documents, as amended.

Group 1
An applicant's file for initial appointment or reappointment that does not contain one or more of the following items: (1) medical license investigation(s), (2) OIG sanction(s) (Medicare/ Medicaid), (3) adverse NPDB inquiry, (4) patient or quality of care complaint(s), (5) affirmative answer(s) to any disclosure questions, other than question 23 on the Texas Standardized Credentialing Application (TSCA), or (6) malpractice claim(s) that are pending or settled since the last credentialing cycle. Group 1 files must also contain verification that the Applicant is in good standing at the hospital at which Practitioner has designated as his or her primary admitting facility, and the file must contain current copies of required documents.

Network Performance and Membership Standards Committee (NPMS)
A multispecialty committee of four or more Providers appointed by the Board, which is authorized to make decisions based on adherence to set standards.

Provider
A physician or other licensed individual who has been approved for participation in the CIN.

Urgent Care Provider
A provider who meets the Urgent Care Credentialing Criteria listed in Attachment F.

POLICY:

It is the policy of the CIN to ensure that all participants meet minimum credentials standards. The Board will appoint a multispecialty Credentialing Committee, of which the Chief Medical Officer of the CIN shall serve as the Chairman, to assume the task of reviewing applications and making decisions as to an Applicant's adherence to the credentialing requirements; however, the final decision with respect to an Applicant's appointment, reappointment, or continued participation status is with the Board.

The CIN credentials Doctors of Medicine (MD), Doctors of Osteopathy (DO), Doctors of Podiatric Medicine (DPM), Doctors of Dental Surgery (DDS), Physician Assistants (PA) and Nurse Practitioners (NP). Credentialing of other professionally licensed staff will be completed as needed for network adequacy.

The credentialing/re-credentialing procedure will be conducted in a manner to ensure that all credentialing requirements are uniformly applied and shall be non-discriminatory in terms of sex, race, religion, creed, color, national origin, treatment of high risk populations or costly medical conditions, and disabilities and/or Limited English Proficiency or on the basis of any other criterion unrelated to the delivery of quality patient care. Annual audits of credentialing files will be performed to ensure that Providers are not being discriminated against.

The Board will review the Credentialing Policy and Procedures on an annual basis to determine if the terms remain consistent with nationally recognized credentialing standards. Recommendations from Delegating Entities and information received from Texas Department of Insurance, Texas Medical Board or other regulatory agencies will be considered by the Board in its review and revision to the Policy and Procedures. Upon adoption by the Board, the final Policy and Procedures will be provided to all participating Providers and Delegating Entities.

COMMITTEES:

NETWORK PERFORMANCE AND MEMBERSHIP STANDARDS COMMITTEE (NPMS)

Roles and Responsibilities

The purposes of the NPMS will be to support the mission and vision of CIN in areas including, but not limited to: a) access; b) clinical integration; c) safety; d) patient satisfaction; and d) cost effectiveness and efficiency. The NPMS shall assist the Board in its responsibilities as related to:

- Developing the standards of participation for physicians and other network providers who wish to join the CIN.
- Determining the size and composition of the network required to serve the population served by CIN.
- Maintaining relationships between CIN participating physicians and facilities and the organization and working to resolve concerns, complaints, and questions about participation status.
- Identifying and resolving conflicts of interest of applicants and CIN participants.
- Overseeing credentialing of CIN participating physicians and facilities.

Throughout its work, the NPMS will serve as a designee of the Board, which will act upon the findings and recommendations of the NPMS.

Purpose and Authority

The NPMS shall:

- Recommend standards for participation in the network based on quality, safety, care coordination, patient satisfaction, access, and cost effectiveness/efficiency, in alignment with internal and external guidelines.
- Review applications and credentials in view of CIN participation criteria and then recommend participants as appropriate for approval by the Board.
- Ensure that current credentialing documents are maintained.
- Continually review, with the organization's counsel, any legal matter that could have a significant impact on the organization or its relationships with participants or potential participants.
- Report to the Board regularly regarding network status and network needs.
- Periodically review conflict of interest statements.

Membership, Expertise, Size, and Term

The NPMS shall be composed of four or more members, at least one from each chapter, appointed by the Board and each of whom is an independent manager and free from any relationship that would interfere with the exercise of his or her independent judgment as a member of the NPMS. One of the members shall be the CIN Chief Medical Officer and he/she will be a permanent member of the NPMS. The full Board may elect to adjust the NPMS's size. The term of the NPMS members shall be three years, unless otherwise determined by the Board.

Evaluations

- The NPMS shall periodically review and, if necessary, propose updates to the NPMS's charter.
- The Board shall annually (re)appoint NPMS members as terms expire.
- The NPMS will perform an evaluation of its performance at least annually to ensure that the NPMS is functioning effectively.
- The NPMS shall regularly review policies and procedures applicable to its business.
- The NPMS shall review legal and regulatory matters that may have a material effect on the organization.

COMPLIANCE AND PERFORMANCE IMPROVEMENT COMMITTEE (CPIC)

Overall Role and Responsibilities

The CPIC will assist the Board in its responsibilities as related to: clinical integration across the continuum of care, quality and patient safety, utilization of resources and patient outcomes. It is responsible for driving continuous improvement in the provision of care by:

a) Utilizing evidenced based medicine;
b) Overseeing the standards through metric evaluation;
c) Ensuring compliance with outlined standards; and d) ensuring continued efforts to improve performance.

Consistent with this function, the CPIC shall encourage continuous improvement of, and promote adherence to, the organization's policies, procedures, and practices for corporate accountability, transparency, integrity and quality.

Throughout its work, the CPIC will serve as a designee of the Board, which will act upon the findings and recommendations of the CPIC.

Purpose and Authority

The CPIC shall recommend processes, pathways, and bundles of care and services to ensure:

- Clinical integration;
- Superior quality/patient Safety;
- Appropriate utilization of resources; and
- Improved patient outcomes
- Short dashboards for providers and leaders which reflect current status of compliance and quality
- Recommend to the board if action is required to remediate physicians who are not in compliance with the quality standards of the CIN

The CPIC functions at the level of the CHI Texas Division. This is because most contracts have standard metrics regardless of the local market. However, each Chapter should include review of CPIC data and policies during Chapter leadership committee meetings. For this reason, it is recommended that representatives to the CPIC also serve on the appropriate Chapter Leadership Committee for that market. These representatives will thus report to and coordinate CPIC actions with local markets.

Membership, Expertise, Size, and Term

The CPIC will be appointed by the Board and will consist of three or more members. The Board may elect to adjust the CPIC's size for the long-term and/or from time-to-time for specific CIN initiatives. The term of the Committee members shall be three years, unless otherwise determined by the Board.

Subcommittees

Subcommittees may be appointed: a) at the Chapter; b) within the CIN 'Leadership Committee' Structures; and/or c) on an ad hoc basis.

Evaluations

- The CPIC shall periodically review and, if necessary, propose updates to the CPIC's charter.
- The Board shall (re)appoint CPIC members as terms expire.
- The CPIC will perform an evaluation of its performance at least annually to ensure that the CPIC is functioning effectively.
- The CPIC shall review policies and procedures at least annually and as applicable to its business.
- Review legal and regulatory matters that may have a material effect on the organization.

PROCEDURES:

I. Requirements for Applicants

A. **CHI Texas Affiliation.** Applicant must have privileges at, or be in the process of being credentialed by, a CHI Texas facility, unless granted a waiver by the NPMS. Broad waivers have been granted for the following specialties: Rheumatology, Dermatology and Allergy and Immunology. A waiver may be requested in writing and shall include the rationale for consideration. Waivers will be granted based on specific market or specialty needs of the network. Membership in good standing must be maintained throughout the Provider's participation in the CIN. Physician Assistants and Nurse Practitioners must have a supervising physician who is a member of the CIN and located within 50 miles of their practice location.

B. **CIN Application.** In addition to completing the Texas Standardized Credentialing Application, the Applicant must complete a separate CIN Credentialing Application and must provide all documentation as required by the CIN. Work history must be complete for at least five years and all gaps greater than six months must be explained.

C. **Texas License.** Applicant must hold current license to practice his or her designated specialty in the state of Texas. Any restriction to the license must be disclosed during the application process. This information will be verified through the TMB or other appropriate regulatory agency.

D. **DEA.** If applicable to the specialty, Applicant must have a current Federal Drug Enforcement Administration (DEA) Registration. This information will be verified through the issuing agency.

E. **Professional Liability Insurance.** The Applicant must maintain and provide evidence of professional liability insurance coverage in the amounts of at least $200,000 per occurrence and $600,000 aggregate.

F. **Board Eligibility and Certification.** The Applicant must be board certified or Board Eligible by a CIN recognized board in the specialty in which he or she is applying for CIN participation. The NPMS may waive the requirement for board certification or Board Eligibility in individual cases if the Applicant submits the request in writing, including the rationale for the request. Any Applicant so granted a waiver must demonstrate evidence of specialty training and ongoing continuing medical education in his or her medical specialty.

CIN recognized boards:

Type/Degree	Board Name
Medical Doctor (MD)	American Board of Medical Specialties (ABMS)
Osteopathic Physician (DO)	American Osteopathic Board (verified through American Osteopathic Association) or ABMS
Providers who are recognized as Board Certified by the Texas Medical Board as detailed in Texas Administrative Code; Chapter 164 , Rule 164.4	

It is understood that certain health plans require board certification and membership in the CIN does not guarantee acceptance for participation in such plans.

G. **Attestation.** The Applicant must attest to any inability to perform the essential function of the position with or without accommodation, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss or limitation of privileges or disciplinary actions, as well as the correctness and completeness of the application.

H. **Unprofessional Acts.** The Applicant must not have been convicted of any offense or have engaged in any unprofessional act, which in the judgment of the Board is substantially related to the qualifications, functions or duties of said Applicant. A conviction within the meaning of these participating standards means a plea, a verdict of guilty, or a conviction following a plea of nolo contendere. The Applicant shall provide information of such at the time of application. Subject to the provisions of reconsideration and hearings detailed herein, the Board shall determine if such history disqualifies an Applicant from participating.

I. **Revocation or Expulsion History and Professional Liability.** If an Applicant has (1) been suspended from a medical staff, (2) had hospital privileges suspended or revoked, (3) otherwise been disciplined by an institutional or other health care organization, including managed care or insurance plans, professional societies, or any agency of any state or federal government, or (4) has had a judgment entered against him or her pursuant to a claim of professional liability, such information must be disclosed to the CIN at the time of application.

J. **Documentation and Demonstration.** The Applicant must be able to document his or her background, experience, training, and demonstrated competence, adherence to the ethics of the medical profession, good reputation, and ability to work with others with sufficient adequacy to assure the Board those beneficiaries of designated payers' employee health benefit plans treated by the Applicant will be given appropriate medical care and that the CIN will be able to rely on the Applicant to perform the functions, duties, and obligations required of the Applicant by agreements with employers, insurers and other third party purchasers of health care services.

K. **Peer Environment.** The Applicant must be willing to participate in a peer review environment and accept the results of and comply with the CPIC and NPMS of the CIN or its contracted employers, insurers and other third parties as designated by the CIN.

L. **Continuing Medical Education.** The Applicant must demonstrate and provide evidence of current and continued satisfaction of minimum continuing medical education requirements of the Texas Medical Board, or other applicable licensing/credentialing board, and provide evidence of such upon application.

M. **Disclosure of Ownership.** The Applicant must provide evidence of a Disclosure of Ownership and Control Interest Statement. This form can be found at http://www.tmhp.com/Provider_Forms/Provider%20Enrollment/F00108_Disclosure_of_Ownership.pdf.

N. **Practice Site Audits.** The Applicant must be willing to demonstrate that his or her office practice site is clean, presentable, adequately staffed, and reasonably accessible to patients, to include sufficient examining and waiting areas. The Applicant must be willing to allow an office site visit when requested by the CIN or by an entity designated by the CIN and to achieve a passing score established by the CIN or the designated entity. If a passing score is not achieved, the Applicant shall develop a corrective action plan, which shall be implemented within the period required by the CIN or the designated entity. This shall not be required of hospital-based physicians. Failure to comply may result in denial of participation.

O. **Medical Records.** The Applicant must be willing to demonstrate that his or her medical records are legible, reproducible and otherwise meet federal and state medical records standards. The Applicant must allow review of medical records by the CIN or by an entity designated by the CIN when such review is required for Quality Management or the National Committee for Quality Assurance (NCQA) or other accrediting organization, and shall receive a passing score established by such entity and agreed to by the CIN. Such review shall conform to all state and federal regulations with regard to safeguarding the confidentiality of such medical records. If a passing score is not achieved, the Applicant shall develop a corrective action plan that shall be implemented within the period required by the CIN or the designated entity. Failure to comply may result in denial of participation.

P. **Supervision of Employed Non-Physician Practitioners.** The Applicant must agree to maintain an appropriate level of supervision of any non-physician practitioners in his or her employ and to attest to non-physician practitioner's appropriate licensure, certifications, and professional liability insurance.

Q. **Authorization to Release Credentialing Information.** The Applicant must authorize the release to the CIN of information regarding his or her insurance coverage, claims history, CHI privileges, work history, past conduct, and other information as necessary for the Board to evaluate his or her participation in the CIN.

The Applicant must sign a Release of Information Letter of Authorization with respect to his or her credentials, and release from any liability all those who, in good faith and without malice, review, act on, or provide information regarding the Applicant's competence, professional ethics, character, health status, and any other qualifications required for participation.

The Applicant agrees that access to his or her credentialing files and information shall continue beyond his or her termination or resignation from the CIN for such amounts of times as are required by federal or state law or regulation, and by the contractual terms of the CIN's managed care and health plan agreements.

The Applicant agrees to hold the CIN, its officers, directors, and employees harmless for notifying contracted managed care and health plans, and any required federal or state agency or department, of any reportable action, including but not limited to involuntary suspension or termination from the CIN and reason for such.

The Applicant understands that voluntary or involuntary termination or suspension from the CIN shall mean the termination or suspension of his or her participation status with managed care and health plans contracted with the CIN.

R. **Execution of and Compliance with Participation Agreement.** The Applicant must agree to execute and comply with the terms of the Participation Agreement between the Applicant and the CIN (the "Agreement") and, the Applicant must in fact execute the Agreement.

S. **Compliance with Managed Care Agreements.** The Applicant must agree to remain in compliance with the terms of the managed care agreements in which he or she participates through the CIN.

The Applicant understands that, subject to the dispute resolution provisions of the Participation Agreement and the right to reconsideration and hearing herein, failure to remain in compliance with the plan's rules and regulations, credentialing criteria and other factors may result in termination or suspension from participation in specific managed care plans or all managed care plans.

T. **Changes to Any of the Above Information.** The Applicant agrees that he or she will provide immediate notice to the CIN of changes to any of the above information, including restriction, revocation, or suspension of any of the required documents. Such changes may result in immediate suspension from the CIN and participation in the CIN contracted managed care or health plans, which is determined at the sole discretion of the Board.

U. **Expedited Credentialing.** The CIN allows for expedited credentialing/provisional network status if the applicant meets the requirements detailed below:

Criteria for Expedited Credentialing:

- Applicant joins an established medical group that has a current agreement in effect with the CHI Texas Health Network (CIN)
- At least one Provider in the group is credentialed and an active member of the CIN
- Applicant requests expedited credentialing in writing to the CIN office at 3100 Main Street, Suite 830, Houston, Texas 77002
- Meets the requirements of "Group 1" according to the definitions of the CIN policies and procedures
- The provider must have not been previously denied or terminated for cause from network participation
- A completed Texas Standard Credentialing Application with all of the required attachments and documentation must be submitted to the CIN
- All licenses to practice must be in good standing and verified with appropriate medical licensing agency with no history of disciplinary actions

Verifications:

The CIN or its delegates will verify the following within the required time limits:

- A current, valid license to practice
- The past five years of malpractice claims or settlements from the results of the National Practitioner Data Bank (NPDB) query
- A current and signed TSCA with verification

Process:

- Determine within 2 weeks of receiving the application and request for expedited credentialing if the applicant meets the criteria for expedited/provisional credentialing
- Provisional status can be denied if the provider does not meet all of the criteria for expedited credentialing and the provider will then be processed as specified in these policies and procedures
- Follow the same process for presenting provisional credentialing files to the Credentials Committee or medical director as it does for its regular credentialing process
- Notify the provider whether or not the provisional status has been approved
- CIN will not hold providers in provisional status for longer than 60 calendar days
- Complete the initial credentialing process within sixty (60) days from the date the expedited/provisional credentialing status was approved.

II. Re-credentialing

A. **Re-credentialing Application.** All CIN providers will receive a CIN Re-credentialing Packet, which must be completed and returned in order to be considered for continued participation with the CIN. All required documents must be included and the Provider must attest in writing with a dated signature that all information is complete and correct.

B. **Three Year Cycle.** The CIN will re-credential and reappoint the Provider no greater than every three years, or as required by National Committee on Quality Assurance (NCQA).

C. **Maintain Currency of All Standards.** The Provider must maintain currency of all participation standards through the initial term and any subsequent term.

III. Delegated and Retained Credentialing Process

A. **Use of Delegates.** The CIN may delegate its initial credentialing and re-credentialing process to one or more entity. To support this delegation, the CIN will execute a Delegation Agreement with such entities by which its Applicant Providers and participating Providers are credentialed and re-credentialed in accordance with the NCQA Standards and federal and state law. This Agreement will clearly establish the extent of the delegate's duties and the oversight mechanism of the Credentialing Committee and must include at least semiannual reporting by the delegate to the CIN. The agreement will include a provision that gives the Credentialing Committee authority to approve, disapprove or terminate a Provider's membership in the CIN.

All Delegation Agreements between the CIN and such entities are attached hereto.

The CIN shall maintain a process by which it reviews the credentialing process of such entities on no less than an annual basis. This will include a review of the delegate's credentialing plan and reporting requirements, as well as 5%, or ten files, whichever is less. Audit results will be maintained by the CIN. The Credentialing Committee may rescind delegation activities if the Credentialing Committee's audit findings indicate delegate has failed to fulfill its obligations.

B. **Primary Source Verification within 180 Days.** Primary source verification shall be conducted by the CIN or its delegates within 180 days of the receipt of application. If verification of primary source is not conducted within this period, the Provider will re-attest to completeness and correctness of the application information and such re-attestation will be with written signature and date. In the event re-query of primary source information is required due to Provider's failure to provide information or respond to a request within the time period requested, the Provider may be charged for the expense associated with such re-query.

C. **Primary Source Verification.** The CIN or its delegate shall complete the Credentialing Summary Form for each Provider at the time of credentialing or re-credentialing, including dates for primary source verifications. This form will be signed by the credentialing designee.

Primary source verification shall include the following:

- Completeness of application and attestation by Provider
- Texas License
- DEA
- Malpractice claims history
- Board Certification, if applicable
- If not Board Certified, residency or highest level of credentials attained unless this function is performed by the licensing board. Refer to Attachment E for the applicable licensing boards.
- Privileges and disciplinary actions, if applicable, at the hospital designated by the Applicant as the primary admitting facility
- Medicare and Medicaid sanctions
- SAM/Excluded Parties List System (EPLS)
- List of Excluded Individuals/Entities (LEIE)
- National Plan and Provider Enumeration System (NPPES)
- National Practitioner Data Bank – Healthcare Integrity & Protection Data Bank (CIN's record only)
- Medicare Opt Out List
- Verification that all primary source verifications have been completed within 180 days of receipt of Provider's application

IV. Rights to Status Notices, Incomplete Applications, Variances, and File Review

A. **Status Notices.** Once the completed application has been received in the offices of the CIN, the Applicant has the right to be informed of the status of his or her application. The status request may be verbal or in writing. The CIN will respond, verbally or in writing, no more than five days from the status request.

B. **Incomplete Applications.** The Applicant will also be notified in the event the application is incomplete or if additional information is needed. If the application is not completed within 30 days of notice, it will become inactive. If it is a re-credentialing application, it will be considered a voluntary resignation and the Provider will be administratively terminated from the CIN and all associated contracts. A notice of such termination will be sent by certified mail. The Provider may reapply following such termination. Administrative termination will also be taken if a Provider fails to return the re-credentialing application.

C. **Variances.** During the course of credentialing or re-credentialing, if there is a variance of information obtained from primary source verification and that provided by the Applicant, he or she will be notified in writing of such and be given the opportunity to respond to the notice. All responses will be taken to the Credentialing Committee, along with the original application. The Credentialing Committee may request the Applicant to present before the Credentialing Committee for additional clarification of any variance. It is at the sole discretion of the Credentialing Committee to accept or decline the explanation of variance. If the Credentialing Committee feels that the variance was material or deliberate misrepresentation, the Applicant will be disqualified from participation in the CIN.

D. **File Review.** Providers have the right to review their credentials file at any time. The Provider must notify the CIN and request an appointed time to review their file and allow up to five calendar days to coordinate schedules. The Provider has the right to review all information in the credentials file except peer references or recommendation protected by law from disclosure.
The only items in the file that may be copied are the application, the license, and the DEA certificate. Providers may not copy documents that include pieces of information that are confidential in nature, such as the responses from monitoring organizations and verification of hospital privileges letters.

V. Decision Making Process, Credentialing Committee and Board Presentation

A. **Group 1 Applicants.** After the credentials verification process has been completed, Applicants who are in compliance with the Credentialing Elements of the Organization may be forwarded to the Chief Medical Officer who may review, thoughtfully consider, and approve such Applicants. If the Chief Medical Officer does not approve a Group 1 Applicant, that Applicant must be submitted to the Credentialing Committee for review. All credentialing elements must be presented and considered concurrently. The Chief Medical Officer will not approve an Applicant if the Credentialing Elements are not in compliance with the minimum time limits as defined by NCQA. The list of approved Group 1 Applicants will be reported to the Credentialing Committee.
Additional Group 1 Criteria:

- Providers who only have claims more than 10 years old
- Providers who only have claims for incidents that occurred while they were in training

- Providers who have a TMB Reprimand for not using electronic death registry or other administrative only issues
- Providers who have applied for privileges at a CHI facility, but are still in the credentialing process, will be Group 1 pending acceptance at the CHI facility
- Providers who are scheduled or have taken the Board Certification exam and haven't received the results will be Group 1 pending the final results
- PCPs who have no hospital privileges and don't refer specifically to Hospitalists at CHI facilities will be Group 1, but utilization data will be reviewed regularly

B. **Credentialing Committee.** The Credentialing Committee will meet at least quarterly to review all credentialing elements for providers who do not meet Group 1 requirements, and make credentialing decisions, which must be approved by a majority of the Credentialing Committee. A quorum is constituted by three members of the Credentials Committee, either in person or by telephone. All primary source verifications will be current as of the date of the Credentialing Committee meeting. All decisions shall be made by a majority of those present and shall be entered into the Credentialing Committee meeting minutes for presentation to the Board. The requirement for a quorum is three Committee members. The minutes shall be maintained for such period as required by federal and/or state regulations, whichever is longer.

C. **NPMS Presentation.** The Board will review the NPMS minutes, including those of the Credentialing Committee, along with their decisions, at its regularly scheduled meetings.

VI. Acceptance for Participation

A. **Participant Agreement.** The Applicant must sign and return the Participant Agreement and credentialing packet. If the Applicant meets credentialing criteria and the Credentialing Committee approves his or her participation, a written notice and fully executed Participant Agreement, are issued to the Applicant within 60 days. . The Provider will be added to the roster for the CIN after he or she is credentialed. The effective date of the Provider in any plan is dependent upon the policies of the plan, which is not controlled by the CIN.

B. **Orientation.** If requested, an orientation for the Provider and his or her staff will be scheduled.

C. **Site Visit.** When required by a Delegating Entity, or when the CIN becomes aware of three complaints, the CIN will schedule an office site visit within 60 days to include medical records review. If the practice does not attain a passing score, the deficiency is noted to the Provider and the Provider is given a reasonable period to correct such deficiency. A follow-up visit will be scheduled within three months to determine whether or not the deficiency has been corrected. If the deficiency is not corrected, the Provider may be denied participation in the CIN network of Providers. It is the sole right of the CIN or a Delegating Entity to pend or deny a Provider's participation based on the failure to achieve or maintain the required office site standards and medical records standards. Records of site visits will be documented in the Provider's credentialing file.

D. **Compliance with Administrative Guidelines.** Once accepted for participation, the Provider must maintain performance and compliance with administrative guidelines of the CIN, federal, state, Delegating Entities, and other third party payers. If the CIN receives a notice of complaint or grievance that is justifiable and correct, a written notice shall be issued to the Provider with information of the issue or complaint and a recommended course of action. Failure of the Provider to respond to notice of correction or resolution within the period required may result in the suspension or termination of the Provider by the process that is detailed herein.

E. **No Guarantee of Utilization.** The CIN does not warrant or guarantee that Providers will be chosen by any payers or Delegating Entities, or by any minimum number of beneficiaries.

VII. Rights Regarding Non-Acceptance

A. **Credentialing Criteria Concerns.** Applicants or Providers with concerns for meeting the criteria for membership or continued membership may review their situation with the CIN's Division Director, Network Development or other officer before submitting the application.

B. **Notice of Non-Acceptance.** If the Applicant does not meet credentialing criteria, the CIN will provide written notice to the Applicant or Provider within thirty working days of the decision not to accept. The notice will document the basis for non-acceptance, and will provide an opportunity for the Applicant or Provider to request a reconsideration review of his or her application.

C. **Alterations of Application and/or Attestations.** Notwithstanding anything to the contrary in the Policy and Procedures, the Applicant or Provider may not request correction to any information provided in the application form and attestations. False and misleading statements or information are considered the basis for denial, termination, or suspension, as described in Section XI.C.

D. **Process for Reconsideration.** Reconsideration requests must be submitted within thirty days of the receipt of the notification of non-acceptance. The request must be in writing and delivered to the CIN office during normal business hours or by certified registered mail within thirty days of the receipt of the notification of non-acceptance and must outline the basis for the reconsideration request, including any documentation supporting his or her case or disputing any allegations made in regards to the Applicant or Provider during the credentialing process. All reconsideration requests will be reviewed at the next regular meeting of the Credentialing Committee. The majority decision of the Credentialing Committee is final. If the reconsideration review results in non-acceptance, the Applicant may not reapply or request additional reconsideration review for 12 months from the date of final reconsideration decision.

VIII. Ongoing Monitoring and Investigations

A. **Sanctions and Other Disciplinary Actions.** The CIN shall review Medicare, Medicaid, and TMB sanctions and all applicable licensing board reports on a monthly basis.

B. **Currency of Information.** The CIN shall request and maintain currency of licenses, certificates and other documents as such expire, and shall review TMB and other applicable licensing boards to verify currency of the Provider's license to practice in his or her field.

C. **Special Review.** In the event of a material finding during ongoing monitoring, the Credentialing Committee shall be notified and a special review shall take place, either in a specially called meeting or through dissemination of the information. The Provider shall be advised in writing of the special review. If the Credentialing Committee decides that further action is required, the CIN will send a written notice within ten days of the decision notifying the Provider of the action required and the time allowed for the response.

D. **Investigation.** If the Credentialing Committee believes that there are sufficient grounds to justify an investigation, they will appoint a committee to conduct the investigation. Such committee shall be comprised of no less than four Providers, and use best efforts to include one Provider with the same or similar specialty; none of which have a conflict of interest in the investigation. The Chief Medical Officer shall preside over such investigating body. No such investigative process shall be deemed to be a "hearing."

An investigation may also be requested by the Chief of Staff of the applicable CHI Texas facility, CIN Division Vice President, any committee formed by the Board, another Provider, or by request of a Delegating Entity.

E. **Results of Investigation.** No later than 60 days after commencement of the investigation, the committee shall make recommendation to the Credentialing Committee and the Credentialing Committee will act thereon. Such action may include, but is not limited to, no corrective action taken, letter of warning or reprimand detailing the activities or conduct at issue, terms of probation or individual requirements of consultation, suspension or termination of CIN membership, or other actions

appropriate to the facts developed in the course of the investigation. The presence of at least 50% of the Credentialing Committee shall constitute a quorum for purposes of sanctioning or terminating a Provider.

If additional time is needed to complete the investigation, the committee may defer action and it shall so notify the Provider and the Credentialing Committee. A subsequent recommendation for any one or more actions provided shall be within the time period specified by the committee, and if no such time is specified, then within 30 days of the deferral.

IX. Complaint Resolution

A. **Procedures.** The procedures outlined below have been designed to enable the CIN to respond to verbal and written complaints.

In establishing these procedures, the CIN does not assume any legal, financial or regulatory responsibility on behalf of the member or Provider, or any other interested party. These procedures are recommended guidelines for complaint resolution only and do not cover any professional liability complaint. Professional liability complaints must be sent directly to the Provider according to accepted legal procedures.

Preferred Course:

All parties are encouraged to contact the Provider directly with any complaints.
The Provider is encouraged to respond within a reasonable period to resolve the complaint. The Provider is also encouraged to take appropriate action if necessary to correct any quality concerns and to advise the party making the complaint that corrective action has been taken.

Alternative Course:

Party may contact CIN Division Vice President with any complaints.
If the complaint requires corrective action, the Division Vice President will submit a written notice to the Provider detailing the nature of the complaint and any action required. The Provider will respond to Division Vice President within ten business days of action taken. The Division Vice President will respond within fifteen days or sooner to the party making the complaint.
If the complaint requires access to the member's personal medical record, a signed Release of Medical Information must accompany a written request for investigation.
The Division Vice President shall take any quality of care issue to the Chief Medical Officer of the CIN. Action from such report shall be governed by the Policy and Procedures established by the CIN.

B. **Records.** The CIN shall maintain records of all complaints received from members, health plans and Providers. The record shall detail the nature of the complaint, action taken, and resolutions. The record shall be maintained and shall be reviewed at time of re-credentialing or at any time as established by the Policy and Procedures established by the CIN.

X. Suspension and/or Termination of Provider

A. **Summary Suspension.** The Board and/or Credentialing Committee may summarily suspend a Provider's participation in the CIN for any of the reasons listed below. Written notice will be sent to the Provider via certified mail advising him or her of such. If the Provider has not responded to the notice within 30 days, he or she will be terminated from the CIN.

- **Fraud, Abuse and Sanctions.** This includes cases where the Board and/or Credentialing Committee determines that the actions or inactions of a Provider are likely to constitute fraud or abuse, to result in the imposition of sanctions by any governmental authority, or to jeopardize or materially harm the CIN's relationship with any payer or contracted plan. A hearing will be available upon request.
- **Health Safety and Welfare.** This includes cases where the Board and/or Credentialing Committee determine that immediate action must be taken to protect the health, safety or welfare of any patient, to include substandard professional care. A hearing will be available upon request after the investigation is complete.
- **Revocation, Suspension or Nonrenewal of License.** The Provider may request reconsideration upon restoration of license and must complete re-credentialing.
- **Loss, Reduction or Non-Replacement of Insurance.** This includes revocation, suspension, reduction in required limits so that it does not meet the minimum requirements set by the CIN, or expiration and non-replacement of the professional liability insurance of the Provider. The Provider may request reconsideration upon restoration of insurance and must complete re-credentialing.
- **Revocation, Suspension or Nonrenewal of Certificates.** This includes any action taken by a governmental agency resulting in the revocation, expiration, or suspension of the Provider's DEA or DPS. The Provider may request reconsideration upon restoration of certificates and must complete re-credentialing.
- **Revocation, Suspension or Termination of Privileges.** This includes revocation, suspension or termination of the Provider's staff privileges at the CHI Texas facility. The Provider may request reconsideration upon restoration of privileges and must complete re-credentialing.
- **Failure to Provide Current Documents.** If the Provider fails to maintain, or fails to provide within the time period noticed by request of the CIN, current documentation of all CIN required documents, the Credentialing Committee may suspend the Provider. The Provider may request reconsideration upon restoration of certificates and must complete re-credentialing.

B. **Suspension and/or Termination for Noncompliance with Medical Records Requirements, Site Requirements and Other Reasons.** If a site audit by the CIN or a Delegating Entity reveals a deficiency in medical records or other site requirements as adopted by the CIN, the Board and/or Credentialing Committee may suspend the Provider. The Board and/or Credentialing Committee shall give the Provider ten days' notice of the impending suspension as an opportunity to correct the problem or to submit a corrective action plan that shall be implemented within the period required. If the Provider does not respond to the notice, or after response, does not correct the problem in a satisfactory manner within the time period required, the Provider will be terminated from the CIN. The Provider may request a hearing in advance of termination.

C. **Suspension and/or Termination for Nonpayment of Dues.** The Board may suspend a Provider in the event the Provider fails to pay any dues or assessments imposed by the Board. Failure to pay any dues following three notices, not to extend beyond 120 days, will result in the Provider being deemed as voluntarily resigned from the CIN.

D. **Suspension and/or Termination for Noncompliance with Utilization Management, Quality Management and Misrepresentation.** A suspension may be imposed by the Board for failure of the Provider to comply with Utilization Management and Quality Management guidelines as approved and adopted by the CIN, or those published guidelines of Delegating Entities. The Provider will be given ten days written notice of impending action and his or her rights to a hearing. A Delegating Entity may suspend or terminate the Provider according to the terms of the agreement, and the process shall be governed by the Delegating Entity.

The Board may impose a suspension if the Provider's professional competence is not acceptable based on information regarding disciplinary action, criminal conviction, or professional liability claims or judgments against the Provider. The Provider will be given ten days written notice of impending action and his or her rights to a hearing. If the Provider has not responded within 30 days of the notice, the Provider will be terminated.

The Credentialing Committee may impose a suspension if it is determined that the Provider made misrepresentation in his or her initial or re-credentialing information and attestation. The Provider will be given ten days written notice of impending action and his or her rights to a hearing. If the Provider has not responded within 30 days of the notice, the Provider will be terminated.

E. **Voluntary Termination.** A Provider may choose to terminate from the CIN at any time with 90 days' notice. The CIN will notify all applicable managed care plans of the termination date.

XI. The Hearing Process

A. **Informal Meeting.** To facilitate the resolution of issues, a Provider who is entitled to a hearing may request an informal meeting before the Board. The request shall be in writing and shall state the specific reasons and the evidence that supports the request. The Board shall set the time and place for the informal meeting as soon as it may be reasonably convened, but no later than 14 days after the request for the meeting. The Provider shall not be entitled to be accompanied by any other person at this closed informal meeting. The Board shall report its decision within 30 days of the informal meeting.

B. **Right to a Hearing.** Any Provider who is adversely affected by any recommendation or actions by reason of his or her competence or professional conduct shall be entitled to a hearing in accordance with the procedures set forth in this document. The Provider shall be notified of the general grounds for and the nature of the proposed action. The notice shall inform the Provider of his or her right to request a hearing with the Board. The notice shall be in writing and will be delivered by certified mail. The Provider will be given 30 calendar days in which to submit a written request for a hearing and must provide a statement in opposition to such proposed action. The Provider confirms and agrees to be bound by the policies of the CIN regarding immunities, releases from liability, and confidentiality.

The request for a hearing shall be sent via certified mail to:

CHI Texas Health Network CIN
3100 Main St., Suite 832
Houston, TX 77002
Attn: Division Vice President

Failure to properly request a hearing within 30 days constitutes a waiver of his or her right to a hearing.

C. **Burden of Proof.** The Provider who requested the hearing shall have the burden of proving by a preponderance of the evidence that the adverse recommendation or action lacks substantial factual basis or that the conclusions drawn are arbitrary or capricious.

D. **Rights During Hearing.** The parties may each, at their own expense, be represented by an attorney or other person of the party's choice. The Board will use best efforts to include one Provider of the same or similar specialty as the Provider being heard. The parties may call and examine witnesses who will testify under oath. The parties may introduce exhibits and documented evidence as determined to be relevant by the presiding officer. The parties have the right to cross-examine any witness on any matter relevant to the charges and to rebut any evidence.

E. **Record of Hearing.** A record of the hearing shall be kept via detailed transcription, minutes of the proceedings, an electronic recording unit, or a court reporter. The Board shall select the method to be used. The Provider shall be entitled to a copy of the record upon request and responsible for payment of the reasonable expenses incurred in the preparation thereof.

F. **Report of the Board.** Within 15 days following the conclusion of the hearing, the Board shall submit a written report to the Provider. Such report shall contain a statement detailing the findings, conclusions and recommendations, and shall become a part of the hearing record.
The decision of the Board shall be final.

Upon termination of a Provider based on incompetence or professional conduct (consistent with Section 5.06 (a) of the Texas Medical Practice Act), or for reasons which pose a continuing threat to the public welfare (consistent with Section 5.06 (d) of the Texas Medical Practice Act), the CIN shall report such to the TMB, the National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank and to the Delegating Entities within 30 days.

G. **Right to One Hearing.** Notwithstanding any other provisions to the contrary, no Provider shall be entitled as a matter of right to more than one hearing on any matter for which there is a hearing right. Adverse recommendations or actions on more than one matter may be consolidated and considered together or separately, as the Board determines.

XII. Records

A. **Participation Status and Performance Records.** The CIN will maintain a record of each Provider to include the initial acceptance date, reappointment dates, any period of suspension, and termination or resignation date. Any periods of suspension and the termination date will be accompanied by a reason for such action.

B. **Storage of Credentialing Records.** Credentialing records maintained by the CIN will be kept in a locked area on the premises of the CIN and treated as confidential. From time to time, it may become necessary to archive some records due to space limitations. All archived records will be kept in a locked area on the premises of CIN. Access to such records is regulated by federal and state regulations, and in accordance with the terms of the agreements with Delegating Entities. Such access shall survive the termination or resignation of the Provider.

Credentialing records are maintained for ten years following termination or resignation, or as required by federal or state regulations or Delegating Entities.

C. **Confidentiality.** Subject to audit rights described herein, all the information contained in a Provider's credentialing records is maintained in confidence.

The Board, Credentialing Committee and CIN staff shall execute a Confidentiality Agreement, to include any information, including electronic information, presented, discussed or disclosed with respect to peer review records, credentialing records, and patient grievance information. The signed Confidentiality Agreement shall survive the resignation, termination, or expiration of the individual's term of office, appointment, or employment with the CIN.

Organizations seeking to audit the credentialing records shall be required to execute a Confidentiality Agreement and be bound by the covenants therein.

Peer review information in the credentialing file is closed to any access, including subpoena.

D. **Release Authority of Provider Credentialing Information.** Except as otherwise protected by law, Applicants and Providers are required to sign a Release of Information Letter of Authorization allowing the CIN to release and provide access to credentialing and re-credentialing information to medical peer review committees of Delegating Entities, and to any state or federal government agency or such agency's designated representative. Authority for release shall survive the Applicant's or Provider's denial, resignation or termination from the CIN.

ATTACHMENT A

NCQA approved Internet sources

- AACN: American Association of Critical-Care Nurses: https://www.aacn.org
- AANA: American Association of Nurse Anesthetists: http://www.aana.com
- AANP: American Academy of Nurse Practitioners: http://ww.aanp.org
- ABMS: American Board of Medical Specialties: https://www.certifacts.org
- AMA: http://www.ama-assn.org/
- ANCC: American Nurses Credentialing Center: http://www.nursecredentialing.org/
- AOA: https://www.doprofiles.org/
- CDS: http://www.txdps.state.us/crs
- Drug Enforcement Administration: http://www.deadicersion.usdoj.gov
- Medicare Physician Opt-Out List (Texas): http://www.novitas-solutions.com
- NCC: National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties: http://www.nccwebsite.org
- NCCPA: National Commission of Certification of Physician Assistants: http://www.nccpa.net/
- National Student Clearinghouse (NSC): http://www.studentclearinghouse.org/
- NPDB: http://www.npdb.hrsa.gov/
- NPI Source: https://nppes.cms.hhs.gov/
- NTIS vendor: http://deanumber.com
- OIG: http://exclusions.oig.hhs.gov/
- PNCB: Pediatric Nursing Certification Board: http://www.pncbh.org
- Social Security Death Master File: http://www.ssdmf.com
- System for Award Management (SAM): https://www.sam.gov/portal/public/SAM/
- Texas Board of Chiropractic Examiners: https://www.tbce.state.tx.us/verify.html
- Texas Board of Nursing: http://www.bon.state.tx.us/olv/
- Texas Board of Occupational Therapy Examiners: http://www.ptot.texas.gov/
- Texas Board of Physical Therapy Examiners: http://www.ptot.texas.gov/
- Texas Medical Board: http://www.tmb.state.tx.us/
- Texas OIG: https://oig.hhsc.state.tx.us/Exclusions/Search.aspx
- Texas Optometry Board: http://www.tob.state.tx.us
- Texas Podiatric Board: http://verify.sos.ga.gov/websites/verification/
- Texas State Board of Dental Examiners: http://tsbde.state.tx.us/
- Texas State Board of Examiners of Psychologists: http://www.tsbep.state.tx.us/
- Texas State License Verification (Social Worker, Counselor, Audiologist, Marriage and Family Therapists): http://www.dshs.state.tx.us/

ATTACHMENT B
CHI Texas Health Network
Office Site Survey Form

Physician Office Information
Group Name:
Physician Name(s):
Phone:
Fax
Office Manager
Score

I	Appointment Availability	YES	NO
	Are Appointments scheduled in accordance to standards listed below:		
1	Emergency Care-Immediate triage during office hours and have a method for directing patients to alternative care after hours		
2	Urgent Care-Within 24 hours		
3	Symptomatic Non-urgent care-within 7 days		
4	After-hours access through 24 hour on call coverage arrangements - immediate		

II	Physical Accessibility	YES	NO
1	Handicapped parking is available		
2	Entrance/facility accessible to persons with disabilities (entrance, restrooms and exam rooms)		
3	Clearly marked office name and suite number		

III	Physical Appearance	YES	NO
1	Facility is clean and well maintained		
2	There is sufficient lighting in the exam rooms		

IV	Adequacy of Waiting and Exam Room Space	YES	NO
1	There are an appropriate number of exam rooms for the size of the practice		
2	The waiting room has sufficient seating		
3	Room/area is clean		

V Adequacy of Medical/Treatment Record Keeping	YES	NO
1. There are an appropriate number of exam rooms for the size of the practice		
2. The waiting room has sufficient seating		
3. Room/area is clean		

VI Results	YES	NO
Acceptable Score (90% or higher)		
Deficient Areas:		
Action Plan:		

Reviewer Signature

Date

Office Contact Signature

Date

ATTACHMENT C
Credentialing Checklist

Name:
Site Visit: **Yes** **No** **N/A**
SV Date:
Date Application Received:
Target Credentialing Date:

	TSCA Review	TSCA Location
1 ☐	TSCA includes attestation, all pages & p. 11 contains CIN as entity.	pp. 11 & 12
2 ☐	Response on all disclosure questions; if yes, explanation provided	pp. 8,9
3 ☐	If yes to disclosure question 16 re Malpractice claims, attachment G provided.	p. 9
4 ☐	Work History	p. 3

	Received Copies of the Following
1 ☐	DEA Registration Certificate
2 ☐	Current professional liability insurance policy face sheet showing (past 5 years) expiration dates, limits and applicants name
3 ☐	W-9
4 ☐	CV
5 ☐	State license
6 ☐	Photo

	Queried the Following for Primary Source Verification	Initial & Date
1 ☐	OIG	
2 ☐	Texas OIG	
3 ☐	DEA	
4 ☐	Sam (EPLS)	
5 ☐	Medicare Opt Out Report	
6 ☐	Texas Medical Board	
7 ☐	National Practitioner Data Bank	
8 ☐	Board Certification: ________________ expiration date________ ________________ expiration date________ ________________ expiration date________ ________________ expiration date________	List in directory? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
9 ☐	Post-Graduate Education/training if not BC	☐ Yes ☐ No

Action Items /Comments

ATTACHMENT D
Delegated Credentialing Agreements

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ATTACHMENT E
Education and Training

Licensing Boards that Perform Primary Source Verification:

- Texas Board of Nursing
- Podiatry license verified through Texas Department of Licensing and Regulation
- Texas Medical Board
- Texas Optometry Board

The CIN verifies annually, that the above listed entities include verification of education and training by a primary source.

ATTACHMENT F

Urgent Care Credentialing Criteria

A physician may have the designation of "urgent care" if his/her practice conforms to the following:

I. **Accreditation by Joint Commission or UCAOA**

II. **OR Meets the following Requirements:**

- Expanded hours (beyond 8-5 weekdays) including at least 8 hours on the weekend
- Medical supervision of extenders must be available in person or remotely by licensed, Board Certified physicians during ALL hours of operation
- If referral for admission is required; referral to CHI facility
- All providers staff must have AT LEAST BLS training
- Facility must be equipped with
    i. Oxygen
    ii. Oral airway and bag/masks
    iii. Defibrillator or AED
    iv. Electrocardiogram
    v. Pulse Oximetry
    vi. Emergency kit to include steroid injection, Epinephrine and Narcan
- Maintain CLIA waiver for point of care testing
- Utilize electronic health record
- Provide summary to patient AND primary care provider at the end of the visit
- Medical direction must be by Board Certified primary care physician
    i. Internal Medicine
    ii. Family Medicine
    iii. Emergency Medicine
    iv. Pediatrics if the facility provides pediatric care
- The center must provide general care for common medical ailments (e.g., diagnosis and treatment of sinus symptoms, sore/strep throat, upper respiratory infections, urinary tract infections, ear aches, and eye infections) as well as the following:
    i. Laceration Repair
    ii. Abscess I & D
    iii. Splinting
    iv. STI Testing and Treatment

III. **Must be able to provide the following, at a minimum:**

- Laboratory at point of care
    i. Rapid Strep
    ii. Flu Test
    iii. Urine
    iv. Dipstick Urine Pregnancy
    v. Finger Stick Glucose
    vi. RSV Test

IV. Pharmacy:

- Policy that adheres to state requirements for storage, administration and documentation.
- Emergency Medications
- Oxygen
- SVN Inhalation Therapy (nebulizer treatments)
- Injectable, at a minimum:
    - i. Antibiotics
    - ii. Steroids
    - iii. Pain Medications
    - iv. Anti-Migraine
    - v. Anti-Nausea
    - vi. Benadryl

V. Policy for utilizing outside lab services including:

- Ordering, collecting, storing and identifying specimens
- Lab results review and patient notification

VI. Diagnostic Imaging (X-Ray):

- Documentation of equipment certification and safety measures
- Licensed health professional providing x-ray
- Available STAT over-reads when needed, and all x-rays to have official report within 24 hours

VII. Infection Control:

- Policy in place for Blood Borne Pathogen exposure
- Hand hygiene and room cleaning measures
- Equipment sterilization/autoclave
- Use of PPE

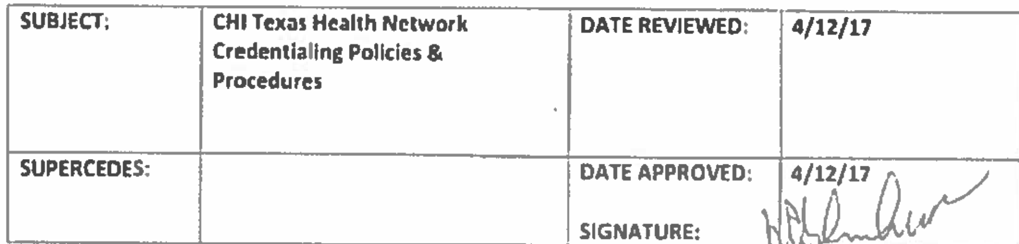
VIII. Special Populations:

- Readily available policy for identification, evaluation, and reporting of child abuse, elder abuse, domestic violence and sexual assault
- Readily available policy and procedure for response to life or limb threatening conditions

Billing for services rendered by extenders must comply with the requirements of "incident to" billing established by CMS. Physician must be physically on site to bill "incident to" for services rendered by extender. Otherwise, billing should be under the name of the extender who is also credentialed by the CIN.

*Approved by CHI Texas Division CPIC Committee on 5/7/2018

Initial Approval Date: 4/12/2017



SUBJECT:	CHI Texas Health Network Credentialing Policies & Procedures	DATE REVIEWED:	4/12/17
SUPERCEDES:		DATE APPROVED: SIGNATURE:	4/12/17

PURPOSE

To establish mechanisms for gathering relevant data that will serve as the basis for decisions regarding credentialing of physicians and other health care Providers for the purpose of determining their professional qualifications and competency for appointment and reappointment as participating Providers in CHI Texas Health Network (CIN) and contracted health care services agreements.

DEFINITIONS

Applicant. An individual who has submitted an application for appointment or reappointment to the CIN requesting to be approved for participation or continued participation in the CIN. In accordance with NCQA and the Texas Department of Insurance (TDI), credentialing is not required for Providers who practice exclusively within a hospital setting, also known as hospital-based providers.

Board of Managers. The governing body of the CIN, as described in the CIN's Operating Agreement and other organizational documents, as amended. It may also be called the Division Board.

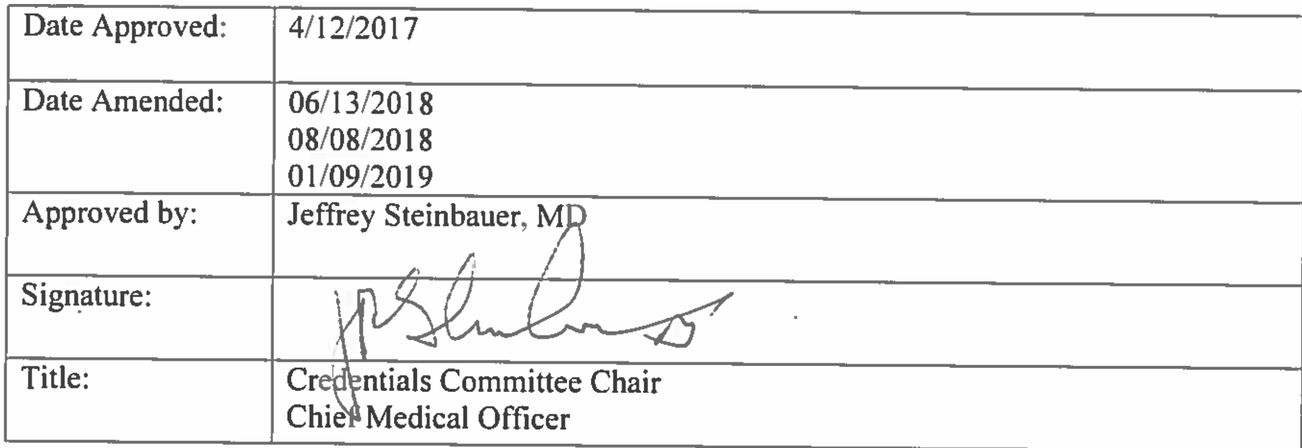
Board Eligible. A description for a physician who has completed the requirements for admission to a medical specialty board examination, but has not passed that examination. Each medical specialty board has the right to define this period. See Attachment F.

Compliance and Performance Improvement Committee (CPIC). A multispecialty committee of three or more Providers appointed by the Board of Managers, which is authorized to recommend and oversee processes, pathways, bundles of care and services to ensure clinical integration.

Credentialing Committee. A multispecialty subcommittee of the Network Performance and Membership Standards Committee consisting of three or more Providers, which is authorized to use a peer review process to evaluate the qualifications and competence of all Applicants.

Credentialing Elements. Means those items discovered, including Primary Source verification and supporting documents, in the credentialing process by the CVO and/or submitted by the Applicant that

Annual Review of Policies and Procedures
Credentialing Policies and Procedures



Date Approved:	4/12/2017
Date Amended:	06/13/2018 08/08/2018 01/09/2019
Approved by:	Jeffrey Steinbauer, MD
Signature:	
Title:	Credentials Committee Chair Chief Medical Officer