Policy - Credentialing and Recredentialing (28th ed.)

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Important: Contact Compliance or the Law Department prior to providing this document to any external party.

Scope:

Practitioners are within the scope of credentialing if all criteria listed below are met:

- Practitioners are licensed, certified or registered by the state to practice independently (without direction or supervision).
- Practitioners have an independent relationship with Humana (an independent relationship exists when Humana directs its members to see a specific practitioner or group of practitioners, including all practitioners whom a member can select as primary care practitioners).
- Practitioners provide care to members under Humana's medical and vision benefits.
- Dental practitioners who provide care to members under Humana's Medicaid plans

Credentialing Criteria apply to practitioners in the following settings:

- Individual or group practices
- Rental networks
- Telehealth
- Locum Tenens:
  - Practitioners working less than 60 calendar days require provisional credentialing.
  - Practitioners working more than 60 calendar days require full credentialing.

Unless otherwise required by applicable law, practitioners who do not require credentialing include:

- Practitioners, including hospitalists and extenders (who are not individually contracted and who do not print in the directory) who practice exclusively in the inpatient setting and who provide care for members only because of members being directed to the hospital or another inpatient setting. This includes hospital-based anesthesiology, emergency medicine, hospitalist, neonatology, pathology and radiology providers.
- Practitioners who practice exclusively in freestanding facilities and who provide care for members only because of their being directed to the facility
- Pharmacists who work for a pharmacy benefits management (PBM) organization

- Covering practitioners (e.g., locums tenens) who do not have an independent relationship with Humana
- Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants)
- Rental network practitioners who are specifically for out-of-area care
- Non-licensed applied behavior analysis (ABA) providers
- Physician extenders who do not act as a primary care physician (PCP) and who do not print in the directory. This includes nurse anesthetists, registered nurses and registered nurse first assistant, as well as surgical assistants and surgical first assistants. See "Types of Practitioners to Credential and Recredential" regarding Nurse Practitioners and Physician Assistant

Policy Statement:

This policy defines the credentialing and recredentialing process for selecting and evaluating licensed and independent practitioners and the assessment process for organizational providers who provide care to Humana members. Consistent with Humana's mission to assist members in achieving life-long well-being, the goal of this policy is to enable selection of qualified practitioners and providers.

In some circumstances, Humana is subject to certain credentialing requirements, such as state and federal regulations, that exceed or differ from those outlined in this policy. An addendum to Humana's Credentialing and Recredentialing Policy is maintained by Humana's Commercial and Specialty Regulatory Compliance Department to ensure compliance with state requirements that exceed current CMS (Centers for Medicare & Medicaid Services) and NCQA (National Committee for Quality Assurance) requirements.

Additional compliance with individual state Medicaid credentialing and recredentialing requirements are governed by Humana's separate individual state policies.

Definitions:

- "Humana" means Humana Inc. and its affiliates and subsidiaries that underwrite or administer health, vision, and Medicaid dental plans, long-term services and support (LTSS), CarePlus Health Plans Inc. and Health Value Management Inc., d/b/a ChoiceCare Network and d/b/a Humana Behavioral Health Network.
- "Humana members" means participants in health, vision, and Medicaid dental plans, LTSS and programs provided by Humana.
- An "independent relationship" exists when Humana directs its members to see a specific provider, including all practitioners whom a member can select as a primary care provider, to provide care under Humana's medical benefit.
- "Organizational providers" means providers described as hospitals or other healthcare facilities.
- "Telehealth Services" includes "OM Telehealth Covered Services," "Additional Telehealth Covered Services," and "Supplemental Telehealth Covered Services," provided to Medicare plans as outlined

in the Claims Payment Policy CP2008102 or its successor policy, and any telehealth services that are covered by any Humana commercial and Medicaid plans.
- CCM – Humana Compliance Research and Reporting Team
- GSA - The United States General Services Administration
- NPI - National Provider Identifier (aka NPPES - National Plan & Provider Enumeration System)
- Office of Inspector General
- PDF - Portable Document Format
- SAM - System of Award Management
- CAQH – Council for Affordable Quality Healthcare
- NPDB- National Provider Data Bank

Other terms are defined throughout this policy.

Requirements:

Standard: Types of Practitioners to Credential and Recredential

Practitioners who require credentialing include all participating practitioners who fall within the scope of credentialing, not limited to:

Medical practitioners:
- Medical doctors
- Oral surgeons
- Chiropractors
- Osteopaths
- Podiatrists
- Dentists
- Optometrists
- Nurse Practitioners
- Physician Assistants
- Other medical practitioners who may be within the scope of credentialing and who are licensed, certified or registered by the state to practice independently or as required by state regulations. This category may include Doctor of Pharmacy practitioners who practice within a medical office setting.

Behavioral health practitioners:
- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or master's level psychologists who are state certified or licensed
- Master's level clinical social workers who are state certified or licensed

- Master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
- Other behavioral health specialists who may be within the scope of credentialing. Who are licensed, certified or registered by the state to practice independently or as required by state regulations.

All practitioners requiring credentialing should complete the credentialing process prior to the provider's contract effective date, except where required by state regulations. All credentials must be current at the time of the credentialing committee decision. Additionally, a provider will print in the provider directory only when credentialing is complete.

Standard: Verification Sources for Credentialing and Recredentialing

Verification of credentialing information should come from one of the following sources:

- The primary source (or its website), the entity that originally conferred or issued the credential
- A contracted agent of the primary source (or its website)
- Another National Committee for Quality Assurance (NCQA)-accepted source (or the source's website) listed for the credential

Appropriate documentation of verifications includes:

- Credentialing documents signed (or initialed) and dated by verifier.
- A checklist, * including the name of the source used, the date of verification, the signature or initials of the person who verified the information and the report date, if applicable.
- Copies of credentialing information and checklist. If the checklist does not include checklist requirements, appropriate credentialing information should be included.

*This checklist must have a single signature and a date for all verifications that has a statement confirming the signatory verified all the credentials on that date. The statement should include the source and report date of each verification, if applicable.

Humana assigns each member of its credentialing staff a unique electronic identifier. The identifier, along with the date of verification, verification source and report date, if applicable, are recorded as part of the credentialing and recredentialing process in the automated credentialing system.

Education and training verifications do not expire, are valid indefinitely and must be completed prior to Credentials Committee decisions. Licensure, board certification, and malpractice insurance verifications must be completed within 120 calendar days effective on or after July 1, 2025. All other credentialing verifications must be completed within 180 calendar days prior to the Credentials Committee's decision date. DEA and CDS are prior to the credentialing decision.

The following sources may be used to verify credentialing information:

Licensure (current and valid in all states where the practitioner provides care to Humana members, unless practitioner meets exception for Indian Health Care Improvement Act)
Verification should come directly from the state licensing or certification agency.
Compact licensures are accepted in states that are actively issuing and accepting compact privileges. A physician or non-physician practitioner working under the authorization of a compact must meet both the licensure requirements outlined in the primary state of residence and those established by the compact laws adopted by the legislatures of the interstate compact states.

NOTE: Physicians and other practitioners providing Telehealth Services must hold appropriate licensure, certifications, and registrations (including Drug Enforcement Agency [DEA] registration if applicable) and comply with applicable professional practice standards and telehealth requirements in the state(s) in which they practice and also in the state(s) in which any Humana member receiving Telehealth Services is located at the time of such encounter. See the Telehealth Credentialing and Recredentialing Standards for more detail on applicable requirements for physicians and other practitioners providing Additional Telehealth Covered Services (as described in Claims Payment Policy CP2008102).

DEA and a controlled dangerous substance (CDS) certificate (current and valid in all states where the practitioner provides care to Humana members)

- Confirmation with the state pharmaceutical licensing agency, where applicable
- Documented visual inspection of the DEA and CDS certificate(s)
- Confirmation with the DEA and CDS agency:
- American Osteopathic Association (AOA Physician Profile Report or Physician Master File (DEA only)

NOTE: If the practitioner states in writing that they do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances, they are therefore not required to have a DEA/CDS certificate but must describe their process for handling instances when a patient requires a controlled substance. Humana includes the practitioner's statement and process description in the credentialing file.

If practitioner is practicing in a state where a CDS is not required, only DEA will be required.

Education and Training
Verification of the highest of the three levels of education and training obtained by the practitioner:

- Graduation from medical or professional school
- Residency, if appropriate
- Board certification, if appropriate

Physician (M.D. or D.O.)
Graduation from medical school

- Medical school
- AMA Physician Master File
- American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File
- Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986
- Association of schools of the health professions, if the association performs primary-source verification of graduation from medical school. At least annually, Humana should obtain written confirmation from the association that it performs primary-source verification of graduation from medical school.
- State licensing agency, if the state agency performs primary-source verification. At least annually, Humana should:
  - Obtain written confirmation from the state licensing agency that it performs primary-source verification of practitioner education and training information OR
  - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information.

- Completion of residency training: AMA Physician Master File
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File
- Association of schools of the health professions, if the association performs primary-source verification of residency training. At least annually, Humana should obtain written confirmation from the association that it performs primary-source verification of residency training.
- State licensing agency, if the state agency performs primary-source verification of residency training. At least annually, Humana should:
- Obtain written confirmation from the state licensing agency that it performs primary-source verification of residency training of practitioner education and training information OR
- Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including residency training
- The Federation Credentials Verification Service (FCVS) for closed residency programs

Chiropractor:
Graduation from chiropractic college

- Chiropractic college whose graduates are recognized as candidates for licensure by the regulatory authority issuing the license
- State licensing agency, if the state agency performs primary-source verification of graduation from chiropractic college. At least annually, Humana should:

- Obtain written confirmation from the state licensing agency that it performs primary-source verification of practitioner education and training information including graduation from chiropractic college OR
- Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including graduation from chiropractic college.

Oral surgeon:

Completion of residency

- Training programs in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation (CODA)
- Appropriate specialty board if the board performs primary-source verification of graduation from a CODA-accredited training program. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of graduation from a CODA-accredited training program.
- State licensing agency, if the state agency performs primary-source verification of graduation from a CODA accredited training program. At least annually, Humana should:
  - Obtain written confirmation from the state licensing agency that it performs primary-source verification of practitioner education and training information including graduation from a CODA accredited training program OR
  - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including graduation from a CODA accredited training program.

Podiatrist:

Graduation from podiatry school

- Podiatry school
- Appropriate specialty board, if the specialty board performs primary-source verification of podiatry school graduation. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of graduation from podiatry school.
- State licensing agency, if the state agency performs primary-source verification of graduation from podiatry school. At least annually, Humana should:
- Obtain written confirmation from the state licensing agency that it performs primary-source verification of practitioner education and training information including graduation from podiatry school OR
- Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including graduation from podiatry school.

Completion of residency

- Residency training program
- Appropriate specialty board, if the specialty board performs primary-source verification of completion of residency. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of completion of residency.
- State licensing agency, if the state agency performs primary-source verification of completion of residency. At least annually, Humana should:

  – Obtain written confirmation from the state licensing agency that it performs primary-source verification of practitioner education and training information including completion of residency OR

  – Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including completion of residency.

Dentist:

Graduation from dental school

- Dental school
- Appropriate specialty board, if the specialty board performs primary-source verification of dental school graduation. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of graduation from dental school.
- State licensing agency, if the state agency performs primary-source verification of graduation from dental school. At least annually, Humana should:

  – Obtain written confirmation from the state licensing agency that it performs primary-source verification of practitioner education and training information including graduation from dental school OR

  – Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including of graduation from dental school.

Completion of postdoctoral education, if applicable

- Postdoctoral education program
- Appropriate specialty board, if the specialty board performs primary-source verification of completion of postdoctoral education. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of completion of postdoctoral education.
- State licensing agency, if the state agency performs primary-source verification of completion of postdoctoral education. At least annually, Humana should:

  – Obtain written confirmation from the state licensing agency that it performs primary-source verification of completion of practitioner education and training information including postdoctoral education OR

- Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including completion of postdoctoral education.

Optometrist:
Graduation from optometry school

- Optometry school
- Specialty board or registry, if the board or registry performs primary-source verification of professional school training. At least annually, Humana should obtain written confirmation from the specialty board or registry that it conducts primary-source verification of graduation from optometry school.
- State licensing agency, if the state agency performs primary-source verification of professional school training. At least annually, Humana should:
  - Obtain written confirmation from the state licensing agency that it performs primary-source verification of practitioner education and training information including professional school training OR
  - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including professional school training.

Other healthcare professional:

- Professional school
- Specialty board or registry, if the board or registry performs primary-source verification of professional school training. At least annually, Humana should obtain written confirmation from the specialty board or registry that it conducts primary-source verification of professional school training.
- State licensing agency, if the state agency performs primary-source verification of professional school training. At least annually, Humana should:
  - Obtain written confirmation from the state licensing agency that it performs primary-source verification of practitioner education and training information including professional school training OR
  - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including professional school training.

Board Certification

Physician (M.D. or D.O.):

- American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS display agent, where a dated certificate of primary-source authenticity has been provided. NOTE: The ABMS' "Is Your Physician Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.

- AMA Physician Master File
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File
- Boards in the United States that are not members of the ABMS or AOA. For non-ABMS or non-AOA boards, Humana will decide which specialty boards to accept and should include the information in its policies and procedures. At least annually, Humana should obtain written confirmation from the non-ABMS or non-AOA board that it performs primary-source verification of education and training.
- State licensing agency, if the state agency performs primary-source verification of board status. At least annually, Humana should:
  - Obtain written confirmation from the state licensing agency that it performs primary-source verification of board status OR
  - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including board status.

Oral surgeon:

- Appropriate specialty board, if Humana provides documentation that the specialty board performs primary-source verification of education and training. At least annually, Humana should obtain written confirmation from the board that it performs primary-source verification of education and training.
- State licensing agency, if the state agency performs primary-source verification of board status. At least annually, Humana should:
  - Obtain written confirmation from the state licensing agency that it performs primary-source verification of board status OR
  - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including of board status.

Podiatrist:

- Appropriate specialty board, if Humana provides documentation that the specialty board performs primary-source verification of education and training. At least annually, Humana should obtain written confirmation from the board that it performs primary-source verification of education and training.
- State licensing agency, if the state agency performs primary-source verification of board status. At least annually, Humana should:
  - Obtain written confirmation from the state licensing agency that it performs primary-source verification of board status OR
  - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including board status.

Dentist:

- American Dental Association-recognized dental specialty certifying boards when a dated certificate of primary-source authenticity has been provided
- Appropriate specialty board, if Humana provides documentation that the specialty board performs primary-source verification of education and training. At least annually, Humana should obtain written confirmation from the board that it performs primary-source verification of education and training.
- State licensing agency, if the state agency performs primary-source verification of board status. At least annually, Humana should:
  - Obtain written confirmation from the state licensing agency that it performs primary-source verification of board status OR
  - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including board status.

Optometrist:

- Appropriate specialty board, if Humana provides documentation that the specialty board performs primary-source verification of education and training. At least annually, Humana should obtain written confirmation from the board that it performs primary-source verification of education and training.
- State licensing agency, if the state agency performs primary-source verification of board status. At least annually, Humana should:
  - Obtain written confirmation from the state licensing agency that it performs primary-source verification of board status OR

Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including of board status.

Other healthcare professional:

- Appropriate specialty board, if Humana provides documentation that the specialty board performs primary-source verification of education and training. At least annually, Humana should obtain written confirmation from the board that it performs primary-source verification of education and training.
- State licensing agency, if the state agency performs primary-source verification of board status. At least annually, Humana should:
  - Obtain written confirmation from the state licensing agency that it performs primary-source verification of board status OR
  - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including of board status.

- Registry, if Humana provides documentation that the registry performs primary-source verification of board status. At least annually, Humana should obtain written confirmation from the registry agency that it performs primary-source verification of board status.

NOTE: Verification of board certification does not apply to nurse practitioners unless Humana communicates to its members that the nurse practitioner is board-certified.

The Credentialing Department reviews the information contained in verification systems to verify that practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification and specialty. If inconsistencies with credentialing data are found, the credentialing department notifies the appropriate department for correction.

Work history

Most recent five years of relevant work history included on the application or curriculum vitae. If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date.

NOTE: An explanation of any gaps in employment that exceed one year should be supplied in writing. An explanation of any gaps in employment greater than six months but less than one year can be supplied verbally or in writing.

Malpractice history

Confirmation of the past five years of malpractice settlements from the malpractice carrier or query to the National Practitioner Data Bank (NPDB)

Sanctions and Exclusions:

National Provider Identifier (NPI) and Healthcare Provider Taxonomy

- Appropriate agency or website approved by CMS

State sanctions and restrictions on licensure

- Appropriate state agencies
- NPDB

Medicare and Medicaid sanctions and exclusions

- NPDB
- List of excluded individuals and entities maintained by Office of the Inspector General (OIG): exclusions.oig.hhs.gov/
- General Services Administrations (GSA) via the System for Award Management (SAM): www.sam.gov/SAM/
- CMS Medicare preclusion list (Medicare only)
- Current Medicare opt-out list (Medicare only)

- State Medicaid agency or intermediary and Medicare intermediary

NOTE: In certain circumstances, Humana is subject to certain credentialing requirements, such as individual state Medicaid credentialing requirements that exceed or differ from those outlined in this policy.

Standard: Practitioner Educational and Training Requirements

Credentialed practitioners should have completed education and training programs in their contracted and/or published specialty. Residents and fellows are generally not credentialed until their training has been completed.
Specific education/training guidelines for specialties are as follows:

General practitioner

- Medical school and
- Verifiable one-year U.S. (including Puerto Rico) or Canadian residency program in a primary care specialty; and
- Independent and unrestricted* license

Note: *Unrestricted license required, provisional license is not accepted.

Pain management

- Training in anesthesiology, physical medicine and rehabilitation, or psychiatry and neurology (Accreditation Council for Graduate Medical Education [ACGME] approved); and
- Completion of a 12-consecutive-month training program in pain medicine

Midwife

Graduate and/or nursing school completion that includes an accredited education program for this specialty.

In instances where a credentialed practitioner elects to change contracted and published specialties, the Credentialing Operations Department should confirm that the practitioner meets the criteria for the new specialty. This process should include re-verification of additional education and training related to the new specialty and re-verification of the board certification related to the new specialty.

Standard: Telehealth Credentialing and Recredentialing

Licensure

Physicians and other practitioners providing Telehealth Services must hold all applicable licensure, certifications, and registrations (including DEA/CDS registration if applicable as indicated in Standard: Verification Sources for Credentialing and Recredentialing section of this policy) and comply with

applicable professional practice standards in the state(s) in which they practice and also in the state(s) in which any Humana member receiving Telehealth Services is located at the time of such encounter.

Recredentialing

Humana shall conduct recredentialing in accordance with its existing policies (see Recredentialing and Sanction Information) but may elect to recredential physicians and practitioners providing Telehealth Services more frequently than every 36 months.

Standard: Decision-making Criteria for Credentialing and Recredentialing

The decision to credential or recredential practitioners is based on the criteria listed below, including, but not limited to, the information gathered through the credentialing and recredentialing process ("Credentialing Criteria"). Credentialing Criteria is reviewed and approved by the credentialing committee on an annual basis. While contracted with Humana, Practitioners are required to meet Humana's Credentialing Criteria at all times. Humana may decredential a Practitioner at any time for failure to meet Humana's Credentialing Criteria. All practitioners must be fully credentialed before providing care to members.

Administrative Criteria: Practitioners must meet the following requirements. Any decisions to deny credentialing based on Administrative Criteria are final and not subject to reconsideration rights unless otherwise noted below. Provider may notify the credentialing team if they believe an error has occurred.

Education and Training. Practitioner has completed appropriate education and training for applied specialty.

Eligible for Medicaid. Practitioner demonstrates current eligibility for participation in Medicaid, as applicable.

Eligible for Medicare. Practitioner demonstrates current eligibility for participation in Medicare as applicable.

Work History. Practitioner demonstrates appropriate history of employment and clinical practice. Practitioner should explain any gaps in work history greater than six (6) months. Explanations shall be reviewed by the Medical Director, and if necessary, reviewed by the Credentials Committee.

Facility Privileges. Practitioner holds current clinical privileges in good standing at a participating facility or provides an explanation of admitting arrangements applicable to the care the practitioner provides.

Medical License. Practitioner holds a current state professional license, certificate or registration in the state(s) in which Practitioner will treat Humana members. Pursuant to the Indian Health Care Improvement Act (IHCIA), practitioners employed by a tribal health program are not required to have a license from the state in which they are currently practicing but must have a license in at least one state. Practitioners must provide documentation to demonstrate qualification under IHCIA.

DEA and/or CDS Certificate. Practitioner shall hold a current federal DEA certificate and/or a CDS certificate in all states where the Practitioner provides care to Humana members. Any Practitioner who does not hold such DEA or CDS certificate may request in writing an exception to this requirement that may be granted if:

1) the Practitioner does not prescribe controlled substances in their profession or practice.
2) in the judgment of the Practitioner, patients receiving their care from the Practitioner do not require controlled substances; and
3) the Practitioner provides a description of the process in their practice for handling instances when a patient requires a controlled substance.

If such written statement is approved as satisfactory by the Credentials Committee, then this Administrative Criteria will not apply as a basis for denial.

Professional Liability Insurance with Acceptable Claims History. Practitioner holds current professional liability insurance (PLI) in contracted amounts, has completed the PLI exception procedure or has documentation of coverage under the Federal Tort Claims Act for professional liability coverage. Practitioner has acceptable liability claims history as determined by the uniformly applied business standards established by Humana. Failure to meet such uniformly applied business standard shall result in denial.

OIG, SAM Exclusion. Regardless of line of business, practitioner is not excluded by OIG, has not been sanctioned and are not listed as excluded by the General Services Administration (GSA) (as reported by the System for Award Management (SAM) exclusions list).

Certain Felony Convictions. Practitioner has not been convicted, found guilty, nor pled no contest to any felony which is either a crime of violence or a sex offense.

Criteria Eligible for Practitioner's Opportunity to Request Reconsideration: A Practitioner will be denied for failure to meet the following criteria, unless the Credentials Committee determines there is no continuing quality of care concerns. Practitioners may request a reconsideration of such denials, and the Practitioner may be deemed to meet criteria if upon reconsideration, the Practitioner can demonstrate to the satisfaction of the Credentials Committee that there is no continuing quality of care concern.

Licensure and Other Adverse Actions. Practitioner should not have a history of any action in effect within the last five years which revoked, denied, or placed Material Limitations on the Practitioner that was taken by any federal, state or local government, including, but not limited to the applicable state licensing body; a hospital, health plan or other healthcare entity; or any professional society. Additionally, the Practitioner's professional license, certificate or registration should not be suspended or revoked and should be free of any other Material Limitations.
For purposes of this Policy, Material Limitations are sanctions, probations or other conditions that include:
(a) any requirement to obtain a second opinion for diagnosis or treatment.
(b) any restriction or limitation on the ability to prescribe medicine or treatment.
(c) any requirement for the presence of a second person during any examination, diagnosis or procedure; or
(d) any other serious restriction or limitation.
Note: Unless otherwise required by a government agency, Medicare preclusion is not considered to be Material Limitation.

Relinquishments. Practitioner, within the last five years, should not have voluntarily relinquished any membership, license, privileges or participation status or other ability to render healthcare services, including but not limited to a state license or clinical privileges, while under investigation by the entity providing such membership, privileges, participation status or other ability to render healthcare services, or in return for such entity not conducting an investigation.

Other Convictions. Practitioner has not been convicted, found guilty, nor pled no contest to any other felony than those prohibited in the Administrative Criteria, Certain Felony Convictions provisions set forth above (meaning any felony that is not a crime of violence or a sex offense). Additionally, the Practitioner shall not have been convicted, found guilty, nor pled no contest to any misdemeanor that is reasonably related to the Practitioner's qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct.

Absence of Physical or Mental Impairment. Practitioner should not be physically or mentally impaired, including impairments due to a substance use disorder that may affect the practitioner's ability to practice or may pose a risk of harm to patients.

Quality. For recredentialing purposes only, practitioner should demonstrate an acceptable performance record related to Humana members with no evidence of quality issues. This record includes activities/findings collected through Humana's quality improvement programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys and other plan activities. "Quality" refers to the measure of competence, professional conduct, care and safety that a practitioner affords a patient.

Standard: Decision-making Process for Credentialing and Recredentialing

Humana acts only upon complete credentialing and recredentialing applications. A complete application is defined as a submitted application form that is fully filled in with responsive and accurate information, dated and signed as required and accompanied by all required and requested documents. The burden of submitting a complete application rest solely on the applicant. Humana may return unprocessed any incomplete application. An applicant's failure to respond to Humana's requests for application information may result in a denial of credentialing or recredentialing on an administrative basis.

Upon receipt of a complete credentialing application, the credentialing process should be completed within 30 calendar days or as required by state or federal regulations. The credentialing staff should designate files that meet all the Credentialing Criteria as Category I files. Credentialing staff should designate as Category II each file that does not meet all Credentialing Criteria.

The medical director may approve any Category I file that meets all Credentialing Criteria. The medical director review and approval should be recorded in each such file or include a report with a signature that lists all required credentials for all practitioners with clean files and includes the approval date being after appropriate review.

Category II files that fail to meet any of the Credentialing Criteria eligible for Credentials Committee Reconsideration will be reviewed, approved, or denied by the Committee (Category II – Committee). All other Category II files, including those that fail to meet an Administrative Criteria, will be reviewed, approved or denied as specified by the Committee (Category II – Administrative). The medical director should present all Category II - Committee files to the Credentials Committee. The Credentials Committee may postpone a decision on a Category II – Committee file to receive additional information. Humana should process the credentialing or recredentialing decisions as follows:

Approvals: Practitioners with Category II files approved by the Credentials Committee should be notified of the decision. Humana should notify the applicant in writing of the Credentials Committee's approval within 30 calendar days or sooner as required by state or federal regulations. Notice of approvals will be provided as required under Standard: Practitioner Rights.

Denials: The Credentials Committee must notify a practitioner of a denial based on Credentialing Criteria. The notice must inform the practitioner of the reasons for the denial and, in the case of a denial based on Credentialing Criteria eligible for Credentials Committee Reconsideration, will provide notice of such opportunity to request reconsideration of the decision in writing within 30 calendar days of the notice or sooner as required by state or federal regulations. Unless otherwise noted, denials based on a failure to meet Administrative Criteria are final with no reconsideration rights. Where applicable, in the event such reconsideration is timely requested, the Credentials Committee may affirm, modify or reverse the initial decision. Humana should notify the applicant in writing of the Credentials Committee's reconsideration decision within 30 calendar days. Practitioners who

have been denied are eligible to reapply for network participation once they meet the minimum health plan Credentialing Criteria.

NOTE: Practitioner denials due to missing DEA and/or hospital privileges have 30 business days to provide the missing documentation to Humana for review as a Category I file.

Adverse Actions: Adverse actions are actions or recommendations that limit, reduce, restrict, suspend, revoke, terminate, deny or fail to renew a practitioner's participation in a Humana health plan for reasons relating to quality and that adversely affect, or could adversely affect, a patient's health or welfare. Such actions may include decredentialing or the denial of credentials or recredentialing upon Credentials Committee reconsideration of action based on Credentialing Criteria eligible for Credentials Committee Reconsideration. Adverse actions lasting longer than 30 calendar days entitle the applicant to prompt notice of his or her right to request a hearing.

Standard: Delegation of Credentialing and Recredentialing

Humana may delegate credentialing and recredentialing activities to organizations or entities that are able to demonstrate compliance with federal, state and accreditation requirements such as NCQA. Humana retains the right to approve, suspend and terminate individual practitioners, providers and sites where it has delegated credentialing decision-making.

Prior to approving delegation, the – prospective delegate's performance capacity is evaluated through the pre-delegation audit process to ensure the entity demonstrates compliance with the applicable federal, state and accreditation requirements.

When Humana has approved delegation of credentialing and/or recredentialing activities, a written delegation agreement is required to be is mutually agreed upon and contain the following information:

- A description of the delegated activities and the responsibilities of Humana and the delegated entity.
- Requires minimum of semi-annual reporting to Humana
- A process by which Humana evaluates the delegated entity's performance
- A process by which delegated entity complies with Credentialing information integrity requirements
- A description of the remedies, including revocation of the delegation agreement, available to Humana if the delegated entity does not fulfill its obligations
- A statement that Humana retains the right to approve, suspend and terminate individual practitioner, providers and sites where it has delegated decision-making.

Once the delegation agreement is executed, the delegate's performance is evaluated at a minimum of an annual basis to ensure the delegated entity remains compliant with applicable federal, state and accreditation requirements. Humana also evaluates and collects semi-annual reports from all

delegated entities. Opportunities for improvement should be identified and followed up on at least once every two years.

If a delegate sub-delegates credentialing to another entity, documentation verifying that the delegate performs oversight and conducts annual audits is required, unless Humana chooses to conduct these activities itself on behalf of the delegated entity. Complete listings of all practitioners credentialed and/or recredentialed are due from the delegate on a semi-annual basis and reviewed by Humana.

Standard: Nondiscrimination in Credentialing and Recredentialing

Humana does not make credentialing decisions based on an applicant's race, ethnic/national identity, gender, age or sexual orientation or on type of procedure or patient (e.g., Medicaid) in which a practitioner or organizational provider specializes. Humana does not discriminate against a provider on the basis of the practitioner's license or certification or because the provider services high-risk populations and/or specializes in the treatment of costly conditions.

Standard: Confidentiality of Credentialing Information and Credentialing Information Integrity:

The information used in the credentialing and recredentialing process is securely safeguarded and protected from unauthorized use or modification. Staff responsible for conducting verifications and reviewing practitioners' applications will ensure that all relevant documents are saved in a Portable Document Format (PDF), digitally uploaded to the credentialing system, and stored within the practitioner's specific record for review. The credentialing system automatically records verification dates based on user input, and an automated process generates a unique electronic identifier that includes the user's identity, the verification source used, date of the verification, and the report date (if applicable). All documentation and verifications, including:

- The practitioner's application(s) and attestation(s)
- Verifications and dates received from designated sources and or agents including:
  - License(s) to practice
  - Education and Training
  - Board Certification / Board Certification Status
  - Drug Enforcement Administration License (DEA), if applicable
  - Controlled Substance License (CDS, CSR), if applicable
  - Malpractice Insurance Coverage / Face sheet / Certificate of Insurance (COI)
  - Medicare and Medicaid Sanctions and Exclusions
  - Licensure Sanctions
  - Practitioner Specific Complaints and Adverse Events
- Documentation of credentialing activities such as:
  - Verification Dates
  - Report Dates, if applicable (complaints, adverse events, and sanctions)

  - Credentialing decisions and decision dates
  - Signature and or initials of the reviewer or verifier

- Credentialing Committee Meeting Minutes
- Credentialing Checklist
- Decision Letter(s)

Credentialing information is confidential and should be held in strict confidence. Humana should keep credentialing files and committee meeting minutes locked in a secured area. Access to electronic credentialing information (i.e., the credentialing system) should be password protected using strong passwords that are regularly changed and limited to staff that requires access for business purposes. The records should be retained for at least 10 years or as applicable to Humana's record-retention policy. Password-protecting electronic systems, include user requirements to:

- Use strong passwords.
- Avoid writing down passwords.
- User IDs and passwords unique to each other.
- Change passwords systematically as required by Humana corporate requirements, as requested by staff or if passwords are compromised.
- Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security.

Primary source verifications are received directly from the issuing entity, such as the state licensing board, educational institution, or an authorized source of such organizations, as described within this policy. The staff conducting such verifications will ensure the document is saved in portable document format (PDF), digitally uploaded to the credentialing system and saved within the specific record of the review. The credentialing system electronically adds the verification date as dictated by the user, and an automated process adds the unique electronic identifier of that specific user, the verification source and the date of the report, as applicable.
Oversight of credentialing functions, including audits, falls under the purview of the Credentialing Director. This includes ensuring compliance with organizational policies and regulatory standards, managing audit processed to verify accuracy and completeness of credentialing data, and overseeing implementation of corrective action plans. Additionally, the Director also identifies opportunities for process improvement and ensures all credentialing activities along with the organization's goals and quality standards, thereby maintaining the reliability and credibility of credentialing operations.
Informational modifications are only permitted by an authorized user prior to final committee review and are tracked in the historical data within the automated credentialing system. Authorized users are staff and management within the Credentialing Operations Department who perform practitioner and provider credentialing verification functions as part of their role assignment. Authorized user roles include:

- Director, Credentialing

- Manager, Credentialing
- Senior Credentialing Professional
- Senior Data and Reporting Professional
- Credentialing Professional 2
- Supervisor, Credentialing
- Credentialing Assistant 4
- Credentialing Assistant 3

Informational modifications are authorized when:

- Credentialing committee members request additional documentation or provider clarification.
- Updating of information is required to correct typographical errors or omissions identified through system review.
- Updated or clarification documents are received from practitioners or providers, to include:
  - addition of a line of business, specialty, new education
  - address change
  - expiration updates to license, DEA/CDS certificates, board certification
  - updated professional liability information
  - new information to request reconsideration.
- Practitioners are being decredentialed for reasons that include sanctions, retirement, deceased, unable to locate, failure to respond, practitioner request and/or contract closure.
  Credentialing Operations Department staff do not delete provider information from the system.
  Three processes are in place to oversee Credentialing operation's adherence to its processes:
  1. Credentialing Operations management oversees internal weekly audits of each authorized associate who performs practitioner and provider credentialing verifications.
  2. Humana's Regulatory Compliance team administers audits at least annually to ensure the compliance of policies, procedures, accreditation standards as well as state specific requirements.
  3. Annually, the Credentialing Operations auditor conducts a modification audit of all modifications using a random sample size of 5% or 50 (whichever is less).

Unauthorized modifications or deletions are prohibited. Identification of an unauthorized modification or deletion by any of the four areas listed above is researched and addressed through education, corrective action and monitored quarterly until improvement is seen. Disciplinary action can include but is not limited to coaching, performance improvement plans, or termination as warranted.

Quality management files that contain peer-review information are highly confidential and should be kept separate from credentialing files. Credentialing files should not be produced for outside parties without prior approval from the Corporate Law Department and/or the Corporate Insurance Risk-

management Department. The records should be retained for at least ten (10) years or as applicable to Humana's record retention policy.

Standard: Medical Director Responsibility

The medical director is responsible for overall compliance with the credentialing process. The medical director, or designee, is the chairperson of the Credentials Committee. The chairperson oversees committee voting procedures and verifies approval of each report and file. The medical director, or designee, does not have voting privileges except in the event of a tie vote by the committee. In that event, the chairperson may vote to break the tie.

Standard: Practitioner Rights

Notification of practitioner rights is contained in the Provider Manual for Physicians, Hospitals and Other Healthcare Providers. Practitioners have the right to review information obtained to evaluate their credentialing application, attestation or CV and the right to correct erroneous information. Any instances of varying information received from the practitioner's application are addressed directly to the practitioner by Humana in a professional and timely manner. The practitioner should be notified within seven (7) days of the discrepancy. The notification indicates which part of the application is discrepant, the format for submitting corrections and the person to whom corrections should be submitted. If the application, attestation and/or CV must be updated, only the practitioner may attest to the update, a staff member may not. The practitioner has 14 business days to respond to resolve the discrepancy. The receipt of any corrections should be documented in the credentialing file.

A practitioner has the right, upon request, to be informed of the status of his/her application. Humana should respond to these requests in a timely manner. Once a practitioner application for initial credentialing has been approved or denied, the practitioner should be notified within 30 calendar days. Credentialing denials will be communicated to the practitioner by the medical director in writing, will include the reason(s) for the denial and should be provided within 30 calendar days of denial.

Humana will make available all application and verification policies and procedures upon written request from the applying healthcare professional.

NOTE: The Provider Manual for Physicians, Hospitals and Other Healthcare Providers is available at **Humana.com/ProviderManual** for more details regarding practitioner rights.

Standard: Credentials Committee

Humana designates a Credentials Committee that uses a peer review process with members from the type of practitioners participating in its network to make recommendations regarding credentialing decisions. The Credentials Committee uses participating practitioners to provide advice and expertise for credentialing decisions. The Credentials Committee reviews credentials for practitioners who do not meet Humana's established criteria and considers the credentialing information. The Credentials

Committee also ensures files do not meet established criteria and are reviewed and approved by a medical director. The Credentials Committee has final approval or disapproval decision-making authority for credentialing and recredentialing applications.

The Credentials Committee comprises representation from a range of participating practitioners in both primary care and specialty disciplines, i.e., the types of practitioners the committee is reviewing. Participating practitioners are external to Humana and participate in its practitioner network. Clinical peer input from non-committee members may be accessed when discussing Credentialing Criteria for specific specialties. Members of the Credentials Committee are asked to sign a confidentiality and conflict of interest agreement. The Credentials Committee meets monthly, for the purpose of conducting credentialing and recredentialing activities and reviewing, offering input and approving credentialing and recredentialing policies and procedures.

Evidence of the Credentials Committee's discussions and decisions are documented in meeting minutes. The chairperson, or designee, should sign and date the committee minutes.

Humana's corporate credentialing and recredentialing policy is reviewed at least annually by the Credentials Committee.

NOTE: Credentials Committee meetings and decision-making may take place in the form of real-time virtual meetings (e.g., through videoconferencing or web conferences with audio). Meetings may not be conducted only through email.

Standard: Initial Credentialing and Sanction Information

The following items are verified through primary or NCQA-approved sources prior to initial credentialing, unless otherwise noted:

- Current and valid license to practice
- Current and valid DEA or CDS certificate, as applicable
- Education and training and board certification, as applicable
- Work history
- History of professional liability claims that resulted in a settlement or judgment paid on behalf of the practitioner (NPDB)

The following sanction or exclusion information is documented prior to initial credentialing, unless otherwise noted:

- State sanctions, restrictions on licensure and limitations on scope of practice
- Medicare and Medicaid sanctions and exclusions
- CMS Medicare preclusion list (Medicare only)
- Current Medicare opt-out list (Medicare only)

Standard: Application and Attestation

Practitioners are required to complete an application for initial credentialing and recredentialing that includes a current, signed attestation regarding their health status and any history of loss or limitation of licensure or privileges. Applications should be signed within 180 days of the credentialing decision and should include any necessary explanations, as applicable. Applicant signatures may be faxed, digital, electronic, scanned or photocopied, but signature stamps are not acceptable. The submission of false information or deliberate omission of requested information on the application may constitute grounds for the denial of credentialing or recredentialing.

The signed and dated application should include detailed information concerning:

- Current state professional license number(s)
- Current federal DEA certificate number(s) or state CDS certificate number(s) (if applicable)
- Current Medicare/Medicaid provider number (if applicable)
- Professional education, residency and board certification (if applicable)
- Work history of at least five years
- Current professional liability insurance coverage and claims history
- Clinical privileges at a primary participating hospital (if applicable)
- Signed and dated consent and release form

The signed and dated application also includes an attestation that addresses the following:

- Reasons for any inability to perform the essential functions of the position
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice coverage
- Current and signed attestation confirming the correctness and completeness of the application
- Practitioner race, ethnicity and language

NOTE: Humana requires participation in the Council for Affordable Quality Healthcare's (CAQH) Universal Credentialing DataSource initiative, an online service that helps physicians and other healthcare providers with the credentialing process, including state-specific credentialing applications required by state regulations. Except for practitioners employed by a tribal health program (pursuant to the IHCIA), each market's vice president must approve use of any application other than CAQH, if use of other applications is permitted by state law.

Standard: Recredentialing and Sanction Information

Humana formally recredentials its practitioners at least every 36 months. The following items are re-verified through primary or NCQA-approved sources prior to recredentialing, unless otherwise noted:

- Current and valid license to practice
- Current and valid DEA or CDS certificate, as applicable
- Board certification, as applicable

- History of professional liability claims that resulted in a settlement or judgment paid on behalf of the practitioner (NPDB)
- Performance indicators
- Quality Provider Professional Evaluation (QPPE) form only for providers who participate in CarePlus Health Plans Inc.

The following sanction or exclusion information is documented prior to recredentialing, unless otherwise noted:

- State sanctions, restrictions on licensure and limitations on scope of practice
- Medicare and Medicaid sanctions and exclusions
- CMS Medicare preclusion list (Medicare only)
- Current Medicare opt-out list (Medicare only)

Practitioners on active military duty, maternity leave or sabbatical may be recredentialed upon return. The reason for delaying recredentialing should be documented in the practitioner's file. In these cases, a practitioner should be recredentialed within 60 calendar days of his or her return to practice.

Practitioners in areas affected by an emergency declaration issued by the federal or state government will be reviewed for possible extension or grace period to respond to requests for credentialing and recredentialing materials. Such extension will begin on the effective date of the emergency declaration and continue until the expiration of the emergency declaration.

Practitioners who have been administratively decredentialed may be re-activated within a 30-calendar-day time. Any practitioner who has been decredentialed for longer than 30 calendar days should undergo the initial credentialing process.

NOTE: Practitioners who have missed the 36-month time frame for recredentialing may be administratively decredentialed. Humana may recredential the practitioner within 30 calendar days of missing the deadline. If recredentialing is not completed within 30 calendar days, Humana will complete an initial credentialing review of the practitioner.

Standard: Ongoing Monitoring and Interventions

Humana monitors practitioner sanctions, complaints and quality issues between recredentialing cycles and ensures that corrective actions are undertaken and effective when it identifies occurrences of poor quality (refer to Humana's Provider Quality Review Process).

Ongoing monitoring and appropriate interventions up to and including removal from the network are implemented by collecting and reviewing the following information from applicable sources within 30 calendar days of its release:

- Medicare and Medicaid sanctions and exclusions
- CMS Medicare preclusion list (Medicare only)
- Current Medicare opt-out list (Medicare only)
- Sanctions and limitations on licensure
- Complaints
- Identified adverse events

Evidence of sanction and exclusion reviews is available from the Credentialing Operations Department. Evidence of practitioner complaint and identified adverse-events reviews are available from the Quality Management Department.

This Standard: Notification to Authorities and Practitioner Review Rights

When the Credentials Committee recommends an adverse action lasting longer than 30 days against a practitioner, Humana must offer the applicant the right to request a hearing in accordance with the Humana provider quality-review process. Humana must report to the National Practitioner Data Bank all final adverse Clinical Privilege Actions against practitioners and any Other Adjudicated Actions or Decisions as defined in and required by federal law. Humana also may be required to report certain actions to state authorities and must do so in accordance with applicable state laws.

For details pertaining to hearing and reporting requirements, please refer to the Humana Provider Quality Review Process.

For all required hearings on credentialing decisions, the following definitions in the Humana provider quality review process are changed as follows:

- All references to the “HMD” (the Humana Health Plan Market Medical Director) shall mean the credentialing medical director.
- All references to “Peer Review Committee” shall mean the Credentials Committee.

Standard: Assessment of Organizational Providers

Humana evaluates the quality of organizational providers with which it contracts. All organizational providers requiring evaluation should complete the assessment process before a provider’s effective date is assigned, except where otherwise required by state regulations. Additionally, an organizational provider will print in the provider directory and provide care to members only after assessment is complete. Organizational providers are reassessed at least every three years thereafter. This assessment includes:

- Confirmation that the provider is in good standing with state and federal regulatory bodies (state license, where required; Medicare/Medicaid intermediaries; OIG and GSA)
- Confirmation that the provider has been reviewed and approved by an accrediting body and/or certified by Medicare*
  - The Joint Commission (TJC)
  - Accreditation Association for Ambulatory Health Care (AAAHC)

  - Center for Improvement in Healthcare Quality (CIHQ)
  - Federal Drug Administration (FDA)
  - Commission on Accreditation of Ambulance Services – American Ambulance Association (CAAS)
  - Commission on Accreditation of Rehabilitation Facilities (CARF)
  - Continuing Care Accreditation Co (CCAC)
  - Community Health Accreditation Program (CHAP)
  - Accreditation Commission for Healthcare (ACHC)
  - Healthcare Quality Association on Accreditation (HQAA)
  - Healthcare Facilities Accreditation Program (AOA HFAP)
  - American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
  - American College of Radiology (ACR)
  - National Integrated Accreditation for Healthcare Organizations (DNV-NIAHO)
  - Council on Accreditation (COA)
  - Clinical Laboratory Improvement Amendments (CLIA)
  - Clinical Laboratory Accreditation (COLA, Inc.)
  - American Association of Diabetes Educators (AADE)
  - Indian Health Service (IHS)
  - Commission on Accreditation for Home Care New Jersey (NJCAHC)
  - Commission for the Accreditation of Birth Centers (CABC)
  - Intersocietal Accreditation Commission (IAC)
  - Substance Abuse and Mental Health Services Administration (SAMHSA)
- Performance of an onsite quality assessment if the provider is not accredited**
- Current malpractice coverage or participation in Federal Tort Program; as applicable per state requirement

Pharmacy assessment also includes:

- Confirmation of National Council for Prescription Drug Programs (NCPDP)/National Association of Boards of Pharmacy (NAPB) number
- Current and valid DEA or form attesting pharmacy does not have a DEA
- Current malpractice coverage

Organizational providers to be assessed include, but are not limited to:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing surgical centers
- Hospices
- Clinical laboratories

- Comprehensive outpatient rehabilitation facilities
- Outpatient physical therapy and speech pathology providers
- Pharmacies
- Providers of end-stage renal disease services
- Providers of outpatient diabetes self-management training
- Portable X-ray suppliers
- Rural health clinics and federally qualified health centers
- Durable medical equipment entities

Behavioral healthcare facilities providing mental health or substance abuse services in the following settings are also assessed:

- Inpatient
- Residential
- Ambulatory

Assessment may be documented in the form of a checklist, spreadsheet or record and should include the prior validation date and current validation date for licensure, accreditation status, CMS or state reviews or site visits (if applicable) for each organizational provider.

For organizational providers, ongoing monitoring and appropriate interventions are implemented by collecting and reviewing quality reports from The Leapfrog Group, at least quarterly.

The decision to credential or recredential Organizational providers is based on the above Standard for the Assessment of Organizational Providers and includes, but is not limited to, the information gathered through the credentialing and recredentialing process. While contracted with Humana, Organizational providers are required to meet the above Standard for the Assessment of Organizational Providers and always stated requirements. Humana may decredential an Organizational Provider at any time for failure to meet such Standard for the Assessment of Organizational Providers. In the event of such a denial or decredentialing of an Organizational Provider, written notice will be provided and effective upon mailing. An Organizational Provider subject to such denial or decredentialing shall have no right to a hearing but may request a reconsideration of such denial or decredentialing in writing within thirty (30) days of the date of mailing of the notice. The Organizational Provider may be deemed to meet the above Standard for the Assessment of Organizational Provider if upon reconsideration, the Organization can demonstrate to the satisfaction of the Credentials Committee that the above Standard for the Assessment of Organizational Providers has been met.

*Providers in Humana's Medicare network(s) must be Medicare-certified. Humana will verify an organizational provider's Medicare certification status by obtaining the certification letter CMS issues

to the provider. The CMS certification letter may not be more than three years old at the time of verification and must include the CMS certification number (CCN).

**If an organizational provider is not accredited, Humana may substitute a CMS or state review in lieu of performing its own onsite quality assessment. Humana will verify that an onsite quality assessment has been completed by a state agency or CMS by obtaining the assessment report or certification letter. The CMS or state review may not be more than three years old at the time of verification. If the CMS or state review is older than three years, Humana will conduct its own onsite quality review. If the state or CMS has not conducted a site review of the provider and the provider is in a rural area (as defined by the U.S. Census Bureau), Humana may choose not to conduct a site visit.

NOTE: The Practitioner Office and Facility Location Survey tool is used in cases where a site visit is required.

Standard: Assessment of Long-Term Services and Support Provider

Humana evaluates the quality of LTSS providers with which it contracts. All LTSS providers requiring evaluation should complete the assessment process before their effective date is assigned, except where state regulations require otherwise. Additionally, an LTSS provider will print in the provider directory and provide care to members only after assessment is complete. LTSS providers are reassessed at least every three years thereafter.

LTSS providers to be assessed include, but are not limited to:

- Adult day care centers (ADC)
- Assisted living facility services (ALF)
- Adult family care homes (AFCH)
- Case management agencies
- Chore providers, including pest-control contractors
- Suppliers of consumable supplies
- Environmental accessibility contractors
- General contractors
- Home-delivered meal services
- Home health agencies
- Home medical equipment (HME) services
- Homemaker/companion services
- Hospices
- Non-emergent/non-traditional transportation service providers
- Nurse registry
- Nutritionist/dietician
- Personal Emergency Response Systems (PERS) and Personal Care Services
- Skilled nursing facility

- Therapy services (occupational, physical, respiratory and speech)

Assessment includes:

- Confirmation the provider is in good standing with state and federal regulatory bodies (state license, Medicare/Medicaid intermediaries, OIG and GSA)
- For provider types not licensed by a state medical regulatory board, confirmation the provider has a current, valid occupational license or other evidence of authority to do business within the scope of contracted service(s)
- Confirmation the provider has been reviewed and approved by an accrediting body, as applicable (AAAHC, CARF/CCAC, CHAP, AOA, CMS, TJC or Occupational Safety and Health Administration [OSHA])
- Performance of an onsite quality assessment if the provider is not accredited*
- Confirmation the provider is compliant with abuse, neglect, exploitation and chore training, as applicable per state requirement.
- Confirmation of current liability and/or worker's compensation insurance coverage, as applicable per state requirement

Documentation of the assessment may be in the form of a checklist, spreadsheet or record and include the prior validation date and current validation date for licensure, accreditation status, CMS or state reviews or site visits (if applicable) for each organizational provider.

*If an LTSS provider is not accredited, Humana may substitute a CMS or state review in lieu of accreditation. Humana should obtain a state report or CMS letter to verify that the review has been performed. The CMS or state review may not be more than three years old at the time of verification. EXCEPTION: Accreditation, CMS or state-agency review will not be substituted in lieu of an on-site visit if a program's contract requires verification of defined characteristics unique to certain provider types.

References:

Provider Manual for Physicians: **Humana.com/ProviderManual**

Owner:	Michele Coddington	Executive Team Member:	George Renaudin
Accountable VP / Director:	Kali Hayes		

Disclaimer:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by an issue, to allow for consistency, Humana will follow the most stringent requirement.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/procedure) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/procedure) supersedes all other policies, requirements, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained in Policy Source to ensure no modifications have been made.

Non-Compliance:

Failure to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may act in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Associate Support Center via Humana's secure intranet on Hi! (Workday & Apps/Associate Support Center).