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CREDENTIALING COMMITTEE BYLAWS

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# 1. Introduction

CSRA State and Local Solutions LLC, a General Dynamics Information Technology (GDIT) Company (hereinafter referred to as CSRA) performs all required enrollment, credentialing, recredentialing, and ongoing monitoring activities (license verification, Medicaid/Medicare sanction/exclusion verifications, etc.) for North Carolina Department of Health and Human Services (NC DHHS) providers which includes all providers contracting with Division of Health Benefits (DHB), Division of Mental Health (DMH), Developmental Disabilities and Substance Use Services (DMH/DD/SUS), Division of Public Health (DPH), Office of Rural Health (ORH) and all NC Medicaid Managed Care health plans.

Following State-approved desk procedures, CSRA Provider Enrollment Specialists complete the required verifications for enrollment, credentialing, and recredentialing applications:

* Identifies applications as clean (no negative findings).
* Ensures all negative findings are disclosed with complete required documentation (copy of legal documents showing final disposition and a signed/dated explanation of the finding).
* Denies applications if a negative finding was not disclosed by the provider.
* Denies applications if the provider’s required licensure is not currently active (revoked or suspended).
* Denies applications if the provider or one of its managing employees or owners is currently excluded from Medicare or any State Medicaid program.
* Denies applications if the provider is on the Sex Offender Registry – Validated on US Department of Justice National Sex Offender Public Website at https://www.nsopw.gov/
* For all other applications, identifies providers as low risk, medium risk, or high risk.

See [Appendix A – Risk Level Criteria](#_Appendix_A._Risk) for more information on how providers and risk levels are categorized.

In addition to applications, following approved desk procedures, CSRA Provider Enrollment Specialists monitor provider licensure boards for licensure actions, Medicare and Medicaid exclusions and sanctions, NC Provider Penalty Tracking Database (PPTD) penalties and actions, and criminal findings as identified by LexisNexis. CSRA monitors the finding information and:

* Terminates providers if the enrolling provider is identified as deceased.
* Terminates providers if a required licensure has been revoked or suspended.
* Terminates providers if the provider or one of its managing employees or owners is currently excluded from Medicare or any State Medicaid program.
* Terminates a provider if on the Sex Offender Registry – Validated on US Department of Justice National Sex Offender Public Website at https://www.nsopw.gov/
* For all other findings, identifies the finding as low risk, medium risk, or high risk.

The North Carolina (NC) Medicaid Credentialing Committee (“Credentialing Committee”) is a peer-review body that performs the following functions:

* Reviews the credentials of providers in medium-risk and high-risk categories as part of enrollment, re-enrollment, recredentialing, and ongoing monitoring.
* Meets weekly to make recommendations and determinations regarding enrollment/credentialing decisions for the identified providers to ensure quality of care to members.

Clean and Low Risk provider files are approved by the Credentialing Committee’s Medical Director without the need for a full Credentialing Committee review. The approvals will be ratified during a Credentialing Committee Meeting and documented in the Credentialing Committee Meeting Minutes.

# 2. Bylaws

The Credentialing Committee Bylaws are issued and sponsored by NC DHHS DHB, which retains ultimate authority over the entire process of authorizing providers to participate in the North Carolina Medicaid program and affiliated payers. This policy establishes a comprehensive credentialing framework and delegates certain authority and powers to the Credentialing Committee to comply with all federal and North Carolina statutes, Medicaid and other payer policies, and the standards established by the National Committee for Quality Assurance (NCQA). This policy upholds the centralized credentialing of providers for contracting with managed care plans.

Prior to implementation of the Credentialing Committee Bylaws, NC DHHS DHB engaged with key North Carolina Stakeholders to solicit input.

The Credentialing Committee Bylaws are approved by NC DHHS DHB and the Credentialing Committee. The bylaws will be reviewed at least annually. CSRA will make edits to the bylaws, if applicable, send to DHB for approval, and then the bylaws will be shared with the Credentialing Committee members and approved during a meeting.

The Credentialing Committee is responsible for abiding by and enforcing all applicable federal Code of Federal Regulations (CFR) and North Carolina statutes, rules and regulations, including but not limited to the following:

1. The North Carolina Medicaid State Plan, as amended; and
2. North Carolina Medicaid CMS-approved State Plan Waivers; and
3. N.C.G.S. §108A and §108C; and
4. 42 USC 1396a, et seq.; and
5. Code of Federal Regulations, Title 42, Chapter IV, Subchapter C;
6. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, including but not limited to the Standard for Privacy of Individually Identifiable Health Information and Health Insurance Reform: Security Standards; and
7. The Family Educational Rights and Privacy Act (FERPA); and
8. Medical coverage policies of NC DHHS; and
9. Guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, NC DHHS and its divisions, its fiscal agent and/or other contracted vendors as directed by NC DHHS and in effect at the time the service is rendered.; and
10. 42 CFR 455 Subpart E - Provider Screening and Enrollment and CMS Medicaid Provider Enrollment Compendium (MPEC).

The Credentialing Committee is responsible for abiding by and enforcing the Credentialing Policies and Standard Operating Procedures issued by NC DHHS, and for making recommendations for the maintenance and improvement of those policies.

Providers have the right to request a reconsideration of a denial or termination decision. If a provider appeals a denial or termination decision made by the Credentialing Committee, NC DHHS DHB reserves the right to review, reverse, or request reconsideration of any Credentialing Committee determination as part of the appeal process.

# 3. Credentialing Committee Members

The NC Medicaid Credentialing Committee is made up of voting and non-voting members.

Voting Members will include the following:

* Credentialing Committee Medical Director (employed by CSRA) and an alternate (provided by CSRA)
* Two NC DHHS Division of Health Benefits Representatives
* One representative from each Pre-paid Health Plan Entity, as designated by the Division, to include:
* One from each Standard Plan
* One from each Tailored Plan/Pre-paid Inpatient Health Plan combined
* One from Tribal Option Entity
* The Child and Family Specialty Plan is represented by the Blue Cross/Blue Shield Standard Plan representative.
* Each representative must have an alternative/proxy from within their entity to attend and vote in their absence.
* One representative from NC DHHS Division of Mental Health, as designated by the division
* One representative from NC DHHS Division of Public Health, as designated by the division
* One representative from NC DHHS Office of Rural Health, as designated by the division

Non-voting members will include the following:

* Credentialing Supervisor (employed by CSRA)
* Credentialing Committee Meeting Coordinator (employed by CSRA)
* Appeals Coordinator (employed by CSRA)
* Peer Expert Specialists – See Section X Peer Review Selection
* Peer Expert Non-Physician Practitioners – See Section X Peer Review Selection

### Membership

* NC DHB is responsible for the recruitment and identification of NC DHB and the Pre-paid Health Plans’ voting members including an alternate for each role.
* Voting members, Peer Expert Specialists, and Peer Expert Non-Physician Practitioners participate for 1-year terms (beginning annually on October 1st), with the option to renew once the term has expired. The Credentialing Committee Meeting Coordinator will contact each member the first week of August confirming continued participation. The member is expected to reply confirming continued participation or selecting not to continue. If no response is received within one week, the assumption will be made that the member does not wish to continue.
* Members can serve no more than two consecutive years.
* Members may resign by submitting a letter of resignation to the Committee Chair fourteen (14) calendar days before the Committee Members resignation date.
* A member may be removed from the committee by the Credentialing Committee Chair for one of the following reasons:
* If a voting member is absent from more than ten meetings per year.
* The member’s conduct during meetings is consistently disruptive, inappropriate, or detrimental to the committee's function. Such behavior includes, but is not limited to, failing to engage respectfully, creating unnecessary disturbances, or hindering productive discussions.
* A member will be removed immediately from the committee by the Credentialing Committee Chair for one of the following reasons:
* A breach of the Credentialing Committee Confidentiality, Conflict Of Interest, and Non-Discrimination Attestation
* Member becomes ineligible to hold the position. See [Eligibility Criteria](#_Eligibility_Criteria).

If a voting member elects not to continue participation for a second term, has reached the two-term limit, has resigned, or was removed from the committee, CSRA will notify NC DHB to identify a replacement.

If a Peer Expert Specialist or a Peer Expert Non-Physician Practitioner elects not to continue participation for a second term, has reached the two term limit, has resigned, or was removed from the committee, CSRA will post an announcement on NCTracks website to recruit a replacement member.

## 3.1 Peer Expert Specialists Membership

To ensure relevant clinical input, CSRA will make reasonable efforts to identify and nominate Peer Expert Specialists across a broad range of specialties reflective of the provider network.

* Primary Care Providers (PCPs)
* Specialists (e.g., cardiology, psychiatry, orthopedics)
* Nurse Practitioners / Physician Assistants (NPs/PAs)
* Dentists
* Pharmacists / Durable Medical Equipment (DME) Providers
* Behavioral Health Providers
* Other provider types as needed

Peer reviewer roles are non-paid and non-voting. They are called upon at the discretion of the Medical Director when specialty-specific expertise is needed for consultation during Credentialing Committee meetings.

### Eligibility Criteria

In order to be a Peer Expert Specialist on the Credentialing Committee, the individual must satisfy the following criteria:

* Must be an actively enrolled and credentialed provider with NC Medicaid
* Must be in good standing, with no current disciplinary actions, investigations, or sanctions
* Must hold appropriate licensure and board certification (as applicable to specialty)
* Must have a minimum of 2 years of experience in their area of practice
* Must sign the *Credentialing Committee Confidentiality, Conflict Of Interest, and Non-Discrimination Attestation*
* Must be willing to comply with all applicable policies, procedures, and ethical standards of the Credentialing Committee

Individuals interested in becoming a Peer Expert Specialist for the NC Medicaid Credentialing Committee should email a copy of their resume. Additional information can be found on the NCTracks website at TBD.

## 3.2 Roles and Responsibilities

| Role | Responsibilities |
| --- | --- |
| Credentialing Committee Medical Director | Chairs the Credentialing Committee Meetings  Approves clean and low risk enrollment, re-enrollment, and recredentialing applications  Oversees the voting procedures, which will be jointly established, documented and agreed upon by NC DHHS and CSRA |
| Credentialing Committee Medical Director Alternate | Backup to the Credentialing Committee Medical Director, assumes their duties when the Credentialing Committee Medical Director is unavailable |
| NC Department of Health and Human Services Representative | Participates in and supports the functions of the Credentialing Committee by attending meetings, providing input, feedback, and overall guidance of the Credentialing Program  Reviews and gives thoughtful consideration of each Provider’s enrollment/credentialing information  Votes to make a final recommendation regarding Provider’s participation or continued participation  Monitors the entire Credentialing Committee process |
| Pre-paid Health Plan Representatives | Participate in and support the functions of the Credentialing Committee by attending meetings, providing input, feedback, and overall guidance of the Credentialing Program  Review and give thoughtful consideration of each Provider’s enrollment/credentialing information  Votes to make a final recommendation regarding Provider’s participation or continued participation |
| Credentialing Certification Supervisor | Ensures CSRA Provider Enrollment is following current NCQA, State, and federal policies  Identifies any changes required to procedures based upon updates from NCQA, State, and federal policies  Ensures meetings are run effectively, including adherence to agenda topics and timing |
| Credentialing Committee Meeting Coordinator | Schedules the Credentialing Committee meetings  Works with the Credentialing Certification Supervisor and Credentialing Committee Medical Director to develop the agenda for the meetings  Creates the provider profile packages, uploading the packages to the NCTracks portal in advance of the meetings  Attends Credentialing Committee meetings and keeps detailed meeting minutes  Takes actions in NCTracks consistent with Credentialing Committee decisions  Answers Credentialing Committee questions about the provider profile packages  Answers Credentialing Committee questions about any aspect of the primary source verification work  Performs follow-up or supplementary research, as required, to enable the Credentialing Committee to render a credentialing decision |
| Peer Expert Specialists | Participate in and support the functions of the Credentialing Committee by attending meetings, providing input, feedback, and overall recommendations on provider’s participation  A Peer Expert Specialist will not be required to attend all meetings. Attendance is only requested when a provider of their type/specialty expertise is needed |
| Peer Expert Non-Physician Practitioners | Participate in and support the functions of the Credentialing Committee by attending meetings, providing input, feedback, and overall recommendations on provider’s participation  A Peer Expert Specialist will not be required to attend all meetings. Attendance is only requested when a provider of their type/specialty expertise is needed. |

## 3.3 Confidentiality, Conflict of Interest, and Non-Discrimination

All members of the Credentialing Committee will be required to sign the *Credentialing Committee Confidentiality, Conflict Of Interest, and Non-Discrimination Attestation* annually. Guest attendees of the Credentialing Committee will also be required to sign this attestation prior to attendance at a Committee Meeting.

Members and guests of the Credentialing Committee will not discuss, share, or use any information presented at Credential Committee meetings for any purpose other than peer review of the NC DHHS provider application at the meeting. Members and invited guests of the Credentialing Committee shall exercise their best efforts to maintain the confidentiality of all information and records of the Credentialing Committee deliberations, except as otherwise required by Law.

Members and guests of the Credentialing Committee will agree to mitigate any conflict of interest. A Member of the Credentialing Committee must refrain from voting when they have a professional involvement or conflict of interest that might have the appearance of partial judgment. The minutes will reflect all situations where a Credentialing Committee Member refrains from voting due to a conflict of interest. If a Credentialing Committee member must recuse themselves based on conflict of interest and there is no longer a quorum, the provider will be deferred until the next regularly occurring Credentialing Committee meeting.

The Credentialing Committee does not make credentialing decisions based on the provider’s race, ethnic/national identity, gender, age, sexual orientation, the types of procedures or patients in which the provider specializes, or the demographic location of the provider.

# 4. Credentialing Committee Meetings

The Credentialing Committee meetings occur weekly, virtually hosted through a web conference with audio. Meetings and voting are conducted live in the meetings and are not conducted through email.

1. The Credentialing Committee Coordinator will work with the Credentialing Certification Supervisor and Credentialing Committee Medical Director to develop the agenda for the meetings.
2. The Credentialing Committee Coordinator will assemble the Provider Profile Packages.
3. The Credentialing Committee Coordinator will send Meeting Agendas to voting and non-voting members three (3) business days prior to the meeting date. The agenda includes the File ID. Members will login to a secure online portal, locate the File ID, and view the Provider Profile Package. See [Appendix B – Meeting Agenda Template](#_Appendix_A_–).
4. The Credentialing Committee Coordinator will make all reasonable efforts to confirm meeting attendance one (1) business day before the meeting date.  
     
   The voting members are expected to confirm their availability. If not available, voting members are responsible for ensuring the availability of their assigned alternate to attend.
5. During the weekly meetings:
   1. The Credentialing Committee Medical Director must always be in attendance.
   2. The Credentialing Committee Medical Director will inform the members of the number of clean and low-risk provider files approved in the previous week and will ask members to vote to ratify the approvals. Note: Those files will be identified and attached to the meeting minutes.
   3. The Credentialing Committee Medical Director will ask the members if there are any medium-risk provider files they have an objection to approving. If no objections, a vote will be taken to approve all medium-risk provider files. If a member wishes to discuss and vote on a specific medium-risk provider file, the file will be reviewed during the meeting.
   4. All high-risk provider files will be reviewed during the meeting.
6. Voting is compulsory for all members with voting rights.
7. A simple majority of more than 50% of the votes cast constitute the final decision of the committee. In cases of a tie, the Medical Director will serve as the tiebreaker.
   1. A vote may result in one of three decisions during the meeting: Approved, Denied, or Terminated. If additional information is needed to make a decision, the vote will be designated as “Deferred” to be discussed in the next meeting.
   2. A quorum is met when at least >50% of voting members, or their alternates, are present for the meeting. If a quorum is not met within ten (10) minutes of the start time of the meeting, the meeting will be adjourned and the profiles on the agenda will be deferred to the next meeting.
8. After the meeting, the Credentialing Committee Coordinator will log in to the NCTracks portal and implement the decision made by the committee. One of the following applicable notes will be added:
   1. Medium Risk provider reviewed at the MM/DD/YYYY Credentialing Committee Meeting. The committee recommended approval of the provider’s application. Application approved.
   2. High Risk provider reviewed at the MM/DD/YYYY Credentialing Committee Meeting. The committee recommended approval of the provider’s application. Application approved.
   3. Medium Risk provider reviewed at the MM/DD/YYYY Credentialing Committee Meeting. The committee recommended denial of the provider’s application. Application denied.
   4. High Risk provider reviewed at the MM/DD/YYYY Credentialing Committee Meeting. The committee recommended denial of the provider’s application. Application denied.
   5. Provider reviewed at the MM/DD/YYYY Credentialing Committee Meeting for the ongoing monitor finding XXXX. The committee recommended to terminate the provider’s enrollment.
   6. Provider reviewed at the MM/DD/YYYY Credentialing Committee Meeting. The Credentialing Committee deferred the provider enrollment decision pending further research. Note: Details of the deferral will be documented in meeting minutes, pending final decisions.

**Note**: The above notes are in addition to the note which identifies why the provider was identified as medium or high risk.

1. The Credentialing Committee Coordinator will email meeting minutes to the voting and non-voting members (who attended the meeting) within two (2) business days following the meeting date. See [Appendix C – Credentialing Committee Meeting Minutes Template](#_Appendix_B_–).

CSRA maintains a copy of all meeting agendas, provider profile packages, meeting minutes, member rosters, the bylaws, and signed *Credentialing Committee Confidentiality, Conflict Of Interest, and Non-Discrimination Attestation*. DHB can access all on NCTracks ShareNet TBD Page.

## 4.1 Provider Profile Packages

A provider profile package is created by the Credentialing Committee Meeting Coordinator. The package is in PDF form and consists of the following: a Provider Profile Package Cover Page and supporting documentation.

CSRA will apply due diligence in redacting identifying information from all supporting documentation included in the package.

To view the provider profile package, the member will log in to the NCTracks Operations Portal with the NCID which has been provisioned to have access to the Credentialing Committee Page. **Note**: Training will be provided to all members on how to access the information in NCTracks.

# Appendix A. Risk Level Criteria

## CLEAN FILES

Clean Files have no negative findings at all.

## Low Risk

In addition to the criteria below, a Low Risk designation includes files in which the medium risk or high risk finding(s) was previously reviewed and the provider’s enrollment was approved by the committee.

Licensure Findings:

* Licensure has a document, public letter, or concern or reprimand in which no adverse action was taken on the provider
* Licensee was fined/penalized monetarily, and the fine has been settled
* Stayed or rescinded suspension in the past

Malpractice cases which meet the following criteria:

* One or two pending cases
* Case was settled more than five years in the past – settlement payment made on behalf of the provider was $100K or less
* Provider was found not liable; no payment was made on behalf of the provider

Criminal Findings listed in G.S. 108C‑3(g) – More than ten years in the past excluding findings listed in the High Risk category.

The provider or one of its managing employees or owners was excluded from Medicare or a State Medicaid program more than 10 years in the past.

Hospital admitting privileges revoked more than five years in the past or revoked but reinstated within two weeks of revocation.

Liability insurance carrier canceled, refused coverage, or rated up because of unusual risk, or have any procedures been excluded from coverage. The action was taken more than five years in the past.

The provider or one of its managing employees or owners has NC Provider Penalty Tracking Database (PPTD) finding that is training in lieu of monetary penalty finding.

The provider or one of its managing employees or owners has NC Provider Penalty Tracking Database (PPTD) finding that is a monetary penalty that has been resolved.

## Medium Risk

Licensure findings:

* Suspension or restrictions, license, or non-practice agreement in the past; license has been clean and clear for at least five years.
* Any prior suspensions, restrictions, or non-practice agreement on a license must have been fully resolved, with the license remaining clean and clear for a minimum of five years. A 'clean and clear' status requires complete relief of obligation, including any applicable Consent Orders. It must also ensure the removal of all restrictions.
* Past revocations – License has been clean and clear for at least 10 years.
* Any prior revocation on a license must have been fully resolved, with the license remaining clean and clear for a minimum of 10 years. A 'clean and clear' status requires complete relief of obligation, including any applicable Consent Orders. It must also ensure the removal of all restrictions.
* Currently on probation with applicable licensing authority.

Malpractice cases which meet the following criteria:

* Malpractice cases settled in past five years – settlement payment made on behalf of the provider was $100K or less with one of the following patient outcomes:
* Emotional injury only
* Minor temporary injury
* Major temporary injury
* Minor permanent injury
* Three or more pending malpractice cases

Criminal Findings listed in G.S. 108C‑3(g) – Less than ten years in the past excluding findings listed in the High Risk category.

The provider or one of its managing employees or owners was excluded from Medicare or a State Medicaid program less than 10 years in the past.

Liability insurance carrier canceled, refused coverage, or rated up because of unusual risk, or have any procedures been excluded from coverage. The action was taken less than five years in the past.

Hospital admitting privileges revoked less than five years in the past but were reinstated by the hospital.

The provider or one of its managing employees or owners has NC Provider Penalty Tracking Database (PPTD) adverse action(s) **other than** penalties or a training in lieu of monetary penalty finding.

## High Risk

Licensure findings:

* License has current restrictions.
* Provider has an active Non-Practice agreement.
* Suspension, restrictions, or non-practice agreement on license in the past; license has been clean and clear for less than five years.  
    
  Any prior suspensions, restrictions, or a non-practice agreement on a license must have been fully resolved, with the license remaining clean and clear for less than five years. A 'clean and clear' status requires complete relief of obligation, including any applicable Consent Orders. It must also ensure the removal of all restrictions.
* Past revocations – License has been clean and clear for less than 10 years.  
    
  Prior revocation on a license has been fully resolved, with the license remaining clean and clear for less than 10 years. A 'clean and clear' status requires complete relief of obligation, including any applicable Consent Orders. It must also ensure the removal of all restrictions.

Malpractice cases which meet the following criteria:

* Malpractice case settlement made on behalf of the provider $1 million or greater (regardless of timeline)
* Malpractice cases settled in past five years – settlement payment made on behalf of the provider $101K – $999K with one of the following outcomes:
* Significant permanent injury
* Major permanent injury
* Grave Permanent Injury, such as quadriplegic or brain damage, requiring lifelong dependent care
* Death

Hospital admitting privileges revoked less than five years in the past and were never reinstated.

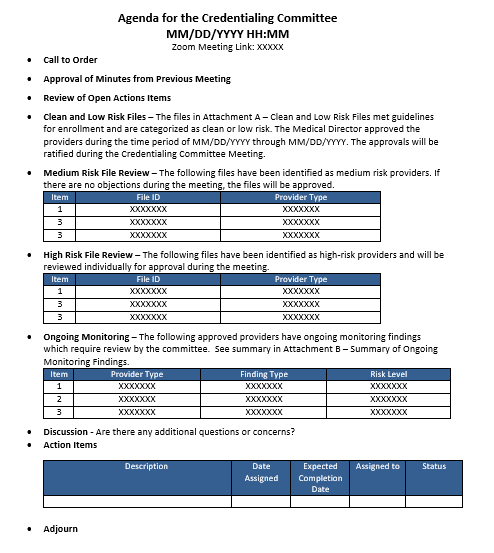
Past Criminal Findings – Regardless of timeframe

* Homicide
* Rape and Other Sex Offenses
* Assaults
* Kidnapping and Abduction
* Embezzlement

Convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or any Children's Health Insurance Program in the last 10 years.

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# Appendix B – Credentialing Committee Meeting Agenda Template



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# Appendix C – Credentialing Committee Meeting Minutes Template

