PLAN OPERATIONS	Advantage Dental From DentaQuest			
	Policy and Procedure			
	Policy Name:	**Credentialing and Re-Credentialing**	Policy ID:	**PLANCG-14**
	Approved By:	Peer Review and Credentialing Committee	Last Revision Date:	03/25/2024
	States:	Oregon	Last Review Date:	3/27/2024
	Application:	Medicaid	Effective Date:	3/28/2024

PURPOSE
To establish guidelines for the credentialing and re-credentialing of providers.

POLICY
The Dental Care Organization (DCO) is committed to providing quality dental care for enrollees. This Credentialing and Re-Credentialing Policy has been developed as part of the Quality Improvement (QI) Program to ensure each licensed Dentist (including TeleDentists), Denturist, and Dental Hygienist meets competency standards established as part of the DCO selection, compensation and retention processes. The DCO contracts only with Dentists (including TeleDentists), Denturists and Expanded Practice Permit Dental Hygienists ("Providers") who are licensed with their state's board. The DCO contracts with Providers based on the needs of its membership and DCO's network capacity, in DCO's discretion. All Providers, including Teledentists, are subject to the same credentialing requirements. (Additional Details regarding the DCO Teledentistry Policy are available in PLANCG-82 Teledentistry).

All licensed Providers who have signed contracts or participation agreements with the DCO shall first be credentialed upon contracting with the DCO, and thereafter re-credentialed no less frequently than every three years. The Vice President of Clinical Services, and/or their licensed designee is responsible for credentialing decisions. The Peer Review and Credentialing Committee is responsible for reviewing all credentialing decisions on a bi-monthly basis.

Prior to the effective date of Provider's contract with the DCO, the Provider shall complete the Oregon Provider Credentialing Application (OPCA), and thereafter shall be re-credentialed at least every three years. The credentialing and re-credentialing process will provide the DCO with information necessary to perform a comprehensive review of the Provider's credentials. The Provider shall have the right to review and correct any credentialing information at any time during the credentialing process. If additional information is needed, or if the information obtained through the credentialing process varies substantially from the information provided by the provider, the Provider Relations Department will contact the Provider and provide instructions on how the additional information can be submitted (i.e. faxing/mailing the necessary forms). The Provider will be given two weeks to supply the missing information. If the timeframe is not met, the Provider's application will remain in a "hold" status until the information is received. Upon receipt of the additional information Provider Relations shall review and notify the Provider within one week if any additional action is needed. Additional information shall be submitted to the DCO and reviewed by the Peer Review and Credentialing Committee, Vice President of Clinical Services and/or designee as needed. Once the Provider has submitted all the necessary information, the DCO will commence a review of the Provider's credentials. Documentation of receipt of the updated information will be stored in the Provider's file.

The Provider Relations Department shall provide administrative assistance throughout the credentialing and re-credentialing process. The DCO shall not make credentialing and re-credentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, type or cost of procedure performed, or type of enrollees treated (e.g. Medicaid, or high-risk population). All

information obtained during the credentialing/re-credentialing process is confidential. Providers' credentialing applications can only be accessed by the submitter, the DCO's Provider Relations staff and the VP of Clinical Services and/or designee. Provider contracting forms are stored in protected drives with access limited to only DCO Provider Relations staff.

The DCO follows National Committee on Quality Assurance (NCQA) standards on credentialing, as well as complying with any additional requirements established by the State. At a minimum, the credentialing and re-credentialing process shall include:

1. Review of information included in the Provider Dental Credentials Verification form;
2. Query of the National Practitioner Data Bank (Continuous Query set up on all Providers for re-credentialing purposes);
3. Query of the US Office of Inspector General (OIG), Excluded Parties List System, CMS Medicare Preclusion List and List of Excluded Individuals and Entities and Social Security Death Master File. (Monthly querying completed for all contracted Providers for re-credentialing purposes).
    a) The DCO will not hire or contract with any Provider or Organization that is currently excluded from participating in federal or state healthcare programs, or who has been excluded from state or federal healthcare programs in the past, or who has ever been precluded from billing a state or federal healthcare program; or who has been the subject of a CMS payment suspension at any time during the past 10 years. If Advantage Dental declines to contract with a Provider based upon any such exclusions, this will be reported to OHA and OIG by the Advantage Dental Compliance Department;
    b) The DCO does not refer enrollees to or use Providers who do not have a valid license or certification required. If Advantage Dental determines that a Provider's license or certification is expired, has not been renewed, or is subject to sanction or administrative action, Advantage Dental will immediately provide OHA and appropriate CCO partners with Administrative Notice of such circumstances.
4. Screening based on the Provider categorization by the OHA. The DCO will screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of "limited," "moderate," or "high." If a Provider could fit within more than one risk level described in this section, the highest level of screening is applicable. The DCO will, when credentialing Providers or Provider types designated by CMS as "moderate" or "high-risk," at the time of enrollment, provide to OHA with documentation, via Administrative Notice, that demonstrates the Provider has undergone a fingerprint-based background check and site visit within the previous 5 years.
    (a) Screening for Providers designated as limited categorical risk.
        a. When OHA designates a Provider as a limited categorical risk, the DCO will:
    - Verify that a Provider meets any applicable Federal regulations, or State requirements for the Provider type prior to making an enrollment determination; and
    - Conduct license verifications, including State licensure verifications in States other than where the Provider is enrolling, in accordance with § 455.412; and
    - Conduct database checks on a pre- and post-enrollment basis to ensure that Providers continue to meet the enrollment criteria for their Provider type, in accordance with § 455.436.

    (b) Screening for Providers designated as moderate categorical risk.
        a. When OHA designates a Provider as a "moderate" or "high" categorical risk, and the DCO intends to credential or recredential the provider, the DCO will:
    - Perform the "limited" screening requirements; and

- Conduct on-site visits in accordance with § 455.432; and
- Conduct a criminal background check; and
- Require the submission of a set of fingerprints in accordance with § 455.434.

5. A signed attestation from the Provider confirming lack of any present illegal drug use;
6. A signed attestation from the Provider confirming the accuracy of all information submitted by Provider;
7. Verification of current licensure, including any disciplinary action, by the Provider's State Board of Dentistry and any applicable certifications (Annual querying completed for all contracted for re-credentialing purposes);
8. Verification of current malpractice insurance policy with correct declarations; and
9. Verification of at least 5 years of work history;
10. Verification that the Provider has an Oregon Medicaid ID (if not the DCO shall submit a Provider Enrollment form – 3108 – to the Oregon Health Authority);
11. The following attestations will be required during the initial and recredentialing process:
    a) Ownership Disclosure Form
    b) Provider Attestation for Policies
12. The following attestations will be required during the initial credentialing process:
    a) Agreement to Pay Form

During the credentialing/re-credentialing process the Provider may request information as to the status of their credentialing/re-credentialing by contacting the DCO's Provider Relations Department via phone or email. The process to responding to such requests includes the timeframe to complete the credentialing/re-credentialing process, not to exceed 60 days from the date the completed application and signed agreement, and all necessary documentation was received from Provider.

After review of items 1-11 above, if no outstanding matters are found the file is considered clean and sent for final approval by the, Vice President of Clinical Services, and/or their licensed dentist designee. Files are considered clean if a review of items 6 and 7 find no more than two disciplinary actions for clinical quality of care or two malpractice actions within the past three years. If there are any outstanding matters discovered during this process, the outstanding matters are presented to the Vice President of Clinical Services, and/or their licensed designee for review and further consideration as to whether the Provider will be contracted, declined, or terminated. All files not considered clean will be presented to the Peer Review and Credentialing Committee for further review. Within 60 days of the date of the decision, the Provider shall be notified via written letter by mail of the acceptance, denial, continuation of contract (upon recredential) or termination of status as a credentialed Provider and has the right to receive the status of their credentialing application upon request. Such letter will include instructions for the Provider's ability to appeal and correct any information given in the credentialing/re-credentialing process.

Once all credentialing verifications are completed and the Provider has been approved for participation in the DCO network, Provider Relations will load the Provider information into the DCOs internal system. Information entered into this internal system will automatically update the DCOs online Provider directory in real time. At this time, the Provider will also be provided a unique Provider Identification Number (PIN).

The DCO does not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification as specified under OAR 410-141-3510 on the basis of that license or certification. If the DCO declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. If a Provider disputes the DCO decision on the basis of discrimination, the

provider can request reconsideration by the Peer Review and Credentialing Committee or appeal directly to the Oregon Health Authority.

The DCO will re-credential all participating providers every 3 years. Upon re-credentialing of contracted Providers, discovery of additional disciplinary or malpractice action within the prior 36 months will deem the Provider file as not clean. These matters will be presented to the Vice President of Clinical Services and/or their licensed designee for review. At the discretion of the Vice President of Clinical Services, and/or their licensed designee complaints and quality of care issues may be presented to the Peer Review and Credentialing Committee for review and final determination on continuation of a contract with the Provider. Committee minutes shall include the name of the committee member who recommended the termination/denial of network participation.

The Provider Relations Department shall maintain records evidencing the review and verification of each Provider, including records documenting each Provider's academic credentials, licenses or certifications, and reports from the National Practitioner Data Bank and Exclusion Databases.

The Plan Processing Department shall present any formal complaints or quality of care issues, received or discovered, to the Peer Review and Credentialing Committee for review at the next Peer Review and Credentialing Committee meeting. Upon re-credentialing of contracted Providers, the Provider Relations Department shall obtain a list of all complaints for the re-credentialed Provider from the Plan Processing Department. These shall be presented to the Vice President of Clinical Services, and/or their licensed designee for review before renewing a contract with the Provider. At the discretion of the Vice President of Clinical Services, and/or their licensed designee complaints and quality of care issues may be presented to the Peer Review and Credentialing Committee for review and final determination on renewal of a contract with the Provider.

The Peer Review and Credentialing Committee may recommend additional actions be completed for Providers whose State Board of Dentistry has issued disciplinary action. The Provider may be required to provide proof of completion of Board required trainings as well as DCO required training. Failure to complete the required actions may result in contract termination.

If a Provider is excluded from participating in Medicaid programs and this is discovered during the credentialing process, the DCO will send a denial of contracting letter to the Provider. Such letter will include instructions for the Provider's ability to appeal and correct any information in order to complete the credentialing process. If a Provider is excluded from participation in Medicaid programs and this is discovered during the re-credentialing process or the DCO's monthly exclusions monitoring process, the DCO will send a 60-day suspension notice to the Provider. Within those 60 days, the Provider may take the necessary action to have themselves removed from the Medicaid exclusions list and provide evidence of removal to the DCO. If the DCO does not receive evidence of the removal from the exclusions list the Provider will be retroactively terminated effective the date of exclusion. The DCO will report any Provider that has been identified as being on one of the exclusion lists during credentialing or re-credentialing to the appropriate CCO within 24 hours of the discovery.

On an annual basis the DCO shall review all credentialing denials/terminations to monitor and identify any potential discriminatory decisions. The DCO's Operations Staff will review if any Provider denied Providers meet the following categories: race, ethnic/national identity, gender, age, sexual orientation, type or cost of procedure performed, or type of enrollees treated (e.g. Medicaid, or high-risk population). If any potential discriminatory practices are discovered these shall be submitted to the DCO's Compliance Committee.

The DCO Provider Relations and Credentialing staff will complete training upon onboarding and annually regarding credentialing of providers and the delivery of covered cervices, applicable administrative rules, and the DCO's administrative policies.

Providers whose participation in the DCO's network has been denied, reduced, suspended, or terminated for quality of care/medical disciplinary causes or reasons are provided notice and opportunity for an appeal. This policy does not apply to practitioners who are administratively denied admittance to, or administratively terminated from, the DCO network. The notice of altered participation status is provided to the affected practitioner and includes:

- Detailed instructions on how to request an appeal (informal reconsideration or formal hearing)
- The action proposed against the practitioner by the Credentialing or Peer Review committee
- The reasons for the action
- The DCO policies and procedures that led to the committee's adverse determination

A Provider may choose to engage in an informal reconsideration and address the Peer Review and Credentialing Committee or move directly to dispute resolution involving an independent third-party arbitrator. Affected Providers who are not successful in overturning the original committee decision during an informal reconsideration are automatically afforded a fair hearing, upon request in writing within 30 days from the date of notice of the denial. A provider must request a reconsideration or fair hearing in writing.

If DCO delegates any of its responsibilities under this policy and procedure to a third party, DCO shall monitor the third party's compliance with the delegated responsibilities and the third party's performance, deficiencies, or areas for improvement. Upon identification of deficiencies, or areas for improvement, DCO shall cause the third party to take corrective action.

Providers have the right to receive a notice/copy of their rights as described in this policy. Providers can request a copy of the Provider's rights by calling the Provider Relations Department, by emailing ProviderRelations@advantagedental.com or by written correspondence.

REFERENCES
OAR 410-141-3510 Provider Contracting and Credentialing
OAR 410-141-3560 Resolving Contract Disputes Between Health Care Entities and CCOs

FORMS AND OTHER RELATED DOCUMENTS
Attestation of Signature Form
Ownership Disclosure Form
Provider Attestation for Policies
Agreement to Pay Form Attestation
Oregon Provider Credentialing Application (OPCA)
Oregon Provider Recredentialing Application (OPRA)

Revision History

Date:	Description
07/10/2013	Approval and adoption.
05/02/2014	Updates based on annual review.
02/23/2015	Updates based on annual review.

02/23/2016	Updates based on annual review.
10/29/2016	Updates based on CCO partner audit findings.
02/14/2017	Updates based on annual review.
03/12/2018	Updates based on annual review.
07/03/2018	Updates based on CCO partner audit findings.
11/13/2018	Updates based on CCO partner audit findings.
01/14/2019	Updates based on CCO partner audit findings.
06/05/2019	Updates based on annual review.
10/07/2019	Updates based on CCO partner audit findings.
12/05/2019	Conversion to revised policy and procedure format and naming convention.
12/16/19	Updates based on CCO partner audit findings.
05/19/2020	Updates based on CCO partner audit findings.
12/08/2020	Updates based on annual review.
11/15/2021	Updates based on annual review.
01/26/2022	Updates based on annual review.
06/02/2022	Updates based on CCO partner audit findings.
07/11/2022	Updates based on CCO partner audit findings.
08/25/2022	Updates based on CCO partner audit findings.
12/31/2022	Updates based on annual review.
11/13/2023	Updates based on annual review.
3/25/2024	Updates based on CCO partner audit findings.