



Pre-Delegation Credentialing Questionnaire

Market/State _____ **Lines of Business** _____

Survey questions and ALL requested documentation must be received to initiate the assessment process

Name of Organization:		
Address:		
City:	St:	Zip:
Contact Person and Title:		
Telephone:	Fax:	
E-Mail Address:		
Credentialing Manager:		
Telephone:	Fax:	
E-Mail Address:		
Name of person completing this form:		
Title:		
Phone:		
Date:		

REQUIRED DOCUMENTS (ALL must be received to initiate the assessment process):

- **Current Credentialing Program and/or Policy & Procedures** (current program/plan description and/or policies and procedures should meet 2022 NCQA standards which took effect 07/01/2022).
- **Credentialing Committee Minutes** at least three sets of Credentialing Committee meeting minutes within the past 12 months, including documentation of annual policy/procedure review. (Identifying information relative to practitioners (may be blinded)
- **Current List of Practitioners** (Include all providers identified in question #2 below) - This list will be used to randomly select provider files for the pre-delegation file audit. Please include the **practitioner's name, degree/title, specialty, initial credentialing date and most recent recredentialing date.**
- **Copy of Full Roster** (Current)
- **Copies of 2021 – 2022 ongoing monitoring logs, or appropriate documentation:** at a minimum:
 - State license sanction log
 - Office of the Inspector General sanction/exclusion log
 - Semi-annual review of complaints
 - Semi-annual review of adverse events
 - Medicare Opt-Out CMS.gov Affidavits List
 - SAM sanction/exclusion log
 - Preclusion List log
 - Medicaid Provider Termination or Exclusion List(s), if applicable
- **Current list of the Credentialing Committee/Board members, including their name, title and specialty.**
- **Sub-Delegation Agreement** (if you answer 'yes' to question #13 below)
- **Completed copy of Disclosure of Ownership Form** (attached)

1. Is your program NCQA Certified/Accredited? Yes No

2. Please select the types of providers included in your credentialing program:

Group credentials and recredentials the following practitioner types:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> ARNPs | <input type="checkbox"/> Dentists (DDS/DMD) | <input type="checkbox"/> Optometrists (OD) | <input type="checkbox"/> RN First Assistants |
| <input type="checkbox"/> Acupuncturists (Lac) | <input type="checkbox"/> Dieticians (RD) | <input type="checkbox"/> PA/PA-C | <input type="checkbox"/> Speech Language Pathologists |
| <input type="checkbox"/> Audiologists (CCC-A) | <input type="checkbox"/> Massage Therapists (LMP/LMP) | <input type="checkbox"/> Podiatrists (DPM) | <input type="checkbox"/> Surgical Assistants |
| <input type="checkbox"/> Chiropractors (DC) | <input type="checkbox"/> Naturopaths (ND) | <input type="checkbox"/> Physicians (MD/DO) | <input type="checkbox"/> Other: Specify _____ |
| <input type="checkbox"/> CRNAs | <input type="checkbox"/> Occupational Therapists (OT) | <input type="checkbox"/> Physical Therapist (PT) | <input type="checkbox"/> Pharmacists |

Behavioral Health Practitioners:

- ARNPs Chemical Dependency Counselors Psychologists (PhD/PsyD) Registered Counselors Other: _____
- Master's Level Therapists, including LCSW, LASW, LMFT Psychiatrists (MD/DO) Licensed Mental Health Counselors

Women's Health Practitioners:

- Certified Nurse Midwives Licensed Midwives Women's Healthcare Specialist ARNPs Other: _____

3. Does your program include facility credentialing? Yes No
a. **If yes, please provide *policies* and *list of facilities credentialed***

Please identify the types of facilities for which credentialing will be delegated to your organization:

- Hospitals
- Home Health Agencies
- Skilled Nursing Facilities
- Surgery Centers
- Behavioral Health Facilities
- Rehabilitation Centers
- Other: _____

4. Please indicate which of the following items you verify at the time of initial credentialing. Please list the source utilized after each.

<u>Verification:</u>	<u>Source:</u>
<input type="checkbox"/> State license	_____
<input type="checkbox"/> Hospital Privileges	_____
<input type="checkbox"/> Board Certification	_____
<input type="checkbox"/> Education/Training (if not Board Certified)	_____
<input type="checkbox"/> DEA Certificate	_____
<input type="checkbox"/> Professional liability history	_____
<input type="checkbox"/> Professional liability coverage	_____
<input type="checkbox"/> Previous disciplinary actions	_____
<input type="checkbox"/> Previous sanctions by Medicare	_____
<input type="checkbox"/> Work history of 5 last years	_____

5. Do you access the National Practitioner Data Bank for each applicant? Yes No

6. Who makes the final decisions relative to the credentialing process and applicants?

7. Please provide the following information regarding the Credentialing Committee:

How often does the committee meet? _____

How many members? _____

What constitutes a quorum? _____

Specialties represented on committee: _____

Is there documentation of appropriate discussion of applicants? Yes No

Do minutes include documentation to support the denial, termination or exceptions to policies?

Yes No

8. When credentialing, do you:

Accept all of the members of a given physician group practice (Tax ID) as a group?

Exclude individuals of the group (Tax ID) based on your credentialing standards?

9. When was your organization founded? _____

10. Does your organization have a formal recredentialing process? Yes No

Recredentialing Cycle: 24-month or 36-month

How many cycles of recredentialing have you performed? _____

11. **Centene Corporation** credentialing standards meet or exceed those published by NCQA and state regulations. If your Organization's current credentialing process does not meet these standards, are you willing to commit to changing your process to meet our standards in a specified time period?

Yes No

12. If we choose to delegate credentialing to your organization, will you agree to the following:

Allow our staff or designees to review your process and files in accordance with accrediting/regulatory body requirements?

Cooperate in a pre-assessment audit and subsequent oversight audits in accordance with accrediting/regulatory body requirements?

Allow **Centene Corporation** to maintain final oversight authority and to contractually retain the right to deny participation or terminate any individual provider without affecting the overall contractual relationship?

Allow **Centene Corporation** access to practitioner files on an as needed basis in accordance with any contractual agreement?

Agree to provide ongoing reporting as required by the Delegation Agreement?

13. Do you delegate ANY of your credentialing functions to any other party such as a hospital, credentialing verification organization, medical society, IPA, etc.? Yes No

If yes, please provide name of entity: _____

Is this entity NCQA Certified/Accredited? Yes No

Please also send a list of the Tax ID numbers to be associated with this Delegation.

Please return this document and all requested items to:

[Insert Contract Negotiator Name and Contact information] and DelCred-Corporate@CENTENE.COM

Thank you!