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 2024 NCQA standards which took effect 07/01/2024.
- ☐ **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 ***practitoner's name, degree/title, specialty, initial credentialing date and most recent recredentialing date***.
- ☐ **Copy of Full Roster** (Current)
- ☐ **Copies of 2024 – 2025 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.**
- ☐ **Credentialing System Controls Report and/or Credentialing Information Integrity Report**
- ☐ **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
   a. *If Certified/Accredited, please send a copy of your certificate.*
   b. *Are you, or have you been under Corrective Action with NCQA?* ☐ Yes ☐ No
      If YES, please provide an explanation. _____

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

Group credentials and recredentials the following practitioner types:

☐ ARNPs	☐ Dentists (DDS/DMD)	☐ Optometrists (OD)	☐ RN First Assistants
☐ Acupuncturists (Lac)	☐ Dieticians (RD)	☐ PA/PA-C	☐ Speech Language Pathologists
☐ Audiologists (CCC-A)	☐ Massage Therapists (LMP/LMP)	☐ Podiatrists (DPM)	☐ Surgical Assistants
☐ Chiropractors (DC)	☐ Naturopaths (ND)	☐ Physicians (MD/DO)	☐ Other: Specify_____
☐ CRNAs	☐ Occupational Therapists (OT)	☐ Physical Therapist (PT)	☐ 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.

Verification:	***Source:***
☐ State license	_____
☐ Hospital Privileges	_____
☐ Board Certification	_____
☐ Education/Training (if not Board Certified)	_____
☐ DEA Certificate	_____
☐ Professional liability history	_____
☐ Professional liability coverage	_____
☐ Previous disciplinary actions	_____
☐ Previous sanctions by Medicare	_____
☐ 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.

Policies and Procedures
Last Revision/Reviewed Date? _____

Please return this document and all requested items to:

*Contract Negotiator Name*_____
*and Contact information*_____
and ***DelCred-Corporate@CENTENE.COM*** **&** ***Lrivolta@centene.com***

Thank you!