

Name:	Credentialing and Recredentialing
Date of Origin:	10/23/2002
Current Effective Date:	6/19/2024
Scheduled Review Date:	6/19/2025

I. CREDENTIALING POLICY

Capitol Dental Care (CDC) participating providers will be initially credentialed and recertified every three years thereafter, based on criteria patterned after NCQA Health Plan Accreditation requirements.

II. CREDENTIALING PROCEDURES

CDC credentials and recertifies the following practitioners:

- Dentists with a DDS or DMD degree
- Dentists with a DDS or DMD degree and advanced training or certification(s), e.g., pediatric dentists, endodontists, orthodontists, periodontists, or oral surgeons
- Expanded practice dental hygienists (EPDHs)
- Denturists
- Dental Therapists

For purposes of this policy, these practitioners are known as dental providers. It is CDC’s policy as well as the policy of OHP that no provider is eligible for reimbursement of Federal program dollars until such time as the provider is credentialed or recertified, as applicable.

A dental provider **approved through our prospective provider process** will complete –the Oregon Practitioner Credentialing Application, including questions regarding his/her education; employment history; hospital affiliations; professional liability malpractice insurance history; physical and mental health status; lack of impairment due to chemical dependency/substance abuse; history of loss of license and/or felony convictions; and history of loss or limitation of any dental privileges or disciplinary activity.

The dental provider will confirm through his/her signature on the application that it has been filled out completely and all statements are true and accurate. The application includes an Authorization and Release of Information, which allows CDC to primary source verify the required information.

When credentialing providers or provider types designated by Centers for Medicare and Medicaid Services (CMS) as “moderate” or “high” risk, CDC will not execute any contract with such Providers unless the Provider has been approved for enrollment by OHA. OHA is responsible for performing site visits for such “moderate” or “high” risk Providers and for ensuring that such “high” risk Providers have undergone a fingerprint based background check. For a Provider who is actively enrolled in Medicare and has undergone a fingerprint-based

background check as part of Medicare enrollment, OHA deems this Provider to have satisfied the same background check requirement for OHA Provider Enrollment.

III. Credentialing System Controls

How Credentialing information is stored, modified and secured:

- All files and provider information including our provider database is stored electronically on a secure drive and inside a secure folder. Older (archived) files are stored separately from active provider files but located inside the same secure folder (credentialing path).
- Only roles involving the credentialing process have access to the credentialing path. This includes:
 - Credentialing coordinator(s) who are directly responsible for requesting, storing, processing and updating provider files,
 - Dental Director, responsible for accessing, reviewing and approving provider files,
 - Office administrator, who also acts as a backup for credentialing and monitors document retention,
 - President, and
 - Director of Operations.
- Access to the secure credentialing file is assigned by role, employee ID and added to the individual permissions which is password-protected via their Windows login. Each log-in is unique to each user and cannot be shared with others. Each log-in requires a password complexity consisting of at least 8 characters including at least one capital and one number. Passwords must be updated annually and upon suspicion that a password may have been shared. Once the staff member is termed, their equipment is returned and their access is revoked including all windows logins.

Receiving and saving credentialing information

- All files are stored electronically on the credentialing path. All older paper files have been scanned into the archive folders found on the credentialing path and their original forms are stored at Iron Mountain for an indefinite retention period. Files submitted via paper (fax or mail) are scanned into our system and their paper originals safely shredded.
- Documentation provided for the credentialing process is watermarked with the date in which it was received. All original documentation is saved in an original file with the date of receipt.
- Any new materials added will be dated by watermark and noted on the checklist as received as well as noted in the tracker. PSV documentation is dated with the printed date on the bottom of each page **and** time stamped "Reviewed" by the person processing the file.
- Once the file is completed by the processor, all documentation and PSV's are complete and the checklist is complete the processor will apply their signature and place a final time stamp on the checklist next to their signature. This means the file is complete and ready for review. All timestamps are expected to be time/dated PRIOR to that final time stamp indicating all items were collected and reviewed prior to the file being completed. See Application Review by the Dental Director for next steps.

Changes and Modification

- No direct modifications or changes to a document is allowed including deleting original documents, altering time stamps, removing information via white out or electronically manipulating a file. Only a provider can make updates or alterations to a file including providing updated documentation, changing or altering an OPCA/OPRA or applying their signature. At times, a processor can make additional notes to help communicate a process and will be completed in a different color and should include a date and initial. Updates to a file such as a name change, update of PLI, license, DEA etc. can be made. These are typically stored OUTSIDE a credentialing file and marked as “Updates”. These are typically performed outside a file process. No other person(s) other than the processor can add new materials to an active file, make notes on a file or make updates.
- Once a file is completed, signed and stamped by the processor, it cannot be changed, altered or have additional information added to a file. If new information is presented, it should be watermarked, saved and a new review time/date stamp applied. Oversight controls for changes are monitored by yearly internal audit process. Starting 7/1/2022, all files completed will be subject to a random sample audit which will be performed once per calendar year 1/1-12/31. The audit is to be completed by our compliance officer who is NOT part of the original credentialing process. The number of files will be 5% (minimum 10 and maximum 50) of all files completed (recredentialed or initially credentialed). The files are reviewed for non-compliant modifications as described above. Any findings will be shared at QI. If there is evidence of inappropriate modifications, we will complete coaching with the processor and implement a quarterly monitoring process to assess the effectiveness of its actions on all findings until it demonstrates improvement for one finding over at least three consecutive quarters.

IV. INITIAL CREDENTIALING

Primary Source Verification within the Credentialing Process

For the initial credentialing of a dental provider, CDC will primary source verify the following records as applicable, and within the prescribed time limits:

- National Practitioner Data Bank history
 - Professional Education; sources are Oregon Board of Dentistry and Board of Denture Technology
 - A current, valid, active license to practice and any history of consent orders; sources are The Oregon Board of Dentistry and The Board of Denture Technology
 - Board certification status, if applicable
 - A valid DEA certificate registered in Oregon, or Prescribing Plan (not applicable to hygienists and denturists)
 - Current, adequate malpractice insurance in accordance with the contract requirements
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- Details involving potential malpractice claims history based on information collected via the credentialing process
- Work history of the last 5 years; gaps greater than 2 months must be explained
- Verification of hospital privileges, if applicable
- OIG and SAM queries, to confirm the dental provider is not debarred or excluded from the Medicaid or Medicare programs or any other federal program
- Collaborative Agreement for EPDHs working outside of a clinic setting
- Covid-19 Vaccination Mandate Attestation

A site visit to view and observe the office structure and record keeping practices will be conducted when CDC identifies a need for this additional information.

Application Review by the Dental Director

Following review and verification of the credentialing application materials by the Credentialing staff, the credentialing file is then reviewed by CDC's Dental Director.

CDC's Dental Director shall have the authority to determine that a file is "clean," i.e.:

- The file is complete and is free from any gaps, missing information, or inconsistencies with respect to either content or timeframe
- All records have been primary source verified
- No additional gaps, questionable issues, inconsistencies, or sanctions exist with respect to the applicant

Upon determination that a file is clean, the Dental Director shall have the authority to approve the application. The effective date of a provider's record is determined by the director's approval date. For staff affiliated providers (such as the Smile Keepers and Gentle Dental group) we will accept their hire date as their effective date due to the corporate hire process which includes the same PSV process as Capitol Dental Credentialing.

The Director must apply her signature to each file on the Credentialing Checklist, Date the signature AND apply a "Reviewed" stamp which includes her name, date and time. All time stamps applied to the file should precede this time stamp. Once the file has been approved, the provider is loaded into our database as an active provider.

The Role of the Quality Improvement Committee in the Credentialing Process

Any applications that are considered complete but that evidence remaining questionable issues or indicate the existence of potential sanctions or adverse incidents are forwarded to the Quality Improvement Committee (QIC or QI Committee) for further review and decision. Please refer to the QIC Credentialing Review Summary Template for a detailed process of files that are sent to QIC.

The QI Committee includes multiple practitioners as well as CDC administrative staff. All

practitioners that participate and advise the QI Committee on credentialing issues are themselves credentialed and serve as participating providers within CDC's network.

CDC's Quality Improvement Committee meets at least 6 times per year to accept or deny a provider's application for credentialing with CDC. The QI Committee may meet with greater frequency in response to matters requiring urgent attention. In such cases, the QI Committee will follow its policies and procedures regarding quorum or voting requirements for off-cycle meetings.

The Committee will review completed credentialing files received from the Dental Director in a fair and impartial manner consistent with CDC policies and procedures. It is the practice of the Committee to have the Dental Director or his or her designated dentist participate in the Committee's review process.

In addition to reviewing Member grievances against providers at the time of recredentialing, the QIC will also review them at their bi-monthly meeting.

Applicant Communication throughout the Review Process

It is the practice of the Committee to keep the applicant apprised of the status of the application throughout the review process, whether upon request or as a courtesy to coincide with an upcoming QI Credentialing Committee review. This includes the right of an applicant to request a review of information submitted on behalf of the applicant as well as information collected from outside sources—with the exclusion of references, recommendations, and peer-review protected information.

Should an applicant request a review of this information, the Committee shall deliver a copy to the applicant within 10 days of a request. Applicants' requests for a copy of the pertinent file information must be made in writing and directed to the Chair of the QI Committee.

When an Applicant Requests File Review

The applicant may submit additional documentation to clarify or correct existing information in the application. This documentation must be submitted to the Committee Chair within 30 calendar days following the applicant's receipt of the file from the Committee, unless the applicant requests an additional reasonable time (not to extend 20 days) due to extenuating circumstances.

The burden shall be on the applicant to demonstrate that the information in the applicant's file that he or she wishes to correct or clarify is ambiguous, incorrect, or erroneous. The additional information submitted by the applicant must be detailed and clearly identify which previous information it addresses, including but not limited to necessary timeframes, names, and dates, as well as other third-party or agency outcomes that would reflect favorably on the applicant's application.

If necessary, after receiving the applicant's additional information, the Chair will call an out-of-cycle Committee meeting (which may be held by telephone conference) to review the applicant's updated submission. The Committee shall respond in writing with its decision to the applicant within ten (10) calendar days of receipt of the applicant's response.

The Committee shall be under no obligation to accept any additional information from the applicant beyond the ten (10) day window noted above. Additionally, the Committee may accept or reject the applicant's submitted additional information.

If the Committee decides that the additional documentation does not meet the burden to support a correction of information in the file, the Committee may decide to deny the applicant's application for credentialing. There shall be no right of appeal from this decision.

When the Committee Identifies Variations in Information

If during the review process the Committee discovers information of a material nature that varies substantially from the information provided to CDC by the applicant, the Committee may require additional time to complete the review process.

In this circumstance, the Committee shall notify the Applicant in writing of the nature of the information discovered and request that the applicant respond to the Committee's inquiry within 10 days of the date of the letter. The applicant may include any supporting documentation or records in responding that bear upon any potential inconsistencies or unresolved questions posed by the Committee.

After receiving the response, the Committee will notify the applicant in writing of receipt and inform the applicant of the date by which it will make its decision, no more than sixty (60) days from the date of receipt of the response.

If the applicant fails to respond within thirty (30) days to the Committee's letter requesting clarification of gaps in the application (or fails to request additional time due to extenuating circumstances), the Committee shall presumptively conclude that the unresolved gap, issue, or concern either renders the application ineligible for credentialing or does not qualify as a finding sufficiently material in nature to deny credentialing.

The Committee is under no obligation to accept information submitted by the applicant beyond the above referenced timeframe. However, the applicant is not barred from resubmitting a new credentialing application subject to CDC's policies and procedures relating to approved timelines for resubmittal of a new application.

Where the review process does not require any additional requests for documentation from the applicant, Capitol Dental shall notify the applicant of the Committee's credentialing decision in writing within sixty (60) days of making the credentialing decision. The Committee shall notify the applicant of the reasons for the decision, regardless of whether the applicant's application was approved or denied.

Additional guidance regarding the Committee’s decision-making process can be found at the end of this policy under “Credentialing Requirements Criteria.” Minutes will record the deliberations of the Committee with respect to this review process and be retained for at least 3 years.

As part of the credentialing review process, the Committee will regularly monitor the Oregon Board of Dentistry minutes regarding actions that may impact the applicant (or existing credentialed providers). The Oregon Board of Dentistry newsletter will also be monitored for pertinent information of the same nature.

Additional Oversight and Tracking of all CDC Providers

The CMS website, which identifies sanctions regarding providers in the Medicaid program, will be reviewed monitored regarding CDC’s panel providers by the QI Committee. Sanction will be included in the Capacity Report as applicable.

A credentialing file will be maintained on each credentialed provider that includes all credentialing information. The file is retained as a sub-folder inside the provider file, that it may be a resource in any credentialing decision.

CDC’s online provider directory is consistent with credentialing data, through regular synchronization of the directory from the credentialing database.

V. CONFIDENTIALITY

The Committee places the highest priority on maintaining the confidentiality of applicants’ information during the credentialing and recredentialing process, and it does not share any information outside of the Committee and with Executive Management except as required by law.

The process of maintaining confidentiality within the Committee includes the following:

- Committee members sign confidentiality agreements, committing to maintain the confidential nature of the review process.
- Credentialing files are kept in locked filing cabinets or password-protected electronic folders.
- Encryption software is utilized when delivering emails among members where confidential information is shared.
- If the Committee meets in a public venue, it reserves a private room within that venue to ensure that the confidentiality of the discussions is not compromised.
- The Committee receives training on the HIPAA Privacy and Security Rules.

VI. RECREDENTIALING:

Recredentialing occurs at least every **three years** and may occur sooner if warranted.

The recredentialing process is consistent with the requirements for initial credentialing. The Oregon Practitioner Recredentialing Application includes a current statement by the dentist regarding physical and mental health status; lack of impairment due to chemical dependency/substance abuse; and any changes or updates in information since the last application was submitted.

The provider will confirm through his or her signature on the application that it has been filled out completely and that statements are true and accurate.

Primary source verification consistent with that indicated under initial credentialing will be conducted. This will include a review of the following records as applicable:

- National Practitioner Data Bank history
- A current, valid, active license to practice as well as any history of consent orders; sources are The Oregon Board of Dentistry and The Board of Denture Technology
- Board certification status, if applicable
- A valid DEA certificate registered in Oregon, or Prescribing Plan (not applicable for hygienists or denturists)
- Current, adequate malpractice insurance in accordance with the contract requirements
- Details involving potential malpractice claims history based on information collected via the credentialing process
- Work history of the last 3 years; gaps greater than 2 months must be explained
- Verification of hospital privileges, if applicable
- OIG and SAM queries, to confirm the dental provider is not debarred or excluded from the Medicaid and Medicare programs or any other federal program
- Collaborative Agreement for EPDHs working outside of a clinic setting

Additionally, credentialing staff shall monitor the meeting minutes posted on the Oregon Board of Dentistry website, no less than bimonthly, regarding credentialed providers that may have received disciplinary action. Credentialing staff shall present relevant Board actions to the QI Committee.

Where the Board delays release of this information and credentialing staff are on notice of a possible action, the staff shall email or call the Board to confirm the status of any suspected actions.

All participating providers must adhere to the recredentialing requirements in order to remain in good standing and continue to treat CDC members. Failure to be recredentialed in accordance with the provider's recredentialing due date will result in administrative termination. In such a case, the credentialing staff will notify the provider in writing that he or she has been termed from the CDC network and that payment will not be made to any provider whose participation has been termed. In order to be re-activated as a CDC participating provider, initial credentialing must be completed and approved.

In addition to the above criteria, the Committee may also consider member complaints, service area needs, results of external/internal quality reviews, site visits, utilization reviews, and/or member satisfaction surveys as part of its decision to recredential a provider. In addition to reviewing Member grievances against providers at the time of recredentialing, the QIC will also review them at their bi-monthly meeting.

A provider's application will be reviewed in conjunction with CDC's Credentialing Requirements Criteria, which are found at the end of this policy.

DEFINING INELIGIBILITY/EXCLUSION – PROHIBITED ACTS

CDC's QI Committee defines an individual or entity as ineligible to be credentialed, per se, that:

- Is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in federal procurement or non-procurement programs; or
- Has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible.

Furthermore:

1. In accordance with 42 CFR § 1002, CDC will not pay for services provided by a provider who has been excluded by either the U.S Department of Health and Human Services Office of Inspector General (HHS OIG) exclusion lists or the General Services Administration (GSA) debarment lists.
2. CDC will review both lists prior to hiring or contracting with a new employee, temporary employee, volunteer, consultant, governing body, member, or all related entities.
3. CDC reviews all OIG and GSA lists monthly to ensure that none of its providers is excluded or has become excluded from participation in Federal programs.
4. CDC shall not maintain a relationship with an excluded provider who has been convicted of a criminal offense, has had civil money penalties or assessments imposed, or has been excluded from participation in Medicare or any of the State health care programs. Such a person includes one who:
 - Has a direct/indirect ownership interest of 5% or more in the entity;
 - Is the owner in whole or part of an interest in any mortgage, deed of trust, or other note secured by the entity;
 - Is an officer or director of the entity;
 - Is an agent (any person who has express or implied authority to obligate or act on behalf of an entity);
 - Is a managing employee (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity;

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- Has failed to provide payment information that is requested to determine whether such payments are or were due;
 - Has failed to grant immediate, reasonable access to records to perform reviews and surveys, to exam performance of the statutory functions, or for the purpose of conducting activities related to the fraud control unit;
 - Has failed to comply with a corrective action plan; or
 - Has defaulted on a health education loan or scholarship obligations.

VII. EXCLUSION AND THE APPEAL PROCESS

Before enforcing an exclusion, CDC affords the provider the opportunity to submit additional documents and a written appeal against the exclusion. This pertains only to the provider's right to disprove the exclusion. Reinstatement after exclusion may only be executed by the agency that imposed the exclusion.

Termination upon Ineligibility

If an individual has become ineligible to participate in Federal health care programs or in Federal procurement or non-procurement programs, the provider will immediately be relieved from his or her responsibilities, or the business will immediately be discontinued.

In addition, when a credentialed provider is terminated for cause, or has been identified as being on a government Exclusion list or is rendered Ineligible, CDC is required to notify the National Practitioner Data Bank of such termination within fifteen (15) days of such termination. CDC is required to deliver a Data Bank record reflecting that termination to its State Dental Board.

Interventions through Corrective Action Plan

In circumstances where a provider demonstrates a pattern of poor quality or indicates other behaviors that shed a negative light on the dental care experience, the QI Committee, at the direction of the Dental Director may review the provider's conduct or delivery of care and implement interventions in an effort to correct negative conduct or behaviors. These interventions may include, but are not necessarily limited to a) formal inquiry before the QI

Committee to provide status report on steps the provider is taking to address the concerns b) provider recredentialing by the QI Committee within a period earlier than the standard three (3) year window, b) reduction of privileges, c) suspension from plan participation d) some other appropriate intervention as determined by the QI Committee.

VIII. TEMPORARY APPROVAL OR PROVISIONAL CREDENTIALING

From time to time, CDC'S QI Committee may determine that it is in the best interest of the organization and its members to grant a dentist Temporary Provider Status or Provisional Provider Status. The decision to grant either status may, but is not necessarily limited to, the need to provide services to an access -hampered area, monitor the progress of a provider faced

with a particular personal challenge, address time constraints associated with the bi-monthly schedule of the Quality Improvement Committee, or obtain additional information regarding a credentialing concern.

For purposes of this policy “Temporary Provider Status” is defined as “the granting of provider recognition for a designated period of time, with status to lapse either on a date certain, at the end of a set period of days or as a result of a condition having been met.” Based on the Committee’s determination of the circumstances surrounding the provider’s application, Temporary Provider Status may be replaced by permanent CDC Provider status or CDC may determine that no additional provider status is available at such time as the temporary status has lapsed.

For purposes of this policy, “Provisional Provider Status” is defined as granting recognition as a fully credentialed provider subject to final approval by the QI Committee or other requirement imposed by CDC. Upon review and approval by the Committee, the provider will be granted “Full Provider Status” without provision or limitation. CDC shall ensure that any provider granted the status of “Temporary Provider Status” or “Provisionally Provider Status” will be notified in writing of any change in that status.

IX. PROHIBITION ON DISCRIMINATION (42 CFR § 422.205)

CDC does not discriminate in terms of participation, reimbursement, or indemnification against any health care professional who is acting within the scope of his or her license or certification under state law solely on the basis of the license or certification. CDC does not discriminate based on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, or the practitioner’s specialty or clientele, i.e., CDC will not discriminate against a provider who serves high-risk populations or who specializes in high-cost treatments.

Due to its mission in serving primarily Oregon residents outside the non-commercial health plan segment, CDC is limited in the types of providers it employs. However, it does not discriminate within the provider types that it does employ, i.e., dentists, denturists, and dental hygienists. Pursuant to statutory requirement and to meet the needs of CDC’s members, CDC will furnish written notice to any provider who inquires about its nondiscrimination policies.

CDC monitors for discrimination by tracking providers that have been termed or denied participation and reporting this list to QI Committee at least annually.

X. REDUCING, SUSPENDING, AND TERMINATING DENTIST PRIVILEGES:

The QI Committee will regularly monitor and review providers’ quality of care. When warranted, and in response to identified deficiencies or an adverse event—the QI Committee may be required to reduce, suspend, or terminate a provider’s privileges with CDC.

Additionally, the QI Committee will decide if the deficiency or adverse event requires that it make a referral to the Board of Dentistry or another appropriate agency. A special meeting of the QI Committee will be held for the purpose of reviewing such deficiencies or adverse events.

Should a serious quality deficiency or adverse event occur that poses a hazard to a member, the Dental Director will decide how best to respond to the alleged deficiency, and that response may include disciplinary action up to and including immediate suspension or termination of the provider.

When a provider is to be terminated for cause—the Dental Director (or her agent) or the QI Committee Chair (if the decision lies with the Committee) will notify the Board of Dentistry of the termination within ten (10) days, subject to the resolution of any appeal proceedings or the expiration of any appeal window if no appeal was submitted on behalf of the provider.

Additionally, CDC is required to notify the National Practitioner Data Bank of provider terminations for cause, within thirty (30) calendar days of the date the action was taken.

Written notice from the Committee will be sent to a provider (by certified mail, return receipt requested) when provider participation is denied or when provider privileges have been reduced, suspended, or terminated by the QI Committee. The action regarding participation will become effective on the date specified in the notification letter.

A participating provider whose participation has been denied or whose privileges have been reduced, suspended, or terminated may request an appeal of those actions. A request for an appeal must be made by the provider in writing and postmarked within 30 days of the date of the notice of the action.

The provider may submit any documentation in response to the letter. When an appeal of a termination is submitted, the QI Committee will designate a Peer Review Subcommittee, consisting solely of licensed practitioners, to review the appeal at a special meeting to be scheduled by the Subcommittee, no later than 30 days from receipt of the request for appeal.

The provider may attend the appeal meeting and may be represented by an attorney or other person of their choice. When the meeting is concluded, the Subcommittee will make a decision regarding the appeal and decide to either uphold the Committee’s initial action or reverse/alter it. In every case, the provider will be advised in writing within 15 days of the Subcommittee’s decision.

XI. REVISION ACTIVITY

Revision Date	Revision and Rationale	Effective Date
10/1/2006	Annual Update/Review	10/1/2006
12/1/2008	Annual Update/Review	12/1/2008
4/28/2010	Annual Update/Review	04/28/2010
4/25/2012	Annual Update/Review	4/25/2012
4/13/2015	Annual Update/Review	4/13/2015
6/25/2015	Review in response to audit findings	6/25/2015
4/30/2018	Review in response to audit findings	4/30/2018
6/14/2018	Annual Update/Review	6/14/2018

6/20/2019	Annual Update/Review	6/26/2019
6/24/2020	Annual Review	6/24/2020
10/11/2021	Revision	10/20/2021
08/17/2022	Revised	08/17/2022
12/07/2022	Revised	12/07/2022
05/09/2023	Revised	05/09/2023
6/21/2023	Annual Review	6/21/2023
6/19/2024	Review only.	6/19/2024

XII. AFFECTED DEPARTMENTS

- All CDC Providers

XIII. REFERENCES

OAR 410-141-3510

XIV. CRITERIA

**Capitol Dental Care
Credentialing Requirements Criteria**

To deny, provisionally/temporarily approve, or fully approve a provider’s application for membership:

1. A provider must meet all minimum credentialing requirements as identified in CDC’s credentialing application, policy, and procedures, i.e., education, licensure, malpractice insurance, and have an office location in or adjacent to a service area county. If a provider does not meet all minimum requirements, the Committee will deny the application for membership.

For purposes of meeting the malpractice insurance requirement, the provider must submit proof of professional liability claims history that covers the most recent five (5) year period.

A provider that fails to complete the credentialing application in full, even if he or she would otherwise qualify for credentialing, cannot be approved for participation.

2. A provider who has had an incident/complaint with a Board or other agency resulting in discipline or reprimand will be reviewed by the Dental Director and may be presented to the Committee as described below.

The number of incident(s); severity of the incident(s); number of years in practice; length

of time between incident(s); and whether the provider is in compliance with a Board or other agency Corrective Action will be considered as mitigating factors in the decision-making process.

- a. If a provider is in compliance with a Corrective Action plan, the Committee may either deny, provisionally approve, or approve the application for membership at its discretion.
 - b. If a provider is not in compliance with a Corrective Action plan, the Committee will deny the application for membership.
3. A provider who has had an incident/complaint with a Board or other agency involving sexual misconduct with a patient, resulting in discipline or reprimand, will be denied participation.
4. A provider who has omitted or misrepresented information on the application will be given an opportunity to provide an explanation or correction. The Committee will review the explanation/correction and the nature of the omission or misrepresentation and will either deny, provisionally approve, or approve the application for membership at its discretion.
5. A provider who has had two (2) malpractice claims paid within a 5-year period that total 2 times the average settlement amount as established by insurance industry guidelines will be reviewed by the Committee.

The number of claim(s); severity of the claim(s); number of years in practice; and length of time between claim(s) will be considered. The Committee will either deny, provisionally approve, or approve the application for membership at its discretion.