

Credentialing and Recredentialing (23rd ed.)

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Scope:

Practitioners are within the scope of credentialing if all criteria listed below are met:

- Practitioners are licensed, certified or registered by the state to practice independently (without direction or supervision).
- Practitioners have an independent relationship with Humana (an independent relationship exists when Humana directs its members to see a specific practitioner or group of practitioners, including all practitioners whom a member can select as primary care practitioners).
- Practitioners provide care to members under Humana’s medical, dental and vision benefits.

Credentialing Criteria apply to practitioners in the following settings:

- Individual or group practices
- Organizational providers
- Rental networks
- Telehealth

Unless otherwise required by applicable law, practitioners who do not require credentialing include:

- Practitioners, including hospitalists and extenders (who are not individually contracted and who do not print in the directory) who practice exclusively in the inpatient setting and who provide care for members only as a result of members being directed to the hospital or another inpatient setting. This includes hospital-based anesthesiology, emergency medicine, hospitalist, neonatology, pathology and radiology providers.
- Practitioners who practice exclusively in freestanding facilities and who provide care for members only as a result of their being directed to the facility
- Pharmacists who work for a pharmacy benefits management (PBM) organization
- Covering practitioners (e.g., locums tenens) who do not have an independent relationship with Humana
- Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants)
- Rental network practitioners who are specifically for out-of-area care
- Non-licensed applied behavior analysis (ABA) providers
- Physician extenders who do not act as a primary care physician (PCP) and who do not print in the directory. This includes nurse anesthetists, registered nurses and registered nurse first assistants, as well as surgical assistants and surgical first assistants. See “Types of Practitioners to Credential and Recredential” regarding Nurse Practitioners and Physician Assistants.

Policy Statement:

This policy defines the credentialing and recredentialing process for selecting and evaluating licensed and independent practitioners and the assessment process for organizational providers who provide care to Humana members. Consistent with Humana’s mission to assist members in achieving life-long well-being, the goal of this policy is to enable selection of qualified practitioners and providers.

In some circumstances, Humana is subject to certain credentialing requirements, such as state and federal regulations, that exceed or differ from those outlined in this policy. An addendum to Humana's Credentialing and Recredentialing Policy is maintained by Humana's Commercial and Specialty Regulatory Compliance Department to ensure compliance with state requirements that exceed current CMS and NCQA requirements.

Additional compliance with individual state Medicaid credentialing and recredentialing requirements are governed by Humana’s separate individual state policies.

Definitions:

“Humana” means Humana Inc. and its affiliates and subsidiaries that underwrite or administer health, dental or vision plans, long-term services and support (LTSS), CarePlus Health Plans Inc. and Health Value Management Inc., d/b/a ChoiceCare Network and d/b/a Humana Behavioral Health Network.

“Humana members” means participants in health, dental and vision plans, LTSS and programs provided by Humana.

An “independent relationship” exists when Humana directs its members to see a specific provider, including all practitioners whom a member can select as a primary care provider, to provide care under Humana’s medical benefit.

“Organizational providers” means providers described as hospitals or other healthcare facilities.

“Telehealth Services” includes “OM Telehealth Covered Services,” “Additional Telehealth Covered Services,” and “Supplemental Telehealth Covered Services,” provided to Medicare plans as outlined in the Claims Payment Policy CP2008102 or its successor policy, and any telehealth services that are covered by any Humana commercial and Medicaid plans.

Other terms are defined throughout this policy.

Requirements:

Standard: Types of Practitioners to Credential and Recredential

Practitioners who require credentialing include all participating practitioners who fall within the scope of credentialing, not limited to:

Medical practitioners:

- Medical doctors
- Oral surgeons
- Chiropractors

- Osteopaths
- Podiatrists
- Dentists
- Optometrists
- Nurse practitioners
- Physician assistants
- Other medical practitioners who may be within the scope of credentialing and who are licensed, certified or registered by the state to practice independently or as required by state regulations. This category may include Doctor of Pharmacy practitioners who practice within a medical office setting.

Behavioral health practitioners:

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or master's level psychologists who are state certified or licensed
- Master's level clinical social workers who are state certified or licensed
- Master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
- Other behavioral health specialists who may be within the scope of credentialing. Who are licensed, certified or registered by the state to practice independently or as required by state regulations.

All practitioners requiring credentialing should complete the credentialing process prior to the provider's contract effective date, except where required by state regulations. Additionally, a provider will print in the provider directory only when credentialing is complete.

Standard: Verification Sources for Credentialing and Recredentialing

Verification of credentialing information should come from one of the following sources:

- The primary source (or its website), the entity that originally conferred or issued the credential
- A contracted agent of the primary source (or its website)
- Another National Committee for Quality Assurance (NCQA)-accepted source (or the source's website) listed for the credential

Appropriate documentation of verifications includes:

- Credentialing documents signed (or initialed) and dated by verifier.
- A checklist,* including the name of the source used, the date of verification, the signature or initials of the person who verified the information and the report date, if applicable. If the checklist does not include these requirements, appropriate credentialing information should be included.
- Copies of credentialing information and checklist. If the checklist does not include checklist requirements, appropriate credentialing information should be included.

*This checklist must have a single signature and a date for all verifications that has a statement confirming the signatory verified all of the credentials on that date. The statement should include the source and report date of each verification, if applicable.

Humana assigns each member of its credentialing staff a unique electronic identifier. The identifier, along with the date of verification, verification source and report date, if applicable, are recorded as part of the credentialing and recredentialing process in the automated credentialing system.

Education and training verifications do not expire, are valid indefinitely and must be completed prior to Credentials Committee decisions. All other credentialing verifications must be completed within 180 calendar days prior to the Credentials Committee's decision date.

The following sources may be used to verify credentialing information:

Licensure (current and valid in all states where the practitioner provides care to Humana members, unless practitioner meets exception for Indian Health Care Improvement Act)

Verification should come directly from the state licensing or certification agency.

Compact licensures are accepted in states that are actively issuing and accepting compact privileges. A physician or non-physician practitioner working under the authorization of a compact must meet both the licensure requirements outlined in the primary state of residence and those established by the compact laws adopted by the legislatures of the interstate compact states.

NOTE: Physicians and other practitioners providing Telehealth Services must hold appropriate licensure, certifications, and registrations (including Drug Enforcement Agency [DEA] registration if applicable) and comply with applicable professional practice standards and telehealth requirements in the state(s) in which they practice and also in the state(s) in which any Humana member receiving Telehealth Services is located at the time of such encounter. See the Telehealth Credentialing and Recredentialing Standards for more detail on applicable requirements for physicians and other practitioners providing Additional Telehealth Covered Services (as described in Claims Payment Policy CP2008102).

DEA and a controlled dangerous substance (CDS) certificate (current and valid in all states where the practitioner provides care to Humana members)

- Confirmation with the state pharmaceutical licensing agency, where applicable
- DEA and CDS certificate
- Documented visual inspection of the original certificate
- Confirmation with the DEA and CDS agency
- Confirmation with the American Medical Association (AMA) Physician Master File
- American Osteopathic Association (AOA) Physician Profile Report or Physician Master File (DEA only)

NOTE: If the practitioner states in writing that they do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances, they are therefore not required to have a DEA/CDS certificate, but must describe their process for handling instances when a patient requires a controlled substance. Humana includes the practitioner's statement and process description in the credentialing file.

If practitioner is practicing in a state where a CDS is not required, only DEA will be required.

Education and Training

Verification of the highest of the three levels of education and training obtained by the practitioner:

- Graduation from medical or professional school
- Residency, if appropriate
- Board certification, if appropriate

Physician (M.D. or D.O.)

Graduation from medical school

- Medical school
- AMA Physician Master File
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File
- Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986
- Association of schools of the health professions, if the association performs primary-source verification of graduation from medical school. At least annually, Humana should obtain written confirmation from the association that it performs primary-source verification of graduation from medical school.
- State licensing agency, if the state agency performs primary-source verification. At least annually, Humana should:
 - Obtain written confirmation from the state licensing agency that it performs primary-source verification
OR
 - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information.

Completion of residency training:

Residency training program

- AMA Physician Master File
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File
- Association of schools of the health professions, if the association performs primary-source verification of residency training. At least annually, Humana should obtain written confirmation from the association that it performs primary-source verification of residency training.

- State licensing agency, if the state agency performs primary-source verification of residency training. At least annually, Humana should:
 - Obtain written confirmation from the state licensing agency that it performs primary-source verification of residency training OR
 - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including residency training
- The Federation Credentials Verification Service (FCVS) for closed residency programs

Chiropractor:

Graduation from chiropractic college

- Chiropractic college whose graduates are recognized as candidates for licensure by the regulatory authority issuing the license
- State licensing agency, if the state agency performs primary-source verification of graduation from chiropractic college. At least annually, Humana should:
 - Obtain written confirmation from the state licensing agency that it performs primary-source verification of graduation from chiropractic college OR
 - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including graduation from chiropractic college.

Oral surgeon:

Completion of residency

- Training programs in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation (CODA)
- Appropriate specialty board if the board performs primary-source verification of graduation from a CODA-accredited training program. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of graduation from a CODA-accredited training program.
- State licensing agency, if the state agency performs primary-source verification of graduation from a CODA accredited training program. At least annually, Humana should:
 - Obtain written confirmation from the state licensing agency that it performs primary-source verification of graduation from a CODA accredited training program OR
 - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including graduation from a CODA accredited training program.

Podiatrist:

Graduation from podiatry school

- Podiatry school
- Appropriate specialty board, if the specialty board performs primary-source verification of podiatry school graduation. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of graduation from podiatry school.
- State licensing agency, if the state agency performs primary-source verification of graduation from podiatry school. At least annually, Humana should:
 - Obtain written confirmation from the state licensing agency that it performs primary-source verification of graduation from podiatry school OR
 - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including graduation from podiatry school.

Completion of residency

- Residency training program
- Appropriate specialty board, if the specialty board performs primary-source verification of completion of residency. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of completion of residency.
- State licensing agency, if the state agency performs primary-source verification of completion of residency. At least annually, Humana should:
 - Obtain written confirmation from the state licensing agency that it performs primary-source verification of completion of residency OR
 - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including completion of residency.

Dentist:

Graduation from dental school

- Dental school
- Appropriate specialty board, if the specialty board performs primary-source verification of dental school graduation. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of graduation from dental school.
- State licensing agency, if the state agency performs primary-source verification of graduation from dental school. At least annually, Humana should:
 - Obtain written confirmation from the state licensing agency that it performs primary-source verification of graduation from dental school OR

- Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including of graduation from dental school.

Completion of postdoctoral education, if applicable

- Postdoctoral education program
- Appropriate specialty board, if the specialty board performs primary-source verification of completion of postdoctoral education. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of completion of postdoctoral education.
- State licensing agency, if the state agency performs primary-source verification of completion of postdoctoral education. At least annually, Humana should:
 - Obtain written confirmation from the state licensing agency that it performs primary-source verification of completion of postdoctoral education OR
 - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including completion of postdoctoral education.

Optometrist:

Graduation from optometry school

- Optometry school
- Specialty board or registry, if the board or registry performs primary-source verification of professional school training. At least annually, Humana should obtain written confirmation from the specialty board or registry that it conducts primary-source verification of graduation from optometry school.
- State licensing agency, if the state agency performs primary-source verification of professional school training. At least annually, Humana should:
 - Obtain written confirmation from the state licensing agency that it performs primary-source verification of professional school training OR
 - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including professional school training.

Other healthcare professional:

- Professional school
- Specialty board or registry, if the board or registry performs primary-source verification of professional school training. At least annually, Humana should obtain written confirmation from the specialty board or registry that it conducts primary-source verification of professional school training.
- State licensing agency, if the state agency performs primary-source verification of professional school training. At least annually, Humana should:

- Obtain written confirmation from the state licensing agency that it performs primary-source verification of professional school training OR
- Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including professional school training.

Board Certification

Physician (M.D. or D.O.):

- American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS display agent, where a dated certificate of primary-source authenticity has been provided. **NOTE:** The ABMS’ “Is Your Physician Certified,” accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.
- AMA Physician Master File
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File
- Boards in the United States that are not members of the ABMS or AOA. For non-ABMS or non-AOA boards, Humana will decide which specialty boards to accept and should include the information in its policies and procedures. At least annually, Humana should obtain written confirmation from the non-ABMS or non-AOA board that it performs primary-source verification of education and training.
- State licensing agency, if the state agency performs primary-source verification of board status. At least annually, Humana should:
 - Obtain written confirmation from the state licensing agency that it performs primary-source verification of board status OR
 - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including board status.

Oral surgeon:

- Appropriate specialty board, if Humana provides documentation that the specialty board performs primary-source verification of education and training. At least annually, Humana should obtain written confirmation from the board that it performs primary-source verification of education and training.
- State licensing agency, if the state agency performs primary-source verification of board status. At least annually, Humana should:
 - Obtain written confirmation from the state licensing agency that it performs primary-source verification of board status OR
 - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including of board status.

Podiatrist:

- Appropriate specialty board, if Humana provides documentation that the specialty board performs primary-source verification of education and training. At least annually, Humana should obtain written confirmation from the board that it performs primary-source verification of education and training.
- State licensing agency, if the state agency performs primary-source verification of board status. At least annually, Humana should:
 - Obtain written confirmation from the state licensing agency that it performs primary-source verification of board status OR
 - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including board status.

Dentist:

- American Dental Association-recognized dental specialty certifying boards when a dated certificate of primary-source authenticity has been provided
- Appropriate specialty board, if Humana provides documentation that the specialty board performs primary-source verification of education and training. At least annually, Humana should obtain written confirmation from the board that it performs primary-source verification of education and training.
- State licensing agency, if the state agency performs primary-source verification of board status. At least annually, Humana should:
 - Obtain written confirmation from the state licensing agency that it performs primary-source verification of board status OR
 - Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including board status.

Optometrist:

NOTE: Board certification is not applicable to optometrists

Other healthcare professional:

- Appropriate specialty board, if Humana provides documentation that the specialty board performs primary-source verification of education and training. At least annually, Humana should obtain written confirmation from the board that it performs primary-source verification of education and training.
- State licensing agency, if the state agency performs primary-source verification of board status. At least annually, Humana should:

- Obtain written confirmation from the state licensing agency that it performs primary-source verification of board status OR
- Obtain a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of practitioner education and training information including of board status.
- Registry, if Humana provides documentation that the registry performs primary-source verification of board status. At least annually, Humana should obtain written confirmation from the registry agency that it performs primary-source verification of board status.

NOTE: Verification of board certification does not apply to nurse practitioners unless Humana communicates to its members that the nurse practitioner is board-certified.

The Credentialing Department reviews the information contained in verification systems to verify that practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification and specialty. If inconsistencies with credentialing data are found, the credentialing department notifies the appropriate department for correction.

Work history

Most recent five years of relevant work history included on the application or curriculum vitae.

NOTE: An explanation of any gaps in employment that exceed one year should be supplied in writing. An explanation of any gaps in employment greater than six months but less than one year can be supplied verbally or in writing.

Malpractice history

Confirmation of the past five years of malpractice settlements from the malpractice carrier or query to the National Practitioner Data Bank (NPDB)

State sanctions and restrictions on licensure

- Appropriate state agencies
- NPDB

Medicare and Medicaid sanctions and exclusions

- NPDB
- List of excluded individuals and entities maintained by Office of the Inspector General (OIG): exclusions.oig.hhs.gov/
- General Services Administrations (GSA) via the System for Award Management (SAM): www.sam.gov/SAM/
- CMS Medicare preclusion list (Medicare only)
- Current Medicare opt-out list (Medicare only)

- State Medicaid agency or intermediary and Medicare intermediary

NOTE: In certain circumstances, Humana is subject to certain credentialing requirements, such as individual state Medicaid credentialing requirements that exceed or differ from those outlined in this policy.

Standard: Practitioner Educational and Training Requirements

Credentialed practitioners should have completed education and training programs in their contracted and/or published specialty. Residents and fellows are generally not credentialed until their training has been completed.

Specific education/training guidelines for particular specialties are as follows:

General practitioner

- Medical school and
- Verifiable one-year U.S. (including Puerto Rico) or Canadian residency program in a primary care specialty; and
- Independent and unrestricted* license

Note: *Unrestricted license required; provisional license is not accepted.

Pain management

- Training in anesthesiology, physical medicine and rehabilitation, or psychiatry and neurology (Accreditation Council for Graduate Medical Education [ACGME] approved); and
- Completion of a 12-consecutive-month training program in pain medicine

Midwife

Graduate and/or nursing school completion that includes an accredited education program for this specialty

In instances where a credentialed practitioner elects to change contracted and published specialties, the Credentialing Operations Department should confirm that the practitioner meets the criteria for the new specialty. This process should include re-verification of additional education and training related to the new specialty and re-verification of the board certification related to the new specialty.

Standard: Telehealth Credentialing and Recredentialing

Licensure

Physicians and other practitioners providing Telehealth Services must hold all applicable licensure, certifications, and registrations (including DEA registration if applicable) and comply with applicable professional practice

standards in the state(s) in which they practice and also in the state(s) in which any Humana member receiving Telehealth Services is located at the time of such encounter.

Recredentialing

Humana shall conduct recredentialing in accordance with its existing policies (see Recredentialing and Sanction Information), but may elect to recredential physicians and practitioners providing Telehealth Services more frequently than every 36 months.

Standard: Decision-making Criteria for Credentialing and Recredentialing

The decision to credential or recredential practitioners is based on the criteria listed below, including, but not limited to, information gathered through the credentialing and recredentialing process.

Education and Training. Practitioner has completed appropriate education and training for applied specialty.

State License. Practitioner holds a current state professional license, certificate or registration in the state(s) in which practitioner will treat Humana members. Pursuant to the Indian Health Care Improvement Act (IHCA), practitioners employed by a tribal health program are not required to have a license from the state in which they are currently practicing but must have a license in at least one state. Practitioners must provide documentation to demonstrate qualification under IHCA.

License certificate or registration should not be suspended or revoked and should be free of any other “Material Limitations.” Material Limitations are sanctions, probations or other conditions that pertain to (a) any requirement to obtain a second opinion for diagnosis or treatment; (b) any condition or limitation on the ability to prescribe medicine or treatment; (c) any requirement for the presence of a second person during any examination, diagnosis or procedure; or (d) any other serious limitations. The Credentials Committee may waive a Material Limitation if the practitioner satisfies the committee that no such Material Limitation indicates a continuing quality-of-care concern.

DEA and/or CDS Certificate. Practitioner holds a current federal DEA certificate and/or a CDS certificate, if applicable to profession.

Eligible for Medicaid. Practitioner demonstrates current eligibility for participation in Medicaid, as applicable.

Eligible for Medicare. Practitioner demonstrates current eligibility for participation in Medicare, as applicable.

Professional Liability Insurance. Practitioner holds current professional liability insurance (PLI) in contracted amounts, has completed the PLI exception procedure or has documentation of coverage under the Federal Tort Claims Act for professional liability coverage.

Claims History. Practitioner has acceptable liability claims history. Any history of repeated catastrophic claims which, after examination by the Credentials Committee and/or the medical/dental director, indicates a propensity for, or trend in, malpractice claims, and/or are unusual for a practitioner in that specialty is grounds for denial, unless the practitioner satisfies the Credentials Committee that such actions do not indicate a continuing quality of care concern.

Work History. Practitioner demonstrates appropriate history of employment and clinical practice. Practitioner should explain any gaps in work history greater than six months and should satisfy the Credentials Committee that such gaps do not indicate a continuing quality-of-care concern.

Facility Privileges. Practitioner holds current clinical privileges in good standing at a participating facility or provides an explanation of admitting arrangements applicable to the care the practitioner provides. Clinical privileges should not contain any Material Limitations.

Federal, State and Local Sanction-free Status. Practitioner holds current sanction-free status from federal, state and local authorities to provide healthcare services, unless practitioner satisfies the Credentials Committee that such sanction does not present a continuing quality-of-care concern. Medicare preclusion list is not considered a sanction.

Prior Actions or Relinquishments. Practitioner should not have a history of any action in effect within the last five years taken by a federal, state or local government, including, but not limited to the applicable state licensing body; by a hospital, health plan or other healthcare entity; or by a professional society to discipline, exclude, suspend, revoke or deny; or any suspensions or other restrictions that include Material Limitations. Additionally, practitioner, within the last five years, should not have voluntarily relinquished any membership, license, privileges or participation status or other ability to render healthcare services, including but not limited to a state license or clinical privileges, while under investigation by the entity providing such membership, privileges, participation status or other ability to render healthcare services, or in return for such entity not conducting an investigation. Such prior actions or relinquishments may not be grounds for denial if the practitioner satisfies the Credentials Committee that such action or relinquishment does not indicate a continuing quality-of-care concern.

Convictions. Practitioner has not been convicted of or pleaded guilty or no contest to any felony or to any misdemeanor involving moral turpitude or related to the practice of a healthcare profession, the Federal Health Program fraud and abuse, third-party reimbursement or controlled substances, unless the practitioner satisfies the Credentials Committee that the conviction or plea does not present a continuing quality-of-care concern.

Absence of Physical or Mental Impairment. Practitioner should not be physically or mentally impaired, including impairments due to chemical dependency that may affect the practitioner's ability to practice or may pose a risk of harm to patients.

Quality. For recredentialing purposes only, practitioner should demonstrate an acceptable performance record related to Humana members with no evidence of quality issues. This record includes activities/findings collected through Humana’s quality improvement programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys and other plan activities. “Quality” refers to the measure of competence, professional conduct, care and safety that a practitioner affords a patient. Denials based on this criterion that constitute an adverse action require further action under the Humana provider quality review process. Please see the “Decision-making Process for Credentialing and Recredentialing” standard for more information.

Standard: Decision-making Process for Credentialing and Recredentialing

The decision to credential or recredential is based upon the criteria described in the “Decision-making Criteria for Credentialing and Recredentialing” standard (“Credentialing Criteria”). Humana acts only upon complete credentialing and recredentialing applications. A complete application is defined as a submitted application form that is fully filled in with responsive and accurate information, dated and signed as required and accompanied by all required and requested documents. The burden of submitting a complete application rests solely on the applicant. Humana may return unprocessed any incomplete application.

Upon receipt of a complete credentialing application, the credentialing process should be completed within 30 days or as required by state or federal regulations. The credentialing staff should designate files that meet all the Credentialing Criteria as Category I files. Credentialing staff should designate as Category II each file that does not meet all Credentialing Criteria.

The medical/dental director may approve any Category I file that meets all Credentialing Criteria. The medical/dental director review and approval should be recorded in each such file or include a report with a signature that lists all required credentials for all practitioners with clean files and includes the approval date being after appropriate review.

The medical/dental director should present all Category II files to the Credentials Committee for review and decision. The Credentials Committee may postpone a decision to receive additional information. Humana should process the credentialing or recredentialing decision of the Credentials Committee as follows:

Approvals: Practitioners with Category II files approved by the Credentials Committee should be notified of the decision. Humana should notify the applicant in writing of the Credentials Committee’s approval within 60 days.

Denials: The Credentials Committee must notify a practitioner of a denial based on Credentialing Criteria. The notice must inform the practitioner of the reasons for the denial and should provide notice of an opportunity to request reconsideration of the decision in writing within 30 days of the notice. Upon reconsideration, the Credentials Committee may affirm, modify or reverse its initial decision. Humana should notify the applicant in writing of the Credentials Committee’s reconsideration decision within 60 days. Reconsideration decisions are

final unless the denial is based on quality criteria and the practitioner has the right to request a fair hearing. Practitioners who have been denied are eligible to reapply for network participation once they meet the minimum health plan Credentialing Criteria.

NOTE: Provider denials due to missing DEA and/or hospital privileges have 30 business days to provide the missing documentation to Humana for review as a Category I file.

Adverse Actions: Adverse actions are actions or recommendations that limit, reduce, restrict, suspend, revoke, terminate, deny or fail to renew a practitioner's participation in a Humana health plan for reasons relating to quality and that adversely affect, or could adversely affect, a patient's health or welfare. Adverse actions lasting longer than 30 days entitle the applicant to prompt notice of his or her right to request a hearing under the Humana provider quality-review process. Denials based on quality may constitute an adverse action and require the Credentials Committee to comply with the Humana provider quality review process. Thus, the committee should consult the Legal Department on each denial based on quality.

Standard: Delegation of Credentialing and Recredentialing

Humana may delegate credentialing and recredentialing activities to organizations or entities that are able to demonstrate compliance with federal, state and accreditation requirements such as NCQA's. Humana retains the right to approve, suspend and terminate individual practitioners, providers and sites where it has delegated decision-making.

The following items may be delegated for credentialing and/or recredentialing and should be included in the delegation agreement:

- Accepts applications, reapplications and attestations
- Collects licensure information from NCQA-approved sources
- Collects DEA and CDS information from NCQA-approved sources
- Collects education and training information from NCQA-approved sources
- Collects work history information from NCQA-approved sources
- Collects history of liability claims information from NCQA-approved sources
- Collects licensure sanction information from NCQA-approved sources
- Collects Medicare and Medicaid sanction information from NCQA-approved sources
- Conducts site visits
- Collects and evaluates ongoing monitoring information
- Makes credentialing and/or recredentialing decisions

When Humana elects to delegate credentialing and/or recredentialing, an approved written agreement outlining those delegated activities and any other responsibilities of the delegate should be signed before the delegate performs any delegated activities. The written agreement should be mutually agreed upon and contain the following information:

- Humana's and the delegated entity's responsibilities
- Description of the delegated activities
- Required minimum of semi-annual reporting to Humana
- Process by which Humana evaluates the delegate's performance
- Remedies, including revocation of the delegation agreement, available to Humana if the delegated entity does not fulfill its obligations
- A statement that Humana retains the right to approve, suspend and terminate individual practitioner, providers and sites where it has delegated decision-making.

Prior to implementing delegation, the delegate's performance capacity is evaluated through the pre-delegation audit process to ensure the entity demonstrates compliance with the applicable federal, state and accreditation requirements. Once the delegation agreement is executed, the delegate's performance is evaluated on an annual basis to ensure the delegated entity remains compliant with applicable federal, state and accreditation requirements. Opportunities for improvement should be identified and followed up on at least once every two years.

If a delegate sub-delegates credentialing to another entity, documentation verifying that the delegate performs oversight and conducts annual audits is required, unless Humana chooses to conduct these activities itself. Complete listings of all practitioners credentialed and/or recredentialed are due from the delegate on a semi-annual basis and reviewed by Humana.

Standard: Nondiscrimination in Credentialing and Recredentialing

Humana does not make credentialing decisions based on an applicant's race, ethnic/national identity, gender, age or sexual orientation or on type of procedure or patient (e.g., Medicaid) in which a practitioner or organizational provider specializes. Humana does not discriminate against a provider on the basis of the practitioner's license or certification or because the provider services high-risk populations and/or specializes in the treatment of costly conditions.

Monitoring for and the prevention of potential discriminatory credentialing and recredentialing decisions should be evaluated at least annually. To identify potential discrimination, the Credentialing Operations Department reviews the reason for denying practitioner or organizational provider. Instances of potential discrimination discovered during this process are referred to the corporate quality improvement committee for review and decision.

Standard: Confidentiality of Credentialing Information and System Controls

Credentialing information is confidential and should be held in strict confidence. Humana should keep credentialing files and committee meeting minutes locked in a secured area. Access to electronic credentialing information (i.e., the credentialing system) should be password protected using strong passwords that are

regularly changed and limited to staff that requires access for business purposes. The records should be retained for at least 10 years or as applicable to Humana's record-retention policy. Password-protecting electronic systems, include user requirements to:

- Use strong passwords.
- Avoid writing down passwords.
- User IDs and passwords unique to each other.
- Change passwords systematically as required by Humana corporate requirements, as requested by staff or if passwords are compromised.
- Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security.

Primary source verifications are received directly from the issuing entity, such as the state licensing board, educational institution, or an authorized source of such organizations, as described within this policy. The staff conducting such verifications will ensure the document is saved in portable document format (PDF), digitally uploaded to the credentialing system and saved within the specific record of the review. The credentialing system electronically adds the verification date as dictated by the user, and an automated process adds the unique electronic identifier of that specific user, the verification source and the date of the report, as applicable.

Informational modifications are only permitted by an authorized user prior to final committee review and are tracked in the historical data within the automated credentialing system. Authorized users are staff and management within the Credentialing Operations Department who perform practitioner and provider credentialing verification functions as part of their role assignment. Authorized user roles include:

- Associate Director, Credentialing
- Lead, Credentialing
- Manager, Credentialing
- Senior Credentialing Professional
- Data and Reporting Professional 2
- Credentialing Professional 2
- Supervisor, Credentialing
- Credentialing Assistant 3
- Credentialing Representative 2
- Business Support Coordinator 1

Informational modifications are authorized when:

- Credentialing committee members request additional documentation or provider clarification.
- Updates are needed to correct typographical errors or omissions identified through system review.
- Updated or clarification documents are received from practitioners or providers, to include:
 - Addition of a line of business, specialty or new education
 - Address change

- Expiration updates to license, DEA/CDS certificates or board certification
- Updated professional liability information
- New information to request reconsideration
- Practitioners are being decredentialed for reasons that include sanctions, retirement, deceased, unable to locate, failure to respond, practitioner request and/or contract closure.
- Credentialing Operations Department staff do not delete provider information from the system.

Three processes are in place to oversee the credentialing operation's adherence to its processes.

1. Weekly random audits are conducted by Humana's Provider Quality Audit (PQA) team to ensure adherence to policies, procedures and data-entry accuracy.
2. Humana's Internal Audit and Regulatory Compliance team administers audits at least annually to ensure compliance with policies, procedures, accreditation standards and state specific requirements.
3. Credentialing management oversees weekly audits of each authorized associate who performs practitioner and provider credentialing verifications.

Unauthorized modifications or deletions are prohibited. Identification of an unauthorized modification or deletion by any of the three areas listed above is researched and addressed through education and/or corrective action and monitored quarterly until improvement is seen. Disciplinary action can include but is not limited to coaching, performance improvement plans or termination, as warranted.

Quality management files that contain peer-review information are highly confidential and should be kept separate from credentialing files. Credentialing files should not be produced for outside parties without prior approval from the Corporate Law Department and/or the Corporate Insurance Risk-management Department. The records should be retained for at least 10 years or as applicable to Humana's record retention policy.

Standard: Medical/Dental Director Responsibility

The medical/dental director is responsible for overall compliance with the credentialing process. The medical/dental director, or designee, is the chairperson of the Credentials Committee. The chairperson oversees committee voting procedures and verifies approval of each report and file. The medical/dental director, or designee, does not have voting privileges except in the event of a tie vote by the committee. In that event, the chairperson may vote to break the tie.

Standard: Practitioner Rights

Notification of practitioner rights is contained in the Provider Manual for Physicians, Hospitals and Other Healthcare Providers. Practitioners have the right to review information obtained to evaluate their credentialing application, attestation or CV and the right to correct erroneous information. Humana notifies practitioners when credentialing information obtained from other sources varies substantially from information provided by the practitioner. The practitioner should be notified within seven days of the discrepancy. The notification

indicates which part of the application is discrepant, the format for submitting corrections and the person to whom corrections should be submitted. If the application, attestation and/or CV must be updated, only the practitioner may attest to the update, a staff member may not. The practitioner has 14 business days to respond in order to resolve the discrepancy. The receipt of any corrections should be documented in the credentialing file.

A practitioner has the right, upon request, to be informed of the status of his/her application. Humana should respond to these requests in a timely manner. Once a practitioner application for initial credentialing has been approved or denied, the practitioner should be notified within 60 days. Credentialing denials will be communicated to the practitioner by the medical/dental director in writing, will include the reason(s) for the denial and should be provided within 60 days of denial.

Humana will make available all application and verification policies and procedures upon written request from the applying healthcare professional.

NOTE: Provider Manual for Physicians, Hospitals and Other Healthcare Providers is available at Humana.com/ProviderManual, with references to sections X and XII.

Standard: Credentials Committee

Humana designates a Credentials Committee that uses a peer review process with members from the type of practitioners participating in its network to make recommendations regarding credentialing decisions. The Credentials Committee uses participating practitioners to provide advice and expertise for credentialing decisions. The Credentials Committee reviews credentials for practitioners who do not meet Humana's established criteria and gives thoughtful consideration to the credentialing information. The Credentials Committee also ensures that files it does not see meet established criteria and are reviewed and approved by a medical/dental director. The Credentials Committee has final approval or disapproval decision-making authority for credentialing and recredentialing applications.

The Credentials Committee comprises representation from a range of participating practitioners in primary care and specialty disciplines, i.e., the types of practitioners the committee is reviewing. Participating practitioners are external to Humana and participate in its practitioner network. Clinical peer input from non-committee members may be accessed when discussing Credentialing Criteria for specific specialties. Members of the Credentials Committee are asked to sign a confidentiality and conflict of interest agreement. The Credentials Committee meets monthly, for the purpose of conducting credentialing and recredentialing activities and reviewing, offering input and approving credentialing and recredentialing policies and procedures.

Evidence of the Credentials Committee's discussions and decisions are documented in meeting minutes. The chairperson, or designee, should sign and date the committee minutes.

Humana's corporate credentialing and recredentialing policy is reviewed at least annually by the Credentials Committee.

NOTE: Credentials Committee meetings and decision-making may take place in the form of real-time virtual meetings (e.g., through video-conferencing or web conferences with audio). Meetings may not be conducted only through email.

Standard: Initial Credentialing and Sanction Information

The following items are verified through primary or NCQA-approved sources prior to initial credentialing, unless otherwise noted:

- Current and valid license to practice
- Current and valid DEA or CDS certificate, as applicable
- Education and training and board certification, as applicable
- Work history
- History of professional liability claims that resulted in a settlement or judgment paid on behalf of the practitioner (NPDB)

The following sanction or exclusion information is documented prior to initial credentialing, unless otherwise noted:

- State sanctions, restrictions on licensure and limitations on scope of practice
- Medicare and Medicaid sanctions and exclusions
- CMS Medicare preclusion list (Medicare only)
- Current Medicare opt-out list (Medicare only)

Standard: Application and Attestation

Practitioners are required to complete an application for initial credentialing and recredentialing that includes a current, signed attestation regarding their health status and any history of loss or limitation of licensure or privileges. Applications should be signed within 180 days of the credentialing decision and should include any necessary explanations, as applicable. Applicant signatures may be faxed, digital, electronic, scanned or photocopied, but signature stamps are not acceptable. The submission of false information or deliberate omission of requested information on the application may constitute grounds for the denial of credentialing or recredentialing.

The signed and dated application should include detailed information concerning:

- Current state professional license number(s)
- Current federal DEA certificate number(s) or state CDS certificate number(s) (if applicable)
- Current Medicare/Medicaid provider number (if applicable)
- Professional education, residency and board certification (if applicable)

- Work history of at least five years
- Current professional liability insurance coverage and claims history
- Clinical privileges at a primary participating hospital (if applicable)
- Signed and dated consent and release form

The signed and dated application also includes an attestation that addresses the following:

- Reasons for any inability to perform the essential functions of the position
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice coverage
- Current and signed attestation confirming the correctness and completeness of the application

NOTE: Humana requires participation in the Council for Affordable Quality Healthcare’s (CAQH) Universal Credentialing DataSource initiative, an online service that helps physicians and other healthcare providers with the credentialing process, including state-specific credentialing applications required by state regulations. With the exception of practitioners employed by a tribal health program (pursuant to the IHClA), each market’s vice president must approve use of any application other than CAQH, if use of other applications are permitted by state law.

Standard: Recredentialing and Sanction Information

Humana formally recredentialing its practitioners at least every 36 months. The following items are re-verified through primary or NCQA-approved sources prior to recredentialing, unless otherwise noted:

- Current and valid license to practice
- Current and valid DEA or CDS certificate, as applicable
- Board certification, as applicable
- History of professional liability claims that resulted in a settlement or judgment paid on behalf of the practitioner (NPDB)
- Performance indicators

The following sanction or exclusion information is documented prior to recredentialing, unless otherwise noted:

- State sanctions, restrictions on licensure and limitations on scope of practice
- Medicare and Medicaid sanctions and exclusions
- CMS Medicare preclusion list (Medicare only)
- Current Medicare opt-out list (Medicare only)

Practitioners on active military duty, maternity leave or sabbatical may be recredentialed upon return. The reason for delaying recredentiaing should be documented in the practitioner's file. In these cases, a practitioner should be recredentialed within 60 calendar days of his or her return to practice.

Practitioners in areas affected by an emergency declaration issued by the federal or state government will be reviewed for possible extension or grace period to respond to requests for credentialing and recredentiaing materials. Such extension will begin on the effective date of the emergency declaration and continue until the expiration of the emergency declaration.

Practitioners who have been administratively decredentialed may be re-activated within a 30-calendar-day time frame. Any practitioner who has been decredentialed for longer than 30 calendar days should undergo the initial credentialing process.

NOTE: Practitioners who have missed the 36-month time frame for recredentiaing may be administratively decredentialed. Humana may recredentia the practitioner within 30 calendar days of missing the deadline. If recredentiaing is not completed within 30 calendar days, Humana will complete an initial credentialing review of the practitioner.

Standard: Ongoing Monitoring and Interventions

Humana monitors practitioner sanctions, complaints and quality issues between recredentiaing cycles and ensures that corrective actions are undertaken and effective when it identifies occurrences of poor quality (refer to Humana's Provider Quality Review Process).

Ongoing monitoring and appropriate interventions up to and including removal from the network are implemented by collecting and reviewing the following information within 30 calendar days of its release:

- Medicare and Medicaid sanctions and exclusions
- CMS Medicare preclusion list (Medicare only)
- Current Medicare opt-out list (Medicare only)
- Sanctions and limitations on licensure
- Complaints
- Identified adverse events

Evidence of sanction and exclusion reviews is available from the Credentialing Operations Department. Evidence of practitioner complaint and identified adverse-events reviews are available from the Quality Management Department.

Standard: Notification to Authorities and Practitioner Review Rights

When the Credentials Committee recommends an adverse action lasting longer than 30 days against a practitioner, Humana must offer the applicant the right to request a hearing in accordance with the Humana provider quality-review process. Humana must report to the National Practitioner Data Bank all final adverse actions against practitioners lasting longer than 30 days after hearing and review. Humana also may be required to report certain actions to state authorities and must do so in accordance with applicable state laws.

For details pertaining to hearing and reporting requirements, please refer to the Humana Provider Quality Review Process.

For all required hearings on credentialing decisions, the following definitions in the Humana provider quality review process are changed as follows:

- All references to the “HMD” (the Humana Health Plan Market Medical Director) shall mean the credentialing medical/dental director.
- All references to “Peer Review Committee” shall mean the Credentials Committee.

Standard: Assessment of Organizational Providers

Humana evaluates the quality of organizational providers with which it contracts. All organizational providers requiring evaluation should complete the assessment process before a provider’s effective date is assigned, except where otherwise required by state regulations. Additionally, an organizational provider will print in the provider directory and provide care to members only after assessment is complete. Organizational providers are reassessed at least every three years thereafter. This assessment includes:

- Confirmation that the provider is in good standing with state and federal regulatory bodies (state license, where required; Medicare/Medicaid intermediaries; OIG and GSA)
- Confirmation that the provider has been reviewed and approved by an accrediting body and/or certified by Medicare*
 - The Joint Commission (TJC)
 - Accreditation Association for Ambulatory Health Care (AAAHC)
 - Commission on Accreditation of Rehabilitation Facilities (CARF)
 - Continuing Care Accreditation Co (CCAC)
 - Community Health Accreditation Program (CHAP)
 - Accreditation Commission for Healthcare (ACHC)
 - Healthcare Facilities Accreditation Program (AOA HFAP)
 - American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
 - American College of Radiology (ACR)
 - National Integrated Accreditation for Healthcare Organizations (DNV-NIAHO)
 - Council on Accreditation (COA)
 - Clinical Laboratory Improvement Amendments (CLIA)
 - Clinical Laboratory Accreditation (COLA, Inc.)

- American Association of Diabetes Educators (AADE)
- Indian Health Service (IHS)
- Commission on Accreditation for Home Care New Jersey (NJCAHC)
- Commission for the Accreditation of Birth Centers (CABC)
- Intersocietal Accreditation Commission (IAC)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Performance of an onsite quality assessment if the provider is not accredited**
- Current malpractice coverage or participation in Federal Tort Program; as applicable per state requirement

Pharmacy assessment also includes:

- Confirmation of National Council for Prescription Drug Programs (NCPDP)/National Association of Boards of Pharmacy (NAPB) number
- Current and valid DEA or form attesting pharmacy does not have a DEA
- Current malpractice coverage

Organizational providers to be assessed include, but are not limited to:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing surgical centers
- Hospices
- Clinical laboratories
- Comprehensive outpatient rehabilitation facilities
- Outpatient physical therapy and speech pathology providers
- Pharmacies
- Providers of end-stage renal disease services
- Providers of outpatient diabetes self-management training
- Portable X-ray suppliers
- Rural health clinics and federally qualified health centers

Behavioral healthcare facilities providing mental health or substance abuse services in the following settings are also assessed:

- Inpatient
- Residential
- Ambulatory

Assessment may be documented in the form of a checklist, spreadsheet or record and should include the prior validation date and current validation date for licensure, accreditation status, CMS or state reviews or site visits (if applicable) for each organizational provider.

For organizational providers, ongoing monitoring and appropriate interventions are implemented by collecting and reviewing quality reports from The Leapfrog Group, at least quarterly.

*Providers in Humana's Medicare network(s) must be Medicare-certified. Humana will verify an organizational provider's Medicare certification status by obtaining the certification letter CMS issues to the provider. The CMS certification letter may not be more than three years old at the time of verification and must include the CMS certification number (CCN).

**If an organizational provider is not accredited, Humana may substitute a CMS or state review in lieu of performing its own onsite quality assessment. Humana will verify that an onsite quality assessment has been completed by a state agency or CMS by obtaining the assessment report or certification letter. The CMS or state review may not be more than three years old at the time of verification. If the CMS or state review is older than three years, Humana will conduct its own onsite quality review. If the state or CMS has not conducted a site review of the provider and the provider is in a rural area (as defined by the U.S. Census Bureau), Humana may choose not to conduct a site visit.

NOTE: The Practitioner Office and Facility Location Survey tool is used in cases where a site visit is required.

Standard: Assessment of Long-Term Services and Support Provider

Humana evaluates the quality of LTSS providers with which it contracts. All LTSS providers requiring evaluation should complete the assessment process before their effective date is assigned, except where state regulations require otherwise. Additionally, an LTSS provider will print in the provider directory and provide care to members only after assessment is complete. LTSS providers are reassessed at least every three years thereafter.

LTSS providers to be assessed include, but are not limited to:

- Adult day care centers (ADC)
- Assisted living facility services (ALF)
- Adult family care homes (AFCH)
- Case management agencies
- Chore providers, including pest-control contractors
- Suppliers of consumable supplies
- Environmental accessibility contractors
- General contractors
- Home-delivered meal services
- Home health agencies
- Home medical equipment (HME) services
- Homemaker/companion services
- Hospices

- Non-emergent/non-traditional transportation service providers
- Nurse registry
- Nutritionist/dietician
- Skilled nursing facility
- Therapy services (occupational, physical, respiratory and speech)

Assessment includes:

- Confirmation the provider is in good standing with state and federal regulatory bodies (state license, Medicare/Medicaid intermediaries, OIG and GSA)
- For provider types not licensed by a state medical regulatory board, confirmation the provider has a current, valid occupational license or other evidence of authority to do business within the scope of contracted service(s)
- Confirmation the provider has been reviewed and approved by an accrediting body, as applicable (AAHC, CARF/CCAC, CHAP, AOA, CMS, TJC or Occupational Safety and Health Administration [OSHA])
- Performance of an onsite quality assessment if the provider is not accredited*
- Confirmation the provider is compliant with abuse, neglect, exploitation and chore training, as applicable per state requirement.
- Confirmation of current liability and/or worker's compensation insurance coverage, as applicable per state requirement

Documentation of the assessment may be in the form of a checklist, spreadsheet or record and include the prior validation date and current validation date for licensure, accreditation status, CMS or state reviews or site visits (if applicable) for each organizational provider.

*If an LTSS provider is not accredited, Humana may substitute a CMS or state review in lieu of accreditation. Humana should obtain a state report or CMS letter to verify that the review has been performed. The CMS or state review may not be more than three years old at the time of verification. EXCEPTION: Accreditation, CMS or state-agency review will not be substituted in lieu of an on-site visit if a program's contract requires verification of defined characteristics unique to certain provider types.

References:

Provider Manual for Physicians: [Humana.com/ProviderManual](https://www.humana.com/ProviderManual)

Communication and Training Plan:

- Change Existing Content
 - Updates to reflect new Accreditation and state requirements
 - Statement clarifications

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Disclaimer:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by an issue, to allow for consistency, Humana will follow the most stringent requirement.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/procedure) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/procedure) supersedes all other policies, requirements, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained in Policy Source to ensure no modifications have been made.

Non-Compliance:

Failure to comply with any part of Humana’s policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Associate Support Center via Humana’s secure intranet on Hi! (Workday & Apps/Associate Support Center).