Blue Cross Blue Shield Blue Plus of Minnesota (Blue Cross)

Credentialing & Recredentialing Provider Policy Manual

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The information contained in the Blue Cross Blue Shield of Minnesota Credentialing Plan is considered the sole and exclusive property of Blue Cross.

Purpose:

The purpose of the Credentialing & Recredentialing Provider Policy Manual is to provide guidance to all practitioners and providers who wish to participate in the Blue Cross networks. Blue Cross and Blue Shield of Minnesota uses a credentialing process to provide members with a selection of physicians and other healthcare professionals who have demonstrated backgrounds consistent with the delivery of high quality, cost-effective health care.

The credentialing manual criteria reflects our regulatory agency requirement. Regulatory agencies include but are not limited to the National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS) and Minnesota Department of Health (MDH).

Policy Considerations

Glossary of Terms

- All references to “Blue Cross”, “Blue Cross Networks”, etc., refer to Blue Cross and Blue Shield of Minnesota and Blue Plus, Inc.-and all lines of business.
- "Day" refers to calendar day, unless otherwise specified.
- "Independent Relationship" refers to the circumstances when Blue Cross or its affiliates selects and directs its members to see a specific practitioner who is licensed to practice independently.
- Facility/Organizational Provider, heretofore referred to as “Facility”, refers to a specific facility type for the purposes of Credentialing. The medical provider types are hospitals, home health agencies, skilled nursing facilities/nursing homes and free-standing surgical centers. All types of facilities providing mental health and substance abuse services are also included. Mental health and substance abuse services may be in inpatient, residential or ambulatory settings.
- “Practitioner” refers to an individual health care professional.
- “Credentialing Reconsideration” refers to the ability of a practitioner or provider denied Blue Cross network participation by the Credentialing Committee, due to non-compliance with Clinical Participation Requirements, to submit additional documentation for review by the Credentialing Committee to reconsider their first decision. (reference section 1300).
- “An Appeal Hearing” refers a final step for a practitioner/provider whose participation decision reached by the Blue Cross Credentialing Committee after Reconsideration review has upheld a decision to Terminate their participation. The practitioner/provider may appear

before an independent panel to present their case. The Appeal Hearing panel makes the final Blue Cross Network Participation decision. (Reference section 1300)

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Series 100: Introduction

101: About Credentialing

The credentialing process applies to all Blue Cross and Blue Shield of Minnesota and Blue Plus credentialing policies and procedures for all products or lines of business. Blue Cross is a National Committee for Quality Assurance (NCQA) accredited health plan, therefore; we follow the NCQA Standards. Blue Cross also complements Standards with additional policies that define other regulatory and business requirements.

The lists below identify which practitioner and facility types are required to go through the credentialing process.

01. Medical Specialties That Require Credentialing

- Physician (MD, DO) - Except if hospital-based only
- Podiatrist (DPM)
- Chiropractor (DC) *
- Optometrist (OD)
- Dentist (DDS) *
- Oral and Maxillofacial Surgeon (DDS, DMD)
- Oral and Maxillofacial Surgeon (MD)
- Certified Nurse Midwife (CNM)
- Traditional Midwife (LTM or LM)

- Registered Nurse Clinical Specialist (RNCS, CNS)
- Registered Nurse Practitioner (RNP)
- Physician Assistant (PA)
- Licensed Acupuncturist (LAC)
- Physical Therapists*

02. Behavioral Health Specialties that require Credentialing:

- Psychologist (PHD, PSYD, ED D, MA, MS)
- Social Worker - Licensed to practice independently:
  LICSW - Minnesota and North Dakota
  LISW - Iowa
  LCSW - Wisconsin
  CSW-PIP - South Dakota
- Licensed Mental Health Counselor (LMHC) – North Dakota only
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor (LPC) - Must be able to practice without supervision.
- Licensed Marriage and Family Therapist (LMFT)

* These specialties will be credentialed via Delegated Credentialing Agreement

03. Facilities that require Credentialing (see also section 1400)

- Ambulatory Surgery Center (Free-standing Only)
- Home Health Care Agency
- Hospital (All types, including Psychiatric)
- Skilled Nursing Facility / Nursing Home
- Children's Residential Facility – providing Substance Abuse Treatment
- Children's Residential Facility – providing Mental Health Treatment
- Adult/Adolescent Substance Abuse Treatment – Outpatient and/or Residential
- Behavioral Health Facility – Inpatient
- Mental Health Crisis Lodging for Adults
- Eating Disorders Treatment
- Intense Residential Treatment Services – Adult Mental Health
- Opioid Clinic/Opiate Treatment Program – DHS licensed
- Partial Hospitalization/Partial Psych Program – Freestanding

102: Initiating the Process for Participation in our Networks (Also reference Series 700 for Credentialing Process)

01. Information regarding how to become a participating provider in our networks can be found on our website: *providers.bluecrossmn.com* (do not type www). Instructions for applying for a contract and links to the required documents can be found on this site.

02. If you do not have internet access, call Provider Services at 1-800-262-0820 to request this information.

103: Non-Credentialed Provider Requirements:
Advanced Diagnostic Imaging

01. Advanced diagnostic imaging services are required to be properly accredited in order to bill for or be reimbursed for services, due to Federal and State laws. The following services are subject to these laws:

- Magnetic Resonance Imaging (MRI)
- Computed Tomography (CT)
- Nuclear Imaging, Positron Emission Tomography (PET)

Advanced diagnostic imaging does not include x-ray, ultrasound, or fluoroscopy.

Accreditation of the above providers is required by one of the following entities:

- American College of Radiology (ACR)
- Intersocietal Accreditation Commission (IAC)
- The Joint Commission (TJC); or
- Other relevant accreditation organizations designated by the Secretary of the United States Department of Health and Human Services

All contracted facilities that provide advanced diagnostic imaging (ADI) services must have obtained accreditation by August 1, 2013 and continue to maintain accreditation thereafter. ADI providers requesting network participation must hold current accreditation before a contract offer will be considered. Blue Cross may require advanced diagnostic imaging providers to produce evidence of this required accreditation.

Special Transportation/Common Carrier Providers

02. Transportation/Common Carrier providers are required to carry auto liability insurance coverage.

Series 200: General Policy Information

201: Frequency of Credentialing & Recredentialing Provider Policy Review
The Credentialing & Recredentialing Provider Policy Manual is reviewed and revised for publication on an annual basis.

202: Impact of Policy Revisions
Within a six-month timeframe, staff shall review any credentialing files that were negatively affected by a policy when a subsequent revision of the same policy would result in a more favorable position. Staff shall take reasonable steps to inform practitioners and facilities of policy revisions and of potential or actual changes in participation status.

203: Effective Dates

The Credentialing Manual effective date will be as of the last revised date as noted in the footer on the document

Series 300: Credentialing Information - *This series is subject to Federal and State data privacy laws including HIPAA and to the Blue Cross Corporate Policy: Confidential and Proprietary Information (6-15).*

301 – 309 Intentionally left blank

310: Blue Cross (internal) Access to Credentialing Information

01. Blue Cross utilizes an electronic, paperless credentialing system to process and maintain credentialing information in a secure, confidential environment. All faxed credentialing documentation is electronically imaged and scanned to the credentialing record. Hard copy documents are shredded after scanning according to corporate policy guidelines. Access to the credentialing database is password protected and limited to authorized staff.

02. Members of the Credentialing Committee, Credentialing and other designated Blue Cross staff shall have access to credentialing records on a need-to-know basis, consistent with the parameters of their employment at Blue Cross. All staff are obligated to protect confidential information and any unauthorized disclosure of this information is cause for disciplinary action.

03. Other Blue Cross staff may access credentialing records upon approval from the Blue Cross Legal Department in consultation with the Credentialing leadership or designee.

04. Confidential internal communication may be prepared and distributed on a need to know basis for the purpose of Credentialing, Contracting or other administration.

315: External Access to Credentialing Information

01. Federal and State regulatory agencies may review credentialing files as part of their authorized oversight responsibilities.

02. Accreditation Agencies, i.e., National Committee for Quality Assurance (NCQA)and Utilization Review Accreditation Committee (URAC), may review credentialing files as part of their authorized plan review.

03. Requests from research groups and any others for summary or aggregated information shall be evaluated by Blue Cross on a case-by-case basis and may be granted, subject to all applicable laws, after appropriate confidentiality agreements are signed.

04. Credentialing Information Release Form. All parties requesting access to summary or individual credentialing information must describe in writing the information needed and the reason(s) why the information is needed. The decision to release information shall be made

by the Blue Cross Legal Department in consultation with the Credentialing leadership or designee.

320: Practitioner/Providers Access to Credentialing Information

01. Practitioner/Providers may review information submitted in support of their credentialing applications, subject to all applicable laws.

02. Credentialing staff will notify practitioner/providers in writing if any information obtained from other sources during the credentialing process varies substantially from that provided to Blue Cross by the practitioner.

03. Practitioners/Providers have the right to correct erroneous information obtained during the credentialing process within thirty (30) calendar days by submitting in writing to the Credentialing Department any corrections or an explanation of discrepancies by either fax, or email. Practitioners/Providers are notified of this right to correct erroneous information during the credentialing process via letter, request for additional information, or on the Blue Cross website: www.bluecrossmn.com. Upon receipt of notification we will document it.

04. Release of a peer reference requires written consent of the reference author.

321: Listings in Practitioner Directories and Other Member Materials

Information provided in member materials, including practitioner directories, shall be consistent with all relevant information obtained during the credentialing process. Specifically, any practitioner information regarding qualifications given to members, should match the information regarding practitioner's education, training, certification and designated specialty gathered during the credentialing process. "Specialty" refers to an area of practice, including primary care disciplines.

At the time of initial credentialing, re-credentialing, and when board certifications expire, credentialing staff enters into our Provider Demographics Database each practitioner's verified information to include: education, training, board certification, and specialty. This information is available to be utilized by other areas within Blue Cross, such as directories and member materials.

Series 400: Credentialing Committee

405: Purpose

The Credentialing Committee is a peer review body with members drawn from practitioners participating within the Blue Cross Network. On a monthly basis, the Committee makes provider and practitioner participation decisions for Blue Cross. This Committee is intended to be a review organization under Minnesota Statutes Section 145.61, and thus shall ensure that all requirements contained in Minnesota Statutes Section 145.61 through 145.67 are maintained and followed.

410: Voting Procedures and Quorums

Fifty-one percent (51%) of all voting Committee members shall constitute a quorum for the purposes of conducting official Committee business. Action shall be taken by a majority vote. The Committee Chair votes only when there is a tie vote, in order to break the tie. If during a meeting, an exact Quorum is no longer met, the voting must cease.

411: Decision Making and Emergency Decisions

01. Committee decisions may be made during meetings, telephone conferences, video-conferences, by mail, or by fax.

Following staff review of the completed credentialing applications, files that meet Blue Cross Network Participation Requirements are presented to the Medical Director for credentialing decision sign off.

The Credentialing Committee reviews files with possible current significant issues or identified significant issues and makes appropriate decisions.

Practitioners/Providers with a restricted, conditional or denied participation status have the right to appeal Committee's decision in accordance with Policy 1115.

02. Qualified and trained Blue Cross credentialing staff may deny participation or terminate the participation status of practitioners or providers, when Network Participation Eligibility Requirements are not met. The right to Reconsideration is extended under these circumstances in accordance with Policy 1115

03. Any Credentialing Appeal Hearing decision is the final administrative participation decision available to practitioners and providers.

04. Emergency Decision-Making

- Emergency decisions may be made by a Blue Cross Credentialing Medical Director, or designee, when reasonable information has been identified by Blue Cross, that a member may be endangered by potentially unsafe or unethical care or treatment.
- When an emergent decision is made, participation may be suspended immediately with written notification sent to the practitioner. Within ten (10) business days of the notification of suspension, all pertinent facts shall be gathered for review by an ad hoc peer review committee consisting of at least three (3) practitioner members of the Credentialing Committee. These three Committee members will make a determination for final decision whether to terminate or recommend full committee review.

Designee means the following positions of authority in the sequence listed: Health Management Medical Director, Chief Medical Officer, other available Blue Cross Medical Director, and Credentialing Leadership. All designees shall participate in a credentialing policy orientation prior to making a decision.

414: Restricted or Conditioned Actions Taken Related to Adverse Practitioner, Provider or Delegated Credentialing Decisions. Actions May Reflect an Increasing Level of Severity.

Note: These are examples only.

1. Increased frequency of recredentialing, site visits, or delegate file review
2. Require a work plan to describe steps to comply with credentialing standards, or if applicable, Documents need to be confidentially shredded or electronic files deleted.
3. Continuing education requirements or education by Blue Cross staff
4. Increased frequency of medical record or coding audits by Blue Cross
5. Counseling by a peer practitioner, approved by a Blue Cross Medical Director or Director designee
6. Formal supervision by a peer
7. Evaluation by an external peer organization, i.e., Health Professionals Services Program (HPSP) or Colorado Personalized Education for Physicians (CPEP)
8. Participation condition or limitation, i.e., practice site, type (group vs. solo), scope of practice
9. Other restrictions or conditions deemed appropriate by the Credentialing Committee

Practitioners or providers may be required to inform Blue Cross members of the restrictions or conditions of their participation

415: Credentialing Committee Membership

01. Credentialing Committee membership is chosen from the Blue Cross participating network. On a yearly basis, the members of the Committee are expected to review the Credentialing Committee Charter and sign a Credentialing Committee Membership Agreement.

02. The Credentialing Committee consists of five (5) physicians and one (1) non-physician practitioners who are participating practitioners in at least one Blue Cross Blue Shield of Minnesota and Blue Plus Network. An additional 2 voting members are Blue Cross staff. One (1) member is Blue Cross Legal Counsel, and the other is a Blue Cross management level staff from a department outside Credentialing.

417: Term of Office

Unless otherwise approved by the Chair of the Credentialing Committee, Medical Clinicians serving on the Committee shall have a term of one (1) year and not to exceed ten (10) years. Internal voting members, Blue Cross Legal Counsel and Blue Cross management level will have term as designated by the Credentialing Manager.

420: Committee Chair/Medical Director Responsibilities

The Credentialing Committee is chaired by the Blue Cross appointed Medical Director, who shall direct agenda items relevant to medical quality of care, as well as items relevant to business needs. The Committee Chair is a non-voting member, unless there is a tie vote.

Committee leadership shall include the positions of Chair and recording Secretary. The Committee Chair is appointed by Blue Cross Medical Management.

425: Authority

The Credentialing Committee has the administrative authority to determine the participation status of a provider or practitioner.

430: Reporting Relationships

The Credentialing Committee reports final policy to the Quality Management Committee (QMC) or its representative.

435: Meeting Frequency

The Credentialing Committee conducts business on a monthly basis, or more frequently if necessary.

440: Confidentiality Policy

01. Committee members agree to abide by the published BlueCross Corporate Privacy Policy 2-03, General Rules for Use and Disclosure of Protected Health Information (PHI), including but not limited to Health Insurance Portability and Accountability Act (HIPAA). Any information regarding what transpired at a meeting, or the findings and conclusions of the committee shall be held in strict confidence.

02. Blue Cross shall hold in confidence all data and information that it acquires in the exercise of its duties and functions as a review organization as recognized under Minnesota Statutes Section 145.64. subd.1

The Rules enumerated below shall apply with respect to the peer review process.

- Credentialing Committee members agree to sign an annual statement that they understand their responsibility to preserve the confidentiality of all Blue Cross Proprietary Information and to comply with all requirements related to protection of PHI, even if they do not have regular access to, or review of such information. All external committee participants must also acknowledge that they have received appropriate HIPAA-related privacy training from Blue Cross on an annual basis.

441: Conflict of Interest

Any appearance of a conflict of interest shall be managed as if it were an actual conflict of interest.

01. Committee members shall reveal any associations, conflicts of interest or potential conflicts of interest with any credentialing applicant to the committee chair prior to the consideration of Committee business. The Committee member that declares a conflict of interest or potential conflict of interest shall not participate in discussions and voting on matters affecting the credentialing applicant. Failure to adhere to the intent of such prohibitions may result in a recommended resignation from the Committee and notification to Quality Management Committee (QMC) or its representative. A General discussion of a listing of several providers is permitted.

02. Appeal Hearing members shall also reveal any conflict of interest if any one or more of the following circumstances related to "direct economic competition" applies:

- The Committee member exhibits referral patterns to/from the person requesting the hearing.
- Overlap in clinical privileges or drawing patients from the same geographical area.
- The Committee member practices in the same or closely related specialty with the person requesting the hearing.
- The Committee member is a business partner of the person requesting the hearing.
- The Committee member is a business partner of a member of the Credentialing Committee.
- The Committee member has a current or prior dispute with the person requesting the hearing.
- The Committee member is related by blood or marriage to either the person requesting the hearing or a member of the Credentialing Committee.

442: Indemnification

All individuals who participate in professional review actions shall be protected from damage suits as provided by the Federal Health Care Quality Improvement Act of 1986 and Minnesota Statutes Section 145.63.

443: Minutes

Minutes shall list the date, time, location of meetings, attendees, and absent committee members. In brief narrative, the following additional elements shall also be addressed: topics discussed, significant decisions, follow-up issues and next meeting date, location, and time. Minutes and relevant documents shall be maintained in accordance with any and all applicable Blue Cross policies and state and federal requirements**.** Minutes are signed and dated by the Committee Chair and the Secretary

444: Reporting

If in the course of researching a case for presentation to a credentialing committee, there is evidence to suggest that a practitioner is not in compliance with an existing Board Order, Blue Cross shall notify the applicable licensing Board (in writing) of the apparent discovery.

In addition, Blue Cross shall report adverse Credentialing Committee or Appeal Panel actions required by Federal Law (45 C.F.R. Sec. 60.5) to the Minnesota Board of Medical Practice (MBMP), other State Medical Boards, as well as other entities, including the National Practitioners Data Bank (NPDB), within thirty (30) days from the date of final written notification to the practitioner.

Series 500 and 600: *Intentionally Left Blank*

Series 700: Credentialing Operating Policies (*See also Policy Series 1000)*

701: Non-Discriminatory Processes

The processes used to credential and recredential practitioners/providers are conducted in a non-discriminatory manner. Individual characteristic issues of race, color, creed, religion, sex, national origin, marital status, status with regard to public assistance, disability, age, sexual orientation, status as a disabled or Vietnam-era veteran, or types of procedures, or types of patients the practitioner provides treatment for, are not considered during the credentialing or recredentialing process. The Credentialing leadership monitors credentialing files and practitioner complaints periodically to ensure that the organization does not discriminate.

To comply with this policy, the committee attests by signing a non-discriminatory statement at the beginning of each credentialing committee meeting.

The committee also reviews aggregate data on a quarterly basis that includes reasons for non-participation or termination decisions.

The organization does not collect data on an individual's race, color, creed, religion, national origin, military status or sexual orientation during the credentialing process.

The organization permits practitioners to submit information about birth date or language spoken; however, this is not presented during the credentialing process.

Annually, the Credentialing leadership reviews non-participating and termination decisions to ensure that the organization does not discriminate (e.g. age, languages spoken).

705: Compliance with External Regulatory and Accreditation Organizations.

01. Federal and State Laws and Regulations

All credentialing policies shall be in compliance with all applicable laws and regulations. In the event there is an inadvertent discrepancy between credentialing policy and any law or regulation, then the law or regulation shall override the policy.

02. External Accreditation/Certification
Standards set forth by national groups such as the National Committee for Quality Assurance (NCQA) and Blue Cross Blue Shield Association (BCBSA) shall be regularly reviewed. Revisions of internal criteria shall be made based on standards determined to be of value to Blue Cross, its providers, practitioners and members.

03. Primary Source Verification is completed by an NCQA vendor certified in all current NCQA elements, or by Blue Cross using the following sources.

INFORMATION CATEGORY	SOURCE
License to Practice	Appropriate Licensing Agency
DEA Certificate	DEA Online Search via Nat'l Technical Information Service (NTIS)
Residency/Education	Residency Training Program or State Licensing Agency
Board Certification	ABMS or acceptable specialty boards
Malpractice Coverage	Copy of current malpractice coverage sheet or the completed malpractice coverage application item and a signed and dated attestation statement.
Malpractice History	National Practitioners Data Bank (NPDB)
Sanction Information includes Medicare & Medicaid	NPDB or State Licensing Boards
Work History	Application or Curriculum Vitae
Attestation to the correctness and completeness of information provided by the practitioner	Disclosure Statement on the Credentialing Application Attestation Page
Reasons for inability to perform the essential functions of the position	Disclosure Question #15 on the Credentialing Application
Lack of present illegal drug use	Disclosure Question #17 on the Credentialing Application

708: Break in Service, including Leave of Absence

01. Break in Service or Leave of Absence, which could include, but not limited to health, military, maternity or paternity or sabbatical leave.

- When a practitioner returns to the same PAR location from a verified leave of absence within 32 months of 36-month re-credentialing cycle the practitioner shall be reinstated and may resume seeing Blue Cross members following reverification of credentials that are outside of verification time limits.
- When a credentialed practitioner leaves a PAR location and moves to another Par location and has a verified break in service that is less than 32 months of 36-month recredentialing cycle the practitioner may see Blue Cross members following liability insurance and license verification.
- A break in service exceeding 180 days (6 months) requires Blue Cross to clarify the reason for the break in service either verbally or in writing; and, a gap in service that

exceeds one year must be clarified in writing. If the practitioner returns within the 36-month time frame no other credentialing is required.

- If Blue Cross Blue Shield of Minnesota is unable to re-credential a practitioner within the 36-month time frame because the practitioner is on active military assignment, maternity leave or sabbatical, Blue Cross may
- credential the practitioner upon his or her return. Blue Cross must document the reason for the delay in the practitioner's file.
- If the practitioner was on a health leave of absence, the re-credentialing process requires a report from his/her attending physician, indicating that the practitioner is physically
  and mentally capable of resuming and performing all essential functions of his/her clinical duties.
- If re-credentialing is due, Blue Cross must complete the re-credentialing cycle within 60 days of the practitioner resuming practice or the practitioner is terminated from Blue Cross Networks.

02. Break in Service, including Termination of Contract

- If either the practitioner or Blue Cross terminates a contract, and the practitioner returns to practice at another network location having a break in service of more than 30 days, Blue Cross must initially credential the practitioner before he or she rejoins the network.
- If either the practitioner or Blue Cross terminates a contract and there is a break in service of less than 30 days and the practitioner is within the 36-month time frame no credentialing is required.

710: Conditions/Circumstances When a Practitioner is *Not* Credentialed by Blue Cross

01. Practitioner is currently in approved residency training. (See Policy 806 also.)

02. Locum Tenens

BlueCross and BlueShield's definition of a Locum Tenens is: A substitute physician who takes over another physician's practice when that regular physician is absent for specific reasons (for example: illness, maternity leave, military duty or sabbatical). The services rendered by the locum tenens physician may be submitted under the absent physicians' provider number or NPI. The modifier Q6 should be appended to these services. Additional or replacement physicians not substituting for an absent physician must be credentialed and submit claims with their own NPI.

03. Practitioner is providing services that are not covered by Blue Cross products.

04. Practitioner is not licensed or certified in Minnesota (or bordering states) and not providing services to Blue Cross members.

05. Practitioners who practice exclusively within the inpatient setting (see examples below). This refers to those practitioners and allied professionals who provide care for organization members only because the members have been directed to the hospital or other inpatient setting.

Medical Practitioners and Allied Professionals - Examples of this type of practitioner are emergency room physicians, pathologists, radiologists and anesthesiologists, where the hospital employs or contracts with the practitioner and has assumed responsibility for credentialing.

Behavioral Health Practitioners - Examples of this type of practitioner are social service social workers, psychologists performing psychological testing, or counselors providing behavioral health or chemical dependency services, where the hospital employs or contracts with the practitioner and has assumed responsibility for credentialing. These practitioner types practice exclusively within the inpatient setting and provide care for the member only as a result of members being directed to the hospital for services by the health plan.

06. Other Exceptions:

- When a Practitioner who practices exclusively within the inpatient setting, is denied participation or participation is terminated, the credentialing exclusion no longer applies, and he/she is subject to the denial credentialing decision at all other practice locations. However, the Credentialing Committee, at its discretion, may make an exception and grant participation at a specific practice location.
- When a Practitioner, who practices at both inpatient and outpatient practice locations, is denied, or his/her network participation terminated, this decision is applied to all practice locations, including inpatient and ER practice locations. The credentialing exclusion for inpatient locations would no longer apply. However, the Credentialing Committee, at its discretion, may make an exception and grant participation at a specific practice location.
- Practitioners who practice exclusively in free-standing facilities and provide care for organization members only because members are directed to the facility.
- Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates utilization management (UM) functions.
- Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants).
- Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

720: Circumstances Requiring the Initial Practitioner Credentialing Process

All practitioners (refer to credentialed specialty types, sec 102.01) with an independent relationship with Blue Cross are credentialed prior to receiving a Blue Cross contract. Participation status is determined only for practitioners carrying out functions consistent with their current scope of practice.

01. New Request for Blue Cross Participation. All credentialed and non-credentialed practitioners must comply with the Blue Cross Network Participation Requirements as a minimal set of requirements (see policy #800).

02. Recredentialing of practitioners. All credentialed practitioners are recredentialed every three (3) years thereafter. (Also refer to Policy 905)

03. Practitioners who were never credentialed but were associated to a Blue Plus Network and are a specialty needing credentialing as listed in section 102.01, are subject to credentialing according to the terms set forth in Policy 800.

04. A new practitioner joining an existing "participating" group must successfully complete the Blue Cross credentialing process prior to treating any Blue Cross Members/Subscribers.

725: Completeness of Credentialing Applications

01. It is the responsibility of all applicants to provide complete information on all forms, for example, a signed and dated written application, and supply adequate supporting materials as requested, to allow for thorough and uniform review of all applications.

02. Practitioners requiring credentialing shall be responsible for obtaining and forwarding all credentialing information to the credentialing staff in a timely manner.

03. The credentialing staff shall make reasonable efforts to remind practitioners when information is outstanding or missing, prior to any decision or recommendation to deny participation.

726: Practitioners Rights and Notification

01. Practitioners, upon written or verbal request, shall be informed of the status of their credentialing or recredentialing applications.

02. Practitioners shall be notified in writing, within fifteen (15) business days of all initial credentialing decisions or professional review action that has been brought against them. The notice will include reasons for the action and a summary of the appeal rights.

03. Practitioners shall be informed of any credentialing discrepancies and shall have the opportunity to correct any erroneous information gathered during the credentialing process, prior to review by the Credentialing Committee.

04. Practitioners have the right to review the credentialing information they have submitted to the Blue Cross Credentialing Department, via a written request. Blue Cross agrees to respond within 30 calendar days by providing the practitioner the requested information in writing, not otherwise prohibited by law.

05. Practitioners shall be notified of the rights listed in 01 to 04 above, in Credentialing applications cover letters, and via web site information at *www.bluecrossmn.com* describing the credentialing process.

730: E-mail and Fax Submission of Documents

Blue Cross shall accept applications/documents sent via electronic submission through Minnesota Credentialing Collaborative (http://www.mncred.org/) or via email to credentialing@bluecrossmn.com . All documentation requires an original signature by the applicant.

735: Staff Review of Applications

01. The routine review of practitioners and providers credentialing applications shall be completed by qualified and trained Blue Cross staff using established written file review criteria. Files with possible identified significant issues shall be reviewed by the Medical Director.

02. The routine review and recommendation to terminate participation in Blue Cross networks shall be completed by qualified and trained Blue Cross Credentialing staff, when practitioners or providers do not meet Blue Cross Network Participation Requirements.

03. Practitioner/ Provider File Review Criteria:

Based on a careful review of submitted credentialing materials according to established procedures, staff determines whether each practitioner credentialing file "Meets Requirements" (Refer to Series 800 for Participation Requirements). Files meeting Participation Requirements are presented to the Medical Director for Approval. If a credentialing file does not fully meet all requirements, the file is assigned to a Credentialing Analyst for further review and/or action, which may include review by a Medical Director or the Credentialing Committee (Refer to policy 220).

740: External Delegation of Credentialing

01. As of January 1, 2017, Blue cross requires the following for considering potential delegates:

- Accredited in National Committee for Quality Assurance (NCQA); Certified in NCQA, or pursuing NCQA accreditation or certification
- Employ a minimum of 300 practitioners
- Meet all Blue Cross credentialing requirements
- Delegation requests will be reviewed on a case by case basis. Providers interested in a delegated credentialing arrangement should contact their contract manager or Network Management Contact. The Credentialing Department will conduct an extensive pre-delegation evaluation to determine if the provider / practitioner group meets the delegation requirements. Results of the review will be communicated to the prospective delegate.

02. Using a Delegation Agreement, Blue Cross may delegate a part or all of the credentialing process to an external entity. This includes primary source verification and ongoing monitoring. The delegation agreement effectively delegates the credentialing process consistent with Blue Cross' internal standards and established procedures. All

delegation agreements must state that the final decision-making authority for the purposes of establishing Blue Cross participation status is the Blue Cross Credentialing Committee.

03. Prior to signing a new delegation agreement, staff conducts a pre-delegation file audit that includes a staff and Credentialing Committee review and evaluation of credentialing and recredentialing policies, procedures and files. In the event the pre-delegation review identifies credentialing/recredentialing policies or procedures that do not meet Blue Cross standards, Blue Cross shall not enter into any delegation agreement until all identified areas meet Blue Cross standards. Blue Cross shall maintain oversight consistent with applicable laws, which includes an audit on an annual basis. The delegation evaluation findings and recommendations shall be presented to the Blue Cross Committee for review and Credentialing approval.

The Committee may decide to:

- Approve continued delegation
- Approve continued delegation, with restrictions or conditions
- Terminate delegation

04. In the event of a decision to terminate any or all of the activities associated with delegation, the entity must wait one (1) year to participate in a pre-delegation evaluation prior to signing a new delegation agreement.

741: Actions Related to Approval of Continued Delegation with Conditions
Actions may reflect an increasing level of severity.

752: On-Going Monitoring of Sanctions, Quality of Care Complaints and Adverse Events

01. License Sanctions
On a monthly basis or within 30 days of a newly released sanction report Credentialing staff reviews practitioner limitations on licensure and sanction information.

02. Medicare and Medicaid Sanctions:
The Blue Cross Compliance department conducts a monthly exclusionary scan process which compares internal Blue Cross files against the following external entities for a match; Office of Foreign Assets Control (OFAC), Office of Inspector General (OIG) and the General Service Administration (GSA/EPLS) files. Effective January 1, 2019, Blue Cross will access the Preclusion List from the Centers for Medicare and Medicaid Services (CMS) to determine if practitioners are excluded from Medicare and Medicaid. Blue Cross will terminate from our network participation and deny payment for services furnished by an individual or entity on the Preclusion List during their preclusion period.

1. The exclusionary scan process/procedure and the preclusion process are conducted to ascertain that practitioners are not restricted from receiving payments from any Federal programs, including, but not limited to, Medicare,

Medicaid, or third-party programs. The results of the scan are distributed to many departments within Blue Cross including the Credentialing department.

02. Member Complaints:

Member Complaints and grievances are taken into consideration during the initial credentialing and recredentialing process with the possibility of escalation of review by the Credentialing Committee

Based on severity levels, member complaints and grievances regarding practitioners and providers quality of care or quality of service are investigated and tracked monthly by the Medical Management Quality and Compliance area who may escalate concerns for possible review by the Credentialing Committee for appropriate action.

753: Centers for Medicare and Medicaid (CMS) Opt Out Reports

Quarterly, the Provider Data Quality Analyst shall check the Center for Medicare and Medicaid (CMS) “Opt Out” Reports against Blue Cross network practitioner roster, in order to ensure that practitioners who are serving the Medicare population are not identified on such reports.

Series 800: Practitioner Network Participation Requirements

801: Purpose

Blue Cross seeks partnerships with qualified practitioners and providers committed to delivering quality health care services to our members. To this end, Blue Cross credentials practitioners and providers applying for participation with Blue Cross.

802: Compliance

Blue Cross collects and verifies certain eligibility and clinical information to determine whether practitioner/provider applicants meet Blue Cross Policy and Network Participation requirements. Continued participation with Blue Cross is contingent upon maintaining and complying with these participation requirement criteria along with quality performance standards as further set forth in the Blue Cross Credentialing & Recredentialing Provider Policy Manual.

803: Blue Cross Authority

Blue Cross reserves the discretionary authority to deny or approve participation to applicants including special considerations for those practicing in Health Professional Shortage Areas or Medically Underserved Areas, except as otherwise required by law.

Practitioners and providers applying for participation in the Blue Cross Provider Networks shall be responsible for and shall have the burden of proof with regard to demonstrating that all of the following requirements have been met. Blue Cross reviews each practitioners or provider on an individual case-by-case basis. If the practitioner or provider does not adequately demonstrate that all such requirements have been met, Blue Cross may at its sole discretion, except as otherwise required by law, deny participation to such practitioner or provider.

804: Minimum Guidelines

The Blue Cross Network Management Division must have determined that the practitioner's or provider's services are eligible and needed for Blue Cross members. In addition, the following participation requirements are the minimum guidelines used in the development and maintenance of a provider network that supports Blue Cross' Corporate Purpose: "We make a healthy difference in people's lives, consistent with our values of social responsibility, integrity, compassion, continuous learning, and financial responsibility."

Additional factors consistent with our Corporate Purpose are also considered at Blue Cross' sole discretion, including, for example, but not limited to, whether or not a practitioner acts in a professional manner.

01: Practitioner Credentialing

All designated specialty types requiring credentialing (refer to sec 102.01), who have not been formally credentialed, are subject to initial credentialing. These participation requirements serve as a basis for initial and subsequent recredentialing.

02: Provisional Practitioner Credentialing

A practitioner applying to the Blue Cross Network for the first time may be PROVISIONALLY credentialed ONE time. This provision is allowed for the benefit of making the practitioner available before the completion of the entire Initial Credentialing Process. Blue Cross will not hold practitioners in a provisional status for more than sixty (60) calendar days.

Requirements for the provisional credentialing include the following:

- Valid license to practice
- 5-year history of malpractice claims or Nat'l Practitioner Data Bank Query
- A current and signed application with attestation

805: Participating Practitioners / Providers

Practitioners or providers participating in Blue Cross Networks with one or more restrictions or conditions of participation set by the Credentialing Committee, shall acknowledge in writing an understanding of such restrictions or conditions, and agree to comply.

806: Eligibility Criteria

01. Disclosure of Information

Practitioners are accurate and truthful when completing all information in the Credentialing application. Applicants shall be responsible for reviewing and verifying all information in the Credentialing application.

02. Request for Information

Practitioners and providers are compliant and respond in a timely manner to Blue Cross requests for missing information or additional credentialing information.

03. Adverse Actions

In accordance with the Blue Cross Provider Agreement, Provider shall notify Blue Cross immediately if any Health Care Professional's license is ever revoked, suspended, or restricted. Practitioners and providers must maintain compliance with any State Board order or corrective action, and with any established restrictions or conditions for participation in Blue Cross networks.

04. Licensure, Registration or Certification

Network practitioners and providers must maintain the necessary state health care license, registration, or certification appropriate to their practice or type of services provided.

Any independently licensed, certified, or registered health practitioner or provider who applies for participation shall agree to comply with Blue Cross Participation Requirements (described herein) in order to obtain "acceptance for network participation" as described in the provider contract and to maintain participation in the network**.**

There is an additional requirement for Physician Assistants who are requesting a Blue Cross Participating Contract. These Physician Assistants must provide the physician named on their Supervising Physician Agreement or Collaborative Management Plan. The physician named on the Supervising Physician Agreement or Collaborative Management Plan must be participating and credentialed by Blue Cross.

Practitioners Requiring Credentialing:

Doctors

- Physician (MD, DO)
- Podiatrist (DPM)
- Chiropractors (DC)
- Optometrists (OD)
- Oral & Maxillofacial Surgeons (MD)
- Psychologists (Ph.D, Psy.D, Ed.D)

Advanced Practice Practitioners

- Certified Nurse Midwife (CNM)
- Registered Nurse Clinical Specialist (RNCS, CNS)
- Registered Nurse Practitioner (RNP)
- Physician Assistants (PA)

- Psychologists (MA)

Other
- Licensed Acupuncturist (L.Ac.)
- Traditional Midwife (LTM or LM)

Social Workers
- Licensed Clinical Social Worker (LCSW) – Wisconsin only
- Licensed Independent Clinical Social Worker (LICSW) – Minnesota and North Dakota
- Licensed Independent Social Worker (LISW) – Iowa only
- Certified Social Worker Private Independent Practice (CSW-PIP) – South Dakota only

Counselors
- Licensed Mental Health Counselor (LMHC) – Iowa only
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor (LPC) - Must be able to practice independently

Therapists
- Licensed Marriage and Family Therapist (LMFT)
- Physical Therapists (PT)

Note: Practitioners' titles and abbreviations vary from state to state and may change from time to time. Check with appropriate State licensing agencies for specific titles.

Facility Providers that Require Credentialing:

- Hospitals
- Home Health Care Agencies
- Skilled Nursing Facilities/Nursing Homes
- Ambulatory Surgery Centers (Free-standing only)
- Behavioral Health facilities including Substance Abuse treatment facilities (Inpatient, Residential and Ambulatory settings)

05. Liability Insurance

Network practitioners and providers (facilities) maintain continuous minimum insurance coverage as follows:

- ***Practitioner Requirement (Current)***
  Professional Liability (Malpractice) coverage in the amount of $1 million per incident *and* $3 million aggregate, unless the practitioner or provider is covered by a State or Federal Tort Claim liability statute, i.e., Minnesota State Statute 3.736. Practitioners must provide evidence of malpractice coverage or Federal Tort coverage letter, or attestation to the fact that they have the required amounts.

07. Payment Restrictions

Network practitioners and providers are not currently restricted from receiving payments from any State or Federal program, including but not limited to Medicare and Medicaid.

08. Chemical Substances

Network practitioners do not have an active substance use disorder. Determination of network participation status will be at the discretion of the Credentialing Committee and reviewed on a case by case basis. It is at the Committee's discretion to request additional evidence that there is not an active substance related problem. This may include, but is not limited to, a request for clinical assessment findings from an addiction specialist physician or other licensed or certified addiction professional. Network practitioners who have had prior instances of a substance use disorder or problems related to substance use (e.g., a driving offense) must provide Blue Cross with reasonable documentation of being abstinent by providing the number of months of sustained abstinence at the time of submitting an application for first time (initial) credentialing or recredentialing.

Examples of problems related to substance use include, but are not limited to, Driving Under the Influence (DUI) or DUI related offenses, seeking or receiving addiction treatment, or disciplinary actions by any professional organization related to substance use. Note that ASAM sees as inappropriate any disciplinary action taken due to a practitioner's health status; health problems should be referred for appropriate treatment, not discipline, and matters of competence, knowledge, skills, or unprofessional conduct should be within the purview of discipline, whether or not there is an accompanying health problem.

09. Fraud

Network practitioners are not currently charged with and/or have never been convicted of any offense involving fraud, reasonably related to the practice of medicine (including office billing and claims submission processes) since the commencement of their health care professional education and training.

10. Education and Training

Medical Doctors and Doctors of Osteopathy

Medical Doctors and Doctors of Osteopathy must have completed a residency recognized by the Accreditation Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), the Federation of the Royal College of Physicians and Surgeons of the UK, or a one (1) year fellowship recognized by the ACGME, the Royal College of Physicians and Surgeons of Glasgow (UK), the College of Family Physicians of Canada, or the Royal College of Physicians and Surgeons of Canada. Equivalent experience shall be considered for those General Practice practitioners graduating from medical school before 1980. In addition, Foreign Medical School Graduates must also be certified by the Educational Commission for Foreign Medical Graduates (ECFMG).

Practitioners granted an exception to the completed residency requirement shall be permitted to continue as participating practitioners at specifically approved locations as long as all other requirements are met.

Exceptions Made Prior to July 1, 1997
Practitioners granted an exception to the completed residency requirement shall be permitted to continue as participating practitioners at specifically approved locations as long as all other requirements are met.

Doctors of Chiropractic Medicine
Doctors of Chiropractic Medicine must have graduated from a college of chiropractic which is accredited by the Council on Chiropractic Education, or another agency appropriately approved by the U.S. Department of Education.

Doctors of Podiatric Medicine
Doctors of Podiatric Medicine must have completed a residency program. Equivalent experience will be considered for those graduating from Podiatry school before 1980.

Advanced Practice Registered Nurses (APRN)
Advanced Practice Registered Nurse Practitioners, Clinic Nurse Specialists, Nurse Midwifes, and Nurse Anesthetists must be certified for such advance practice registered nursing by a National nurse certification organization and are licensed by the State Board of Nursing.

Physician Assistant
Physician Assistant's must have and maintain certification with the National Commission on Certification of Physician Assistants (NCCPA) and be licensed by the State Board of Medical Practice.

Acupuncturists
Acupuncturists must have completed appropriate training in Oriental Medicine, maintain NCCAOM certification or training that is deemed equivalent by the State licensing board, and hold a current State license to practice acupuncture.

Clinical Psychologists
Doctoral Level: Network psychologists must have a Doctoral degree in psychology from a regionally accredited college or university and are licensed by the Board of Psychology at the doctoral level.
Masters Level: Network psychologists must have a Master's degree in psychology from a regionally accredited college or university and are licensed according to State requirements.

Certified Marriage and Family Therapists
Certified Marriage and Family Therapists must have a Master's degree in an appropriate behavioral science field or mental health discipline and are licensed by the Minnesota Board of Marriage and Family Therapy.

Independent Clinical Social Workers
Independent Clinical Social Workers must have a Master's degree in social work from a Graduate school of social work accredited by the Council on Social Education and are licensed by the Minnesota Board of Social Work.

11. MD, DO and DPM Board Certification

Physicians requesting network participation after March 15, 2005, must be Board Certified or become board certified within their certifying board's eligibility period.

- Physicians having a lapsed board certification must provide evidence of recertification within one year of notification by Blue Cross.

- Practitioners who have been "grand parented" for initial credentialing by Blue Cross shall be permitted to continue as participating practitioners at specifically approved locations as long as all other requirements are met.
  - A Blue Cross Approved Board refers to the American Board of Medical Specialties (ABMS), the American Osteopathic Associated (AOA), the Royal College of Physicians and Surgeons of Glasgow (UK), the College of Family Physicians of Canada, or the Royal College of Physicians and Surgeons of Canada, the American Board of Addiction Medicine (ABAM). To be considered board eligible, foreign educated physicians must have completed or have in process a one (1) year fellowship recognized by the Accreditation Council for Graduate Medical Education. Podiatrist approved board refers to American Board of Podiatric Medicine (ABPM) and American Board of Foot and Ankle Surgery (ABFAS)
  - Physicians with specialties which require certification must comply with their Board's recertification requirements. It is Blue Cross' expectation that physicians will maintain their certification to remain eligible for network participation. This applies only to practitioners initially credentialed for network participation after March 15, 2005.
  - Physicians who have a Boards-in-Process status must become Board Certified within the eligibility period allowed by their certifying board of specialty. Additionally, board certification must follow the specialty of the physician's training and primary practice specialty.
  - The Credentialing Committee makes the final decision on a case-by-case basis.
  - The Medical Director may approve practitioners on a case-by-case basis for foreign educated physicians.

807: Clinical Criteria

01. Scope of Practice

Network MDs, DOs and DPMs: Education and training is appropriate, relevant to, and consistent with their current scope of practice, as demonstrated by completing a residency, fellowship, and obtaining Board Certification.

All other practitioners' scope of practice is appropriate, relevant to, and consistent with their education and training.

02. *Intentionally Left Blank*

03. Professional Conduct

Practitioners engage in cooperative, professional and courteous behavior. Unprofessional conduct is subject to evaluation for participation status at the discretion of the Blue Cross and Blue Shield of Minnesota (Blue Cross) Medical Director and/or the review of the Blue Cross Credentialing Committee.

04. *Intentionally Left Blank*

05. Felony or Gross Misdemeanor

Network practitioners are not currently charged with and/or have never been convicted of a felony or gross misdemeanor, reasonably related to the practice of Medicine (including office billing and claims submission processes) since the time of the commencement of their health care professional education and training. These cases are reviewed on a case by case basis by the Credentialing Committee.

06. Sexual Problems

Network practitioners do not have an incident(s) of sexual misconduct, sexual assault, or sexual harassment. All sexual incidents will be reviewed by the Blue Cross Credentialing Medical Director.

Definition of Incident:
An INCIDENT is defined as Blue Cross' discovery of any of the following four events:

- Any conviction, judgment, jury verdict or the entering of guilty plea involving sexual misconduct, sexual assault, or sexual harassment.
- Any admission of responsibility for sexual misconduct, sexual assault, or sexual harassment.
- Any disciplinary action by a professional organization, such a hospital, a state licensing board, or other regulatory organizations, involving sexual misconduct, sexual assault, or sexual harassment, or
- Any act which Blue Cross reasonably deems to be inappropriate sexual contact or misconduct.

08. DEA Number

Network MDs and DOs in accordance with their scope of current practice, must maintain a valid Drug Enforcement Administration (DEA) number.

09. *Intentionally Left Blank*

10. Physical or Mental Health

Network practitioners do not have a condition that, with or without reasonable accommodation, affect the ability to provide appropriate care to patients, and otherwise perform the essential functions of a practitioner in the same area of practice without posing a health or safety risk to patients.

11. Quality of Care

Network practitioners provide appropriate patient care, maintain appropriate medical record documentation, and do not have malpractice case history, inappropriate prescribing

practices, negative peer references, or any other evidence that indicates concerns regarding patient care and safety.

808: *Intentionally Left Blank*

Series 900: General Recredentialing Policies

905: Frequency and Initiation of Recredentialing (See Policy 720)

01. All practitioners who are required to be credentialed for network participation are recredentialed at a minimum of every three (3) years using the contractually binding "Network Participation Requirements" described in policy 800 as a baseline.

02. *Intentionally Left Blank*

03. These requirements shall be applied along with a review of quality performance data when Blue Cross is evaluating the continued network participation status of practitioners in the event of any of the following:

- Request for continued network participation (See Policy 726)
- State Licensing Board action
- Blue Cross awareness of a National Practitioner Data Bank (NPDB) entry
- Blue Cross awareness of a situation suggesting a potential for patient harm
- Any other situation which Blue Cross, in its discretion, deems appropriate for review, (i.e., network need, non-compliance with terms of restricted or conditional participation status).
- A request for an information update may be made when a practitioner has a Restricted or Conditional participation status

906: Waiting Time to Reapply

A provider/practitioner that has been "Terminated With or Without Cause", has been "Denied" participation, or has Voluntarily Terminated their participation status, may reapply for Credentialing after waiting two (2) years from the Termination/Denial decision date.

910: Practitioners in Blue Plus who were never credentialed

All practitioners listed in section 102.01 including previous participating network practitioners who have never completed initial credentialing are subject to credentialing according to the terms set forth in Policy 800.

915: *Intentionally Left Blank*

Series 1000: *Intentionally Left Blank*

Series 1100: Credentialing Decisions

1105: Reasons for Participation Status Denials and Waiting Time to Reapply

01. A practitioner or facility provider shall be Denied initial Participation or Continued Participation when one or more of the Blue Cross Network Participation Requirements are not met. (See Policy Series 800.)

Practitioners or Facility providers who fit one of the following categories may resubmit a request for Network Participation via submission of a credentialing application, no earlier than two (2) years from the date of the decision notification.

Categories:

- Are denied initial participation
- Are denied continued participation
- Voluntarily terminate their participation status

1106: Actions Related to Conditional or Restricted Decisions

(See Policy Series 414.)

1110: Notifying Practitioners/Providers

01. Providers and individual practitioners are routinely notified in writing of conditional or restricted participation status decisions, including a description of the restrictions or conditions and appeal rights.

02. Practitioners/providers are notified by credentialing staff in writing, within fifteen (15) days of any denied credentialing participation decision and appeal rights. Clinic administrators are also notified, and are required to facilitate patient transition and proper billing procedures for non-participation status, which means the practitioner shall: inform patients who are Blue Cross members of their non-participating status and if such notice is not given, provider may not bill the member for any amount in excess of the amount allowed by Blue Cross; and obtain written consent from the member prior to rendering any services to verify that the member is aware practitioner is a non-participating provider which will impact their out-of-pocket costs. Blue Cross staff shall make reasonable effort to notify affected practitioners before notifying clinic administrative staff.

1115: Reconsideration Decisions

01. Clinical Basis:

New and currently participating Practitioners or providers who express disagreement with a denied, restricted, conditional or terminated participation decision due to non-compliance with <u>Clinical</u> Blue Cross Network Participation Requirements by the Credentialing Committee, and who have contacted appropriate Blue Cross staff, may submit new or additional information for a Reconsideration at the next scheduled meeting of the

Credentialing Committee. Reconsideration is limited to one (1) occurrence per credentialing application review. The practitioner has the right to be represented by an attorney throughout this process, but a reconsideration review is only conducted via written materials and does not include an in-person interview.

Currently participating practitioners or providers who express disagreement with a terminated, restricted or conditional participation decision due to non-compliance with Clinical Blue Cross Network Participation Requirements by the Credentialing Committee after reconsideration, may request an Appeal Hearing at the next scheduled meeting of the Credentialing Appeal Hearing (See Policy Series 1300). For new (currently not participating with Blue Cross) practitioners or providers, the reconsideration is the final review; no further appeal rights are available.

02. Eligibility Basis:

New and participating network practitioners and providers who express disagreement with the Credentialing Committee's (or its designee) denied, terminated, restricted or conditional participation decision (which is due to noncompliance with Eligibility Blue Cross Network Participation Requirements) may request reconsideration from authorized Credentialing staff.

When the practitioner or provider has contacted appropriate Blue Cross staff to request "Reconsideration" the practitioner or provider must submit evidence that they, in fact, meet all Eligibility Blue Cross Network Participation Requirements. The practitioner may submit new or additional written information to be reviewed at an upcoming Credentialing Committee meeting. The practitioner has the right to be represented by an attorney throughout this process, but a reconsideration review is only conducted via written materials and does not include an in-person interview.

Participation decisions based on eligibility participation requirements are made by the Credentialing Committee or its designee and shall be the final administrative decision available to practitioners and providers. Further appeal is not available.

1116. Restricted, Conditional, and Temporary Participation Decisions

01. Consistent with Credentialing Policy 414, restricted or conditional participation decisions may include specific action resulting from the Blue Cross Quality of Care peer review policy and procedures.

02. To meet member needs, Blue Cross may grant Provisional Participation status to an individual practitioner for a period not to exceed sixty (60) days by providing practitioners to serve immediately. A practitioner may be provisionally credentialed once.

In order to qualify for this designation, a practitioner must at a minimum:

- Hold a current state license in the state that they are requesting temporary credentialing with no current disciplinary actions
- Complete residency training and meet the Credentialing Board Certification requirements as outlined in Credentialing Policy 806.11

- Maintain adequate insurance as defined by Blue Cross
- Be employed by an existing Blue Cross network provider

For this designation to occur, a practitioner or facility may request provisional credentialing by submitting a credentialing application, including a Blue Cross attestation to the Blue Cross credentialing department as posted on our website. Provisional credentialing is optional and at the discretion of the Credentialing Manager or designee. Provisional status is not offered to practitioners who are credentialed by a delegated entity. All decisions regarding the request for provisional credentialing are final.

Series 1200: *Intentionally Left Blank*

Series 1300: Credentialing Reconsideration and Appeal Hearing Policy

(Refer to Policies 1100 and 1115 also. Refer to 1400 for facilities)

1305: Reconsideration Rights

Participating practitioners and providers have the right to request Reconsideration if the participation decision was due to non-compliance with Clinical Blue Cross Network Participation Requirements. To request Reconsideration, practitioners and providers must provide Blue Cross written notice postmarked within thirty (30) days from the date of the restricted, conditional, non-participation or termination decision notification letter. The request typically outlines why the practitioner or provider disagrees with the decision and includes additional information or highlights specific points for reconsideration. Upon receipt of the practitioner's request notice, Credentialing Committee reconsideration is initiated. The practitioner may submit additional written information to be reviewed at an upcoming Credentialing Committee meeting. The practitioner has the right to be represented by an attorney throughout this process, but a reconsideration review is only conducted via written materials and does not include an in-person interview.

1310: Appeal Rights

If a participating practitioner or provider chooses to request Reconsideration and the Committee upholds its original determination, the practitioner or provider also has the right to an Appeal Hearing before a panel of independent practitioners or providers (when the basis for the decision is non-compliance with one or more Clinical Blue Cross Network Participation Requirements). The practitioner or provider shall be sent notice regarding the time, date and place of the hearing. At the hearing the practitioner or provider has the following rights:

- A right to representation by an attorney or other person of the practitioner or provider's choice

- To have a record made of the proceedings
- To call, examine and cross-examine witnesses
- To present relevant evidence determined to be relevant by the appeal panel, regardless of its admissibility in a court of law
- To submit a written statement at the close of the hearing.

For new (currently not participating with Blue Cross) practitioners or providers, the reconsideration is the final review; no further appeal rights are available.

1312: Appeal Hearing Panel

If a practitioner or provider has exercised their right to an Appeal Hearing, a panel of independent practitioners or providers is selected.

The panel will make final credentialing decisions when an Appeal Hearing has been initiated by a participating practitioner or provider who has been given restricted or conditional participation status, or whose network participation has been terminated due to non-compliance with one or more Clinical Blue Cross Network Participation Requirements. This committee is intended to be a review organization under Minnesota Statutes Section 145.61, and thus shall ensure that all requirements contained in Minnesota Statutes Section 145.61 through 145.67 are maintained and followed.

01. Appeal Panel Responsibilities

- To review the provider/practitioner file and all paperwork submitted prior to the scheduled meeting date of the Committee.
- To hear all information presented by or on behalf of the Practitioner/Provider or other person of practitioner's choice during the Committee meeting.
- To act as a final authority in provider/practitioner participation decisions.
- To read and review all Appeal documentation submitted by a practitioner or provider.

02. Appeal Panel Membership

Membership Composition shall consist of three (3) voting practitioners including one practitioner representing the same or similar specialty area of the Appellant; one (1) Blue Cross Medical Director not participating in the Credentialing Committee decision discussion; and one (1) additional external practitioner. Each voting member shall have an equal vote. The Credentialing leadership or designee shall appoint members. In addition, the Medical Director of the Credentialing Committee, the Credentialing leadership, and Blue Cross Legal Counsel, as non-voting members, shall facilitate the Appeal Hearing.

03. Reporting Relationships

Decisions of the Credentialing Appeal Hearing shall be reported to the Credentialing Committee for informational purposes.

04. Meeting Scheduling

Meetings shall be scheduled as soon as possible to accommodate appeals in a timely manner.

1315: Status during Reconsideration/Appeal Process

01. The practitioner or provider's participation status in the Blue Cross Network may continue pending the outcome of the appeal and hearing process. This status is determined on a case-by-case basis by the Credentialing Committee at the time of the decision.

02. If the practitioner or provider chooses not to request a formal appeal of this decision, participating status shall end on the date specified in the original notice or if applicable, the restrictions or conditions shall remain. After that date, the practitioner shall be regarded as non-participating. Details regarding non-participation are conveyed directly to the practitioner and clinic administrator.

1330: Waiver of Right to Appeal

All appeal rights are considered to be voluntarily waived if the request for appeal has not been received by Blue Cross by the thirty-first (31st) day following the date of the Credentialing Committee decision letter.

1335: Notification of Decisions

The practitioner or provider shall be notified in writing of the Reconsideration or Credentialing Appeal Hearing decision within fifteen (15) business days of the decision.

Series 1400: Facility (Organizational Provider) Credentialing and Recredentialing

1401: Purpose:

Blue Cross seeks partnerships with qualified facility providers committed to delivering quality health care services to our members. To this end, Blue Cross credentials facility providers applying for initial or continued participation in the Blue Cross networks.

1405: Scope

These policies apply to the following provider types:

- Behavioral Health facilities providing Mental Health and/or Substance Abuse treatment services - inpatient/residential and outpatient/ambulatory settings
- Ambulatory Surgery Centers – freestanding

- Birth Centers - freestanding
- Home Health Care Agencies
- Hospitals – all types including psychiatric and specialty
- Skilled Nursing Facilities/Nursing Homes

In addition, all of these policies apply to any facility provider when Blue Cross becomes aware of a quality of care concern.

1407: Blue Cross Blue Shield Standards

It is expected that the facility provider will meet the criteria established by Blue Cross as set forth in Policy 1400.

1409: Compliance

Blue Cross collects and verifies certain eligibility information to determine if facility provider applicants meet Blue Cross Policy and Network Participation requirements. Continued participation with Blue Cross is contingent upon maintaining and complying with all participation requirements.

1411: Blue Cross Authority

Blue Cross reserves the discretionary authority to deny or approve participation to applicants including special considerations for those practicing in Health Professional Shortage Areas or Medically Underserved Areas, except as otherwise required by law. Facility providers applying for participation in the Blue Cross Provider networks shall be responsible for and shall have the burden of proof with regard to demonstrating that all requirements have been met. Blue Cross reviews each provider on an individual case-by-case basis. If the provider does not adequately demonstrate that all such requirements have been met, Blue Cross may at its sole discretion, except as otherwise required by law, deny participation to such provider.

1412: Minimum Guidelines

The Blue Cross Provider Relations Department must have determined that the facility provider's services are eligible and needed for Blue Cross members. In addition, the following participation requirements are the minimum guidelines used in the development and maintenance of a provider network that supports Blue Cross' Corporate Purpose: "We make a healthy difference in people's lives, consistent with our values of social responsibility, integrity, compassion, continuous learning, and financial responsibility."

Additional factors consistent with our Corporate Purpose are also considered at Blue Cross' sole discretion, for example, but not limited to, whether the facility has a history of non-compliance with state licensing and/or federal certification standards, has been cited for substantiated determinations of maltreatment or neglect, or has had fines or civil money penalties levied against it.

1413: Eligibility Criteria

01. Disclosure of Information

Facility providers must be accurate and truthful when completing all required information on the Blue Cross *Facility Credentialing Application*. Applicants shall be responsible for reviewing and verifying all information on the Application.

02. Licensure, Certification, Registration

Facility providers must at all times maintain the necessary state health care licensure, certification and/or registration appropriate to the type of services provided.

03. Liability Insurance

Facility providers must maintain continuous insurance coverage as follows:

- **Commercial General liability** coverage in the minimum amount of $1 million per occurrence *and* $3 million aggregate, unless the facility is covered by a State or Federal Tort Claim liability statute, i.e., Minnesota State Statute 3.736. Facilities must provide a copy of the Professional Liability coverage certificate or Federal Tort coverage letter indicating the required amounts.
- **Professional liability** coverage in the minimum amount of $1 million per occurrence *and* $3 million aggregate that includes all facility employees. Facilities must provide a copy of the Commercial General Liability coverage certificate or Federal Tort coverage letter indicating the required amounts.

04. Accreditation/Survey/Site Visit

At the time of initial or recredentialing, **one** of the following is required:

- Current accreditation by a Blue Cross approved accrediting agency
- Completion *within the past 36 months* of an onsite government licensing/certification survey in which the facility was found to be in substantial compliance. Facility is required to submit a copy of its most recent (within the past 36 months) licensing/certification survey along with a copy of the facility's corrective action plan, if corrective action was ordered; or submit written correspondence from the licensing/certification agency stating the facility is in substantial compliance with the most recent onsite survey standards.
- Successful completion of a Blue Cross onsite visit

Exceptions: 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 US Census Bureau.

05. Primary Care Clinic Site Visit

06. Requests for Information

Facility providers must respond *in a timely manner* to Blue Cross requests for missing information or additional credentialing information.

07. Reporting of Adverse Actions

In accordance with the Blue Cross Provider Service Agreement, provider shall notify Blue Cross immediately if any facility license is ever revoked, suspended, or restricted. Facility providers must maintain compliance with all State licensing agency orders of

corrective action and with any established restrictions or conditions of participation in the Blue Cross networks.

1417: Initial Credentialing
Prior to contracting with a facility provider identified in policy 1405, Blue Cross will confirm that all state and federal licensing and regulatory requirements are met and verify that the facility has met all requirements listed in Policy 1413.

1419: Recredentialing

01. Frequency - All facility providers shall be recredentialed at a minimum of every three (3) years.

02. Requirements are the same as those for initial credentialing.

1421: Behavioral Health Facilities

Behavioral health facilities provide mental health and/or substance abuse treatment in licensed residential/inpatient or ambulatory/outpatient settings.

01. Accreditation: Blue Cross accepts current, unconditional accreditation for behavioral health facilities from the following organizations:
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Council On Accreditation (COA)
- Healthcare Facilities Accreditation Program (HFAP)
- The Joint Commission (TJC) - formerly known as JCAHO

02. Non-accredited Behavioral Health Facilities: Non-accredited facilities and those with conditional accreditation must comply with Policy 1441.

03. Opiate Treatment Programs (DHS licensed): Practitioner credentialing is also required for all physicians with prescribing authority at State licensed opioid clinics. Physicians should complete and submit a *Minnesota Uniform Practitioner Credentialing Application*.

1422: Ambulatory Surgery Centers (Free-standing)

A free-standing ambulatory surgery center refers to one that is an independent legal entity and is not physically attached to another health care institution.

01. Accreditation: Blue Cross accepts current, unconditional accreditation for ambulatory surgery centers from the following organizations:
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- American Association of Ambulatory Health Centers (AAAHC)
- Healthcare Facilities Accreditation Program (HFAP)
- The Joint Commission (TJC) - formerly known as JCAHO

02. Non-accredited Ambulatory Surgery Centers: Non-accredited surgery centers and those with conditional accreditation must comply with Policy 1441.

1424: Home Health Care Agencies

Home Health Care Agencies must be licensed to provide skilled nursing services. In Minnesota, the agency must hold a Comprehensive or Class A license.

01. Accreditation: Blue Cross accepts current, unconditional accreditation for home health care agencies from the following organizations:

- Accreditation Commission for Health Care, Inc. (ACHC)
- Community Health Accreditation Program (CHAPS)
- The Joint Commission (TJC) - formerly known as JCAHO

02. Non-accredited Home Health Care Agencies: Non-accredited agencies and those with Conditional accreditation must comply with Policy 1441.

Non-Medicare Certified Home Health Care Agencies: Non-Medicare Certified agencies must meet the following minimum requirements:

- Must offer Registered Nurse (R.N.) services
- Must be available to serve clients 24 hours per day/7days per week
- Must be in business (hold State licensure) for at least 1 year
- Must have served at least 5 patients in the previous year

1425: Hospitals

All hospital types are credentialed, including Psychiatric and Specialty hospitals.

01. Accreditation: Blue Cross accepts current, unconditional accreditation for hospitals from the following organizations:

- Healthcare Facilities Accreditation Program (HFAP)
- The Joint Commission (TJC) - formerly known as JCAHO
- Det Norske Veritas (DNV)

02. Non-accredited Hospitals: Non-accredited facilities and those with Conditional accreditation must comply with Policy 1441.

1426: Skilled Nursing Facilities/Nursing Homes

01. Accreditation: Blue Cross accepts current, unconditional accreditation for skilled nursing facilities and nursing homes from the following organizations:

- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Community Health Accreditation Program (CHAP)
- Continuing Care Accreditation Commission (CCAC)
- The Joint Commission (TJC) - formerly known as JCAHO

02. Non-accredited Skilled Nursing Facilities/Nursing Homes: Non-accredited nursing homes and those with Conditional accreditation must comply with Policy 1441.

1441: Non-Accredited Facilities

Facilities without evidence of current, unconditional accreditation must meet Blue Cross standards and must pass an onsite visit by a government agency or by Blue Cross. *The survey must have been completed within the past 36 months of the re/credentialing approval date.*
Exceptions: 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 US Census Bureau

01. Government Agency Onsite Survey
The following onsite surveys may be accepted in lieu of a Blue Cross site visit:

- **Centers for Medicare and Medicaid Services (CMS) Certification Survey** – *Hospitals, Ambulatory Surgery Centers, Home Health Care Agencies, Skilled Nursing Facilities/Nursing Homes*
  Credentialing staff shall obtain a copy of the most recent (must be within the past 36 months) CMS standard certification survey along with any corrective action plans that would have been ordered by and sent to CMS pursuant to the survey *or* a cover letter from CMS stating the facility is in substantial compliance with CMS survey standards.
- **Department of Health Licensing Survey** - *Non-Medicare (CMS) Certified Home Health Care Agencies, Non-Medicare certified Ambulatory Surgery Centers*
  Credentialing staff shall obtain a copy of the most recent (must be within the past 36 months) standard licensing survey along with any corrective action plans that would have been sent to the Department of Health pursuant to the survey *or* a cover letter from the Department of Health stating the facility is in substantial compliance with Department of Health survey standards.
- **Department of Human Services** (or its Designee) **Licensing Review** – *Most Behavioral Health facilities*
  Credentialing staff shall obtain a copy of the most recent (must be within the past 36 months) Licensing Review report along with any corrective action plans that would have been ordered by and sent to DHS pursuant to the survey *or* a cover letter from DHS stating all citations have been corrected.

02. Blue Cross Site Visit
The facility must meet all core elements and receive a passing score of at least seventy percent (70%) during an onsite visit by Blue Cross or its designee. Blue Cross credentialing site visit standards include, but not limited to, the following:

- The exterior physical plant meets Blue Cross expectations
- The interior of the facility meets Blue Cross expectations
- The facility has infection control policies and procedures in place

- The facility protects member rights and has a Patient Bill of Rights clearly posted
- The facility has appropriate medical record keeping practices and provides evidence that medical records are maintained according to those practices
- The facility has a formalized process for credentialing all licensed practitioners employed or contracted at the facility
- The facility has a written Quality Improvement Program that is integrated throughout the facility and provides evidence of activities, such as meeting minutes or notes
- The facility provides documentation of continuity of care, discharge and/or transfer to another facility or level of care
- The facility provides appropriate instructions and teaching to facilitate member transition from facility with appropriate referrals

1442: Decision Making

The Credentialing Committee makes the final decision regarding facilities with significant issues (see Policy 726) following the recommendations submitted by the Blue Cross Provider Relations leadership, or their designee, prior to completing the contracting process or during mid-cycle monitoring or at the time of routine recredentialing.

1443: Reconsideration Rights

Participating facility providers have the right to request Reconsideration if the participation decision was due to non-compliance with Blue Cross Network Participation Requirements. To request Reconsideration, the facility must provide Blue Cross written notice postmarked within thirty (30) days from the date of the restricted, conditional, non-participation or termination decision notification letter. The request typically outlines why the facility disagrees with the decision and includes new additional information or highlights specific points for reconsideration. Upon receipt of the facility's request notice, Credentialing Committee reconsideration is initiated. The facility may submit new or additional written information at an upcoming Credentialing Committee meeting.

1444: Appeal Rights

If the facility chooses to request Reconsideration and the Committee upholds its original determination, the facility also has the right to an Appeal Hearing before a panel of independent providers (when the basis for the decision is non-compliance with one or more Blue Cross Network Participation Requirements). The facility shall be sent notice regarding the time, date and place of the hearing. At the hearing the facility provider has the following rights:

- A right to representation by an attorney or other person of the facility's choice
- To have a record made of the proceedings
- To call, examine and cross-examine witnesses
- To present relevant evidence determined to be relevant by the appeal panel, regardless of its admissibility in a court of law
- To submit a written statement at the close of the hearing.

1445: Status During Reconsideration/Appeal Process

- The facility's participation status in the Blue Cross Network may continue pending the outcome of the appeal and hearing process. This status is determined on a case-by-case basis by the Credentialing Committee at the time of the decision.
- If the facility chooses not to request a formal appeal of this decision, participating status shall end on the date specified in the original notice or if applicable, the restrictions or conditions shall remain. After that date, the facility shall be regarded as non-participating. Details regarding non-participation are conveyed directly to the facility's administrator.

1446: Waiver of Right to Appeal

All appeal rights are considered to be voluntarily waived if the request for appeal has not Been received by Blue Cross by the thirty-first (31st) day following the date of the Credentialing Committee decision letter.

1447: Notification of Decisions

The facility shall be notified in writing of the Reconsideration or Credentialing Appeal Hearing decision within fifteen (15) business days of the decision.

1450: Required Data Element: Medicare Provider Number

All facility providers that accept Medicare assignment and patients are required to submit a Medicare number as requested on the Credentialing application.

1451: Centers for Medicare and Medicaid Services (CMS) Provider Enrollment Appeal Process

A provider or supplier whose Medicare enrollment is denied or whose Medicare billing privilege is revoked can request an appeal of that initial determination. This appeal process applies to all provider and supplier types, not just those defined in 42 C.F.R. § 498, and Ensures that all applicants receive a fair and full opportunity to be heard. With the implementation of the appeals provision of Section 936 of the Medicare Prescription Drug Modernization and Improvement Act ("MMA"), all providers and suppliers that wish to appeal will be given the opportunity to request an appeal of a contractor hearing decision to an Administrative Law Judge (ALJ) of the Department of Health and Human Services (DHHS). Providers and suppliers then can seek review by the Departmental Appeals Board (DAB) and then may request judicial review.

1452: Complaint Initiated Provider Onsite Visits

01. Blue Cross Blue Shield and Blue Plus of Minnesota will initiate an onsite visit within 60 days of receipt of specific types of complaints: patient safety, oral patient privacy violations, or if a pattern of facility complaints is noted at one site or with a specific practitioner. Complaints received by the Plan from members regarding contracted network provider practices in the Blue Cross, Blue Plus and EPNI networks.

02. Member complaints regarding the quality of a patient visit are reviewed by Health Care Improvement. The nature of the complaint is then reviewed against the following thresholds to determine whether a site visit will be performed by a Site Reviewer.

- Any complaint that alleges an unsafe environment such as lack of infection control measures, lack of facility cleanliness, lack of facility maintenance (interior and/or exterior), inadequate waiting room and/or exam room space, or physical accessibility issues will be referred to Credentialing for an onsite visit with the highest priority.
- Any complaint alleging violation of privacy requirements will be reviewed to determine if the issue involves oral disclosure of components of Personal Health Information (PHI). If so, a site visit will be scheduled.
- If the Quality of Care Reviewer determines an onsite visit could assist in verifying or refuting an allegation, it will be referred to Credentialing. Credentialing will review the nature of the complaint including the number of complaints received against a certain provider to determine whether a site visit would be beneficial. Three complaints against a provider for essentially the same issue will cause a site visit to be scheduled.

03. The Credentialing Site Reviewer will schedule a visit within 60 days of the complaint's receipt by the Plan if it falls within the thresholds listed above. It is up to the discretion of the Site Reviewer if the clinic will be visited with or without notification.

- The site visit will include a full physical environment review as well as any data needed to resolve the specific issue.
- If an issue/problem is identified, a written Corrective Action Plan will be requested from the provider within 30 days of the onsite visit.
- Results of the site visit will be summarized and entered into the Credentialing Software within the appropriate record for that facility.
- The Site Reviewer will follow-up to ensure a Corrective Action Plan (CAP) is received, if one was required of the provider.
- The Site Reviewer will monitor the provider resolution and perform a second site visit, if necessary, within 60 days of the original visit.
- A report to the Credentialing Committee of the complaint resolution or ongoing issues will be prepared for the next Committee meeting.
- The cycle will continue until resolution of the issue(s) or until the provider is non-participating.

04. If subsequent to correcting a deficiency, the office site meets the complaint threshold for a different standard, Blue Cross will perform a follow-up site visit within 60 calendar days on the performance standard pertaining to the new complaint.

- The site visit will include a review of factors needed to resolve the specific issue.
- If an issue/problem is identified, a written Corrective Action Plan will be requested from the provider within 30 days of the onsite visit.
- Results of the site visit will be summarized and entered into the Credentialing Software within the appropriate record for that facility.
- The Site Reviewer will follow-up to ensure a Corrective Action Plan (CAP) is received, if one was required of the provider.
- The Site Reviewer will monitor the provider resolution and perform a second site visit, if necessary, within 60 days of the original visit.

- A report to the Credentialing Committee of the complaint resolution or ongoing issues will be prepared for the next Committee meeting.
- The cycle will continue until resolution of the issue(s) or until the provider is non-participating.