MOUNTAIN STATE BLUE CROSS BLUE SHIELD
NETWORK CREDENTIALING POLICY & PROCEDURE

TITLE: Credentialing and Recredentialing of Allied Health Practitioners, CRNPs (Certified Registered Nurse Practitioners) Nurse Midwives and Physician Assistants (PA)

No: CR-007 Supersedes No: N/A Original Effective Date: 12/31/07
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Related Policies: CR-006
CR-009
CR-014
CR-015
CR-016
CR-018

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Networks and Lines of Business:

PPO (X) POS (X List: ( )

POLICY: Practitioners will meet the established credentialing/recredentialing and quality standards in order to participate in the network(s). Initial credentialing and recredentialing will be conducted in accordance with the standards and guidelines as set forth in the following procedure. Practitioners will be recredentialed every three (3) years to comply with the established quality standards to continue participation in the network(s). This policy covers, as defined below, Allied Health Practitioners, Certified Registered Nurse Practitioners and Nurse Midwives.

PURPOSE: To ensure that practitioners are selected and evaluated in accordance with standards for credentialing and recredentialing as established by the Plan and all regulatory/accrediting bodies, as applicable. This credentialing and recredentialing effort will be in accordance with the 180 calendar day processing time requirement, when applicable.

DEFINITIONS: The following definitions will apply to this policy:

Allied Health Practitioners – This policy will cover the defined Allied Health Practitioners and others, which may be applicable and added to this policy as business conditions warrant.

1. **Acupuncturist** – An individual registered or certified to practice acupuncture, which is the stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or alleviate the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain diseases or dysfunctions of the body. Applicable to only the FEP Mid-Level Practitioner Network.
2. **Audiologist** – A licensed individual who engages in the practice of the evaluation, counseling, habilitation/rehabilitation of individuals whose communicative disorders center in whole or in part in the hearing function.
3. **Certified Diabetic Educator** – An individual who provides self-management education of this ongoing process by facilitating the knowledge, skill, and ability necessary for diabetes self-care. The individual must be certified by the American Association of Diabetes Educators.
4. **Certified Registered Nurse Anesthetist (CRNA)** – A licensed Registered Nurse, with a current RN license who perform anesthesia services. A CRNA who provides

care in Pennsylvania must have current certification by the Council on Certifications of Nurse Anesthetists or its predecessor or who has completed required training and education and is awaiting testing or the results of testing. A CRNA in West Virginia must have a current advanced certification.

5. **Dietitian-Nutritionist** – A licensed individual who engages in the integration and application of principles derived from the sciences of food nutrition, biochemistry, physiology, management and behavior to provide for all aspects of nutrition therapy for individuals and groups, including nutrition therapy services and medical nutrition therapy, compatible with dietitian-nutritionist education and professional competence. Applicable for FEP Mid-Level Practitioner Network only.
6. **Hearing Aid Dealer** – Any person engaged in the business of selling hearing aids.
7. **Hearing Aid Fitter** – A certified individual engaged in the practice of fitting and selling hearing aids (making selections, adaptations, and sale of hearing aids). This includes the physical acts of adjusting the hearing aid to the individual, taking audiograms, and making ear molds, advising the individual with respect to hearing aids, audiogram interpretation, and assisting in the selection of a suitable hearing aid for the sole purpose of the sale of a hearing aid.
8. **Massage Therapist** –A licensed individual who provides therapeutic massage of soft tissue.
9. **Occupational Therapist** – A licensed individual who provides therapeutic and rehabilitation procedures primarily to upper extremities. In addition, the individual may be certified in Hand Therapy.
10. **Optometrist** – A licensed individual who, following formal training, diagnoses and treats conditions of the human visual system and shall include the examination for, and the adapting and fitting of, any and all kinds and types of lenses including contact lenses.
11. **Physical Therapist** – A licensed individual who evaluates and treats any patient by the utilization of physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization and use of therapeutic exercises and rehabilitative procedures
12. **Speech-Language Pathologist** – A licensed individual who engages in the practice of the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the function of speech, voice or language.

Certified Registered Nurse Practitioner (CRNP) – A Registered Nurse, with a current RN license and a current CRNP license who is certified with a secondary license type in one of the following areas of specialization: pediatrics, adult care, family practice, gerontology, or psychiatry/Mental Health for Pennsylvania. For West Virginia CRNP's they must have advanced certification as issued by the West Virginia State Board of Nursing.

Certified Registered Nurse Midwife - A Registered Nurse, with a current RN license and current valid license as a midwife who is certified to perform specified obstetrical and non-surgically related gynecological services.

Physician Assistant (PA) - A licensed individual who examines, evaluates, diagnoses and treats patients under the collaborative agreement with a physician of the same or similar specialty.

CREDENTIALING

Initial Credentialing and Recredentialing Standards and Verification Process

The following procedures will be utilized for both the initial credentialing process and recredentialing process. Practitioners who are considered for participation in the network(s) are held to evidence of the following standards as applicable to each specialty. The process for each standard for verification is outlined. Approximately six months before the practitioner's third year anniversary date or date specified by the Credentials Committee, a pre-filled recredentialing application is generated from the Credentials Database and sent to the practitioner for a review of the information for accuracy, completeness, signature, and date.

1. **Application Process**

   The Plan obtains from the applicant a completed, signed and dated application, which includes, but is not limited to, the following information:

   A. Reasons for any inability to perform the essential functions of the position, with or without accommodations;
   B. Lack of present illegal drug use;
   C. History of loss of license and felony convictions;
   D. History of loss or limitation of privileges or disciplinary activity;
   E. Current malpractice insurance coverage;
   F. Attestation by the applicant to the correctness and completeness of the application.

   The application and attestation must be signed and dated within 180 calendar days for initial practitioners (effective August 1, 2008) and 180 calendar days for recredentialing practitioners prior to review and assessment by the Credentials Committees and rendering of the credentialing decision.

2. **Verification Sources**

   Oral, written, and Internet data will be used to verify information for credentialing and recredentialing. Oral and Internet verifications will include a dated and signed or initialed note/checklist by the staff person who verified the credentials. If the internet source generates a date, that date will be used and signed or initialed note/checklist by the staff person who verified the credentials. In instances where the Internet is used for verification, the appropriate NCQA-approved source for that element is used. A copy of the applicable web page that is initialed and dated is placed in the credentials file.

3. **Verification Process**

   The following process will be utilized for credentialing and recredentialing verification:

   A. Upon receipt of the current completed, signed and dated application from the practitioner, the application will be reviewed to ensure that the signature and date information are accurate. The application will also be reviewed to ensure that all of the requested elements are completed and the required documents are present and complete. Written, electronic or faxed signatures are

acceptable. Stamped signatures are not acceptable. The minimum standards for processing include 1) the ability to enroll new members, 2) ability to directly or through on-call arrangements with other qualified plan-participating practitioners of the same or similar specialty to provide coverage 24 hours a day including a credentialed and contracted practitioner of the same network(s), seven days a week for urgent and emergent care (exceptions: audiologists, occupational therapists, physical therapists, speech language pathologists and dietitians-nutritionists), 3) the ability to provide routine and urgent care (exceptions: dieticians/nutritionists for urgent care only), 4) possess an unrestricted license to practice in the state where the practitioner provides care. If the minimum standards are not present the following process will take place as indicated for initial applicants and recredentialing applicants:

- **Initial Applicants** - Processing will be discontinued on any initial application that does not include at least the above stated minimum standards for participation or failure to comply with the credentialing process including submission of an incomplete application. Notification to the practitioner of discontinuation of the credentialing process will be made via letter.
- **Recredentialing Applicants** – If a practitioner indicates he/she is not able to meet the above stated minimum standards, the Medical Director(s) will review the file for inclusion on the exception listing. The practitioner's failure to comply with the recredentialing process including submission of an incomplete application will be deemed as his/her intention to voluntarily withdrawal from the network(s). The written correspondence related to this withdrawal will be done via certified letter and regular mail.

B. Any application, which is deemed to be incomplete but the missing information can be obtained by telephone from the practice, (e.g., date of birth or Social Security number) will generate a phone call from a Plan representative. If the information is received in a timely manner following the telephone call, the file will continue through the credentialing process. If the information is not available by telephone (e.g., work history or signature) or is not provided within a timely manner following the telephone contact, the file is identified and flagged for additional follow-up activities and will be subject to the following procedures as indicated for initial applicants and recredentialing applicants. If it is necessary to fax any portion of the application back to the practitioner for updated information/signatures, etc; the entire application will be faxed if requested by the practitioner. The practitioner will be instructed to return only the necessary pages for updating. This is intended to ensure adequate review and accurate attestation on the part of the practitioner.
   - **Initial Applicants With Missing Information** - One phone call will be made by PDS staff to obtain the missing information. If the information has not been received within ten business days, a letter will be sent to the practitioner requesting the outstanding information and explaining that the file will be "process discontinued" if the information is not received within ten business days.

- **Recredentialing Applicants With Missing Information** - Two phone calls will be made by PDS staff to obtain the missing information. If the missing information has not been received within five business days of the original phone call, a second phone call will be made requesting the missing information. During the second phone call PDS will explain that the file will be forwarded to the Credentials Committees for possible termination if the information is not submitted. If the missing information is not received five business days after the second phone call, PDS will send a final development letter and contact Provider Relations. If missing information is still not received after ten business days following the mailing of the final development letter the file is sent to the office of Network Credentialing as noncompliant and presented to the Credentials Committee for intent to terminate. If further development for incomplete information is initiated by the credentialing staff, it will be completed for critical month files.

- **Recredentialing Applications Not Received -** If a recredentialing application is not returned within 30 days, PDS will send a letter to the practitioner requesting them to complete their recredentialing application. If the application is not received in 15 days of the original letter a second letter will be sent. If the application is still not received after 15 days of the mailing of the second letter, PDS will call the practitioner requesting the application. If the application is still not received after five business days a third letter with return receipt will be sent and Provider Relations is contacted. The third letter will explain that the file will be forwarded to the Credentials Committees for possible termination.

C. Upon receipt of the requested information, the primary source verification (PSV) process is conducted for applicable elements in compliance with internal requirements and all accrediting and regulatory standards. The process includes the following:

- **Licensure – Credentialing and Recredentialing Standard**
  Applicable Practitioners: Allied Health Practitioners, CRNPs, Nurse Midwives and PAs
  Not Applicable Practitioners: None
  Verification Time Limit: 180 calendar days. Licensure must be in effect at the time of the credentialing decision.
  Verification Process: A practitioner must have a current, valid unrestricted license(s) and certification as applicable to practice in the state(s) where he/she provides care for organization members, with verification directly from the state licensing agency This includes a review for previous and current state sanctions and restrictions on licensure and/or limitations on the scope of practice. A copy of the state license may also be obtained, but is not sufficient to constitute verification. Written confirmation will be obtained annually from the state licensing board regarding their verification of the education prior to issuing the license. Hearing Aid Fitters and dealers must have a current certificate of registration from the Department of Health. Non-physician acupuncturists must have a current license/certificate/registration from the applicable State Board of Medicine or State Board of Osteopathic Medicine. For Certified Registered Nurse Practitioners and Certified Registered

Nurse Anesthetists in West Virginia, verification from the West Virginia State Board of Nursing or certifying board confirming completion of advanced certificate as applicable to specialty type is required. For Nurse Midwives in West Virginia verification from the West Virginia State Board of Medicine confirming completion of advanced certificate as a Nurse Midwife is required.

- **DEA Certificate– Credentialing and Recredentialing Standard**
  Applicable Practitioners: CRNPs, Nurse Midwives, PAs, as applicable and Optometrists, as applicable
  Not Applicable Practitioners: Allied Health Practitioners
  Verification Time Limit: The certificate must be effective at the time of the credentialing decision.
  Verification Process: Practitioners who prescribe medications must have a DEA for the state(s) in which they practice. For optometrists who prescribe medications with a license type of therapeutic, glaucoma or both and have a DEA, a copy of the DEA certificate, with expiration date and/or entry in the National Technical Information Service (NTIS) database. If a practitioner has a pending DEA certificate, the practitioner may be credentialed at the discretion of the Medical Director, who will evaluate that an acceptable contingency plan exists for a practitioner with a DEA certificate to write all prescriptions requiring a DEA number until the practitioner has a valid DEA certificate.

- **Education and Training– Credentialing/Recredentialing Standard As Applicable**
  Applicable Practitioners: Allied Health Practitioners, CRNPs, Nurse Midwives and PAs
  Not Applicable Practitioners: None
  Verification Time Limit: None
  Verification Process: Verification of licensure directly from the state-licensing agency satisfies this requirement. Written confirmation is obtained annually from the State licensing board regarding their verification of education prior to issuing the license. For verification of Certified Nurse Anesthetists, the CCNA (Council on Certifications for Nurse Anesthetists or predecessor) card must be submitted with the application for Pennsylvania. The practitioners must be certified or have taken the examination and are awaiting the results to be considered for network participation. Those practitioners who are awaiting results must be under the supervision of an anesthesiologist and must be reviewed by the Credentials Committees as "exception" practitioners. CRNPs and Nurse Midwives must have verification of completion of advanced practice certification via the American Nurses' Credentialing Center (ANCC) or American Nursing Association (ANA).

- **Work History– Credentialing Standard**
  Applicable Practitioners: Allied Health Practitioners, CRNPs, Nurse Midwives and PAs
  Not Applicable Practitioners: None
  Verification Time Limit: 180 calendar days
  Verification Process: A minimum of 5 years of relevant work history via the application or

curriculum vitae. Gaps of 6 months or more will be evaluated. Verification can be taken by telephone or in writing and will be documented in the file. Gaps of one year or more require written documentation from the practitioner. If the practitioner has practiced fewer than five years from the date of credentialing, the work history starts at the time of initial licensure.

- **Malpractice History – Credentialing and Recredentialing Standard**
  Applicable Practitioners: Allied Health Practitioners, CRNPs, Nurse Midwives and PAs
  Not Applicable Practitioners: None
  Verification Time Limit: 180 calendar days
  Verification Process: History of professional liability claims, which resulted in settlements or judgments paid by or on behalf of, and any pending suits for the practitioner as reported by the practitioner on the application via a query from the National Practitioner Data Bank (NPDB) and/or written confirmation of the past 5 years of history of malpractice settlements from the malpractice carrier. Malpractice history must meet the Plan's Malpractice Index Scoring Guidelines and will primarily focus on the most recent five (5) year time period. (Refer to the separate Credentials Policy titled: "Malpractice Scoring").

- **Malpractice Insurance Coverage Credentialing and Recredentialing Standard**
  Applicable Practitioners: Allied Health Practitioners, CRNPs, Nurse Midwives and PAs
  Not Applicable Practitioners: None
  Verification Time Limit: Coverage must be effective at the time of the credentialing decision
  Verification Process: A copy of the malpractice face sheet from the carrier or the practitioner with the practitioner's name and the dates and amounts of current coverage or attestation signature from the practitioner on the application with the dates and amounts of current malpractice insurance coverage. For Allied Health Practitioners, the practitioner's name is not required under umbrella coverage when addendum is attached. Requirement indicated below:
  - **Requirements for Allied Health Practitioners and CRNPs:** Must have no less than $500,000 per claim and $1,500,000 aggregate per year coverage.
  - **Requirements for Nurse Midwives and PAs:** Must have no less than $1,000,000 per claim and $3,000,000 per year coverage, or whichever is higher according to the state law requirements. Practitioners in Pennsylvania must have current adequate malpractice insurance with limits as required by Medical Care Availability and Reduction of Error Fund (MCARE).

- **Medicare/Medicaid Sanctions Credentialing and Recredentialing Standard**
  Applicable Practitioners: Allied Health Practitioners, CRNPs, Nurse Midwives and PAs
  Not Applicable Practitioners: None
  Verification Time Limit: 180 calendar days
  Verification Process: A query of one of the following: National Practitioner Data Bank, Cumulative Sanctions Report, Medicare/Medicaid Sanctions and Reinstatement Report,

and/or the Federal Employees Health Benefits Program debarment report published by the Office of Personnel Management/Office of the Inspector General.

- **Collaborative Agreement Credentialing and Recredentialing Standard**
  Applicable Practitioners: CRNPs, Nurse Midwives and Physician Assistants (PA)
  Not Applicable Practitioners: Allied Health Practitioners
  Verification Time Limit: Must be within two years.
  Verification Process: Verbal or written confirmation from the practitioner indicating they do have a Collaborative Agreement with a Plan participating medical or osteopathic physician.
  The CRNP with a secondary license type in mental health the collaborating physician must be a credentialed and contracted practitioner within the same network(s) as the CRNP and have clinical privileges with the applicable specialty of the CRNP. For CRNPs with a secondary license type in mental health, the collaborating physician must be a psychiatrist.
  The Nurse Midwife collaborating physician must be a credentialed and contracted practitioner within the same network(s) as the Nurse Midwife and have clinical privileges in Ob/Gyn or Pediatrics.

D. Should any of the verifications expire (i.e., license, DEA certificate, insurance coverage, etc.), a renewed verification will be obtained prior to final decision making. If attempts at obtaining a renewed verification are unsuccessful, the file will be noted accordingly and addressed by the credentialing staff for appropriate follow-up (which may include process discontinuation of the file or Credentials Committee review for potential termination).

4. **Completion Process**

- Refer to the separate Credentials Policy titled: "Decision-Making Process for the Credentialing/Recredentialing of Network(s) Practitioners and Credentialing Related Committees" for the completion and decision-making process.
- If the Plan terminates a practitioner for any reason or if a network(s) credentialed practitioner submits a signed, explicit document stating that he/she no longer wishes to be a network(s) participating practitioner, and there is a break in service/contract of greater than 30 days, the practitioner will be required to undergo initial credentialing if he/she subsequently wishes to return to the network(s). For a period of thirty days or less duration, the Provider Data Services Department will be notified and no credentialing updates will be necessary.
- If a network(s) credentialed practitioner moves from one network practice to another, no further credentialing is required if the notification from the practitioner is received within 30 days, the practitioner will not be terminated; however initial credentialing will be required.
- All practitioners approved by the credentials committees or medical directors for on-going participation will be added to the three (3) year recredentialing cycle, or at more frequent intervals, as specified by the applicable Credentials Committee.
- All practitioners will be evaluated if they are Medicare-eligible as evidenced by UPIN number or by a Medicare welcome letter from the Freedom of Information Office from the CMS state carrier from where the practitioner originally received their welcome letter and confirmation that the practitioner

has not opted out of the Medicare program. Practitioners who have opted out of Medicare will be excluded from participation in the applicable network(s). This is confirmed following the credentialing process and prior to the contracting process. Ongoing assessment will occur on a quarterly basis via a report from Provider Data Services. Refer to the separate Credentials Policy titled: "Ongoing Review and Monitoring of Sanctioning Information".

- If a practitioner is on military leave or on a medical leave of absence, the recredentialing process must be completed within sixty days of his/her return to work. A monthly tickler system will be maintained in the Provider Data Services Department to accommodate practitioners in these situations.

5. **Notification Process**
   - A. Upon request, all practitioners have the right to be informed of the status of their credentialing and recredentialing applications. Practitioner rights and the process for responding to practitioner requests are discussed in greater detail in a separate CR policy titled: "Practitioner's Rights for Review, Notification and Correction of Credentialing Information."
   - B. All initial applicants are notified via letter of credentialing decision within sixty calendar days of the decision.
   - C. All recredentialed practitioners will be notified via letter by Medical Director(s) of any adverse final credentialing decision within sixty calendar days of the decision.