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Credentialing and Recredentialing Policy **2025**

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Purpose/Goal

Blue Cross Blue Shield of North Dakota's (BCBSND) Credentialing/Recredentialing Policy, herein referred to as "Policy," ensures the systematic review of health care providers requesting participation with BCBSND. The Policy includes requirements and procedures for verifying a Professional Health Care Provider or Institutional/Ancillary Provider by reviewing their qualifications to practice. The Policy also includes procedures for verifying that Professional Health Care Providers have met eligibility standards and requirements, such as education, licensure, professional standing, services, accessibility, utilization and quality.

The Policy includes processes to ensure compliance with applicable state and federal laws and URAC standards in verifying records through credentialing/recredentialing, in monitoring and reporting credentialing activities to appropriate BCBSND committees, and in overseeing the functions of site visits and delegated credentialing.

The Policy provisions serve as guidelines for all BCBSND credentialing/recredentialing decisions. The guidelines eliminate unfair business practices, such as:

- Prejudice in favor of or against individual circumstances or actions. The policy promotes consistency of interpretation and application of requirements.
- Issues of race, color, creed, religion, sex, national origin, marital status, disability, age or sexual orientation are not considered during the credentialing/recredentialing process.
- BCBSND does not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law solely on the basis of that license or certification.
- BCBSND does not discriminate against Professional Health Care Providers that serve high-risk populations or specialize in conditions that require costly treatment.

The Policy is reviewed annually by the Credentialing Committee and submitted to the Quality Management Committee for approval. Staff will review any credentialing/recredentialing files within a six-month period that were negatively affected by a policy when a subsequent revision of the same policy would result in a more favorable position. Contracted authorized parties with BCBSND may have access to review provider files in person at 4510 13th Ave. S., Fargo, North Dakota.

Scope

All licensed Providers seeking participation with BCBSND shall meet established Policy requirements.

The Credentialing Committee, Quality Management Committee, Quality Committee of the Board and Board of Directors review and approve the Policy requirements annually.

Evaluation and Accountability Committees

Board of Directors (Board)

As the governing body of BCBSND, the Board has ultimate responsibility for the Policy. The Board delegates oversight of the Policy to the Board's Quality Committee. The Board delegates responsibility for selection, credentialing and recredentialing to the Credentialing Committee.

Quality Committee of the Board (Quality Committee)

The Quality Committee of the Board is a subcommittee of the Board responsible for the oversight and direction of BCBSND's Quality Management Plan, of which the Credentialing and Recredentialing Policy is a part, for all providers and enrollees. The Quality Committee of the Board reports credentialing and recredentialing activities to the Board semiannually or as they arise.

Quality Management Committee (QMC)

The Quality Management Committee (QMC) Coordinates BCBSND's Quality Management Plan for all providers and enrollees. QMC reports credentialing and recredentialing activities to the Quality Committee semiannually or as they arise. This committee reviews and approves recommended changes to this Policy.

Credentialing Committee (Committee)

The Credentialing Committee meets as often as necessary to fulfill its responsibilities, but no less than quarterly, of making determinations on all credentialing/recredentialing applications. The Credentialing Committee Chair conducts the meetings and reports issues relating to credentialing/recredentialing activities to QMC.

Committee Membership

The Committee consists of, at a minimum, the following members:

- Chair, Chief Medical Officer of BCBSND
- BCBSND Credentialing Consultant
- No less than three BCBSND participating practitioners of different specialties who have no other role in BCBSND’s management activities.
- Health Delivery Department designee
- Compliance Department designee
- Credentialing Staff and other designees provide support to Committee meetings

Committee Responsibilities

The Committee is responsible for:

- Establishing, reviewing and approving the policies, standards for participation, procedures and processes that govern credentialing operations.
- Providing guidance to organization staff regarding the overall direction of the credentialing program.
- Evaluating and reporting the effectiveness of the credentialing program goals and objectives to organization management at least annually.
- Reviewing standards of care for reasonableness and the general status of providers’ abilities to meet such standards.
- Ensuring recredentialing is performed thoroughly and in compliance with policy guidelines.
- Monitoring activities of state licensing boards for restricted or terminated licenses.
- Monitoring sanction and termination activities to ensure due process.
- Developing and implementing oversight activities to monitor any delegated credentialing functions.
- Reporting credentialing activities to the QMC and to external entities (i.e., licensing boards, National Practitioners Data Bank (NPDB)) as deemed applicable.
- Accessing and evaluating clinical peer input when discussing standards of care for a particular type of provider.
- Ensuring minutes of Committee meetings are maintained, including all actions determined by the Committee.

Credentialing Committee Chair (Chair)

The BCBSND Chief Medical Officer or his/her designee is the senior clinical person responsible for the oversight of the clinical aspects of the Policy. In addition, the Chair or his/her designee may, acting on behalf of the Committee, approve or pend Provider applications in accordance with Policy standards. Pended applications are reviewed by the Committee and voted on to determine approval or denial.

Voting Procedure and Quorum

Professional Health Care Providers and BCBSND Credentialing Consultant committee members have voting privileges, except for the Chair, who shall vote only in the event of a tie or for quorum purposes. Fifty-one percent (51%) of all voting committee members shall constitute a quorum for the purposes of conducting official Committee business. A virtual vote may be requested so as not to delay the decision-making authority of the committee. Action shall be taken by a majority vote. Committee members may attend by conference call.

Term of Office

BCBSND staff members and the Credentialing Consultant serve on the Committee as a requirement of their position at BCBSND.

Non-employed BCBSND Participating Professional Health Care Providers are appointed by a majority vote of the Committee to a three-year term of office. A Participating Professional Health Care Provider's term of office may be extended upon the Chair's recommendation and majority approval by the Committee. If a Professional Health Care Provider leaves before completing his/her term, the Chair makes a recommendation, which requires majority approval by the Committee.

Recordkeeping

Committee business shall be documented, and a permanent, signed and dated record of meeting proceedings, findings and actions shall be kept. Confidentiality of the meeting minutes, as well as all discussions, deliberations and decisions made, shall be strictly maintained.

Consultations

Professional/Peer Advisors are appointed by the Chair to provide confidential consultation on Policy issues as may arise from time to time. The Chair selects advisors based on reputation, recognized skill in practice and advanced training.

Health Care Provider Definitions

Professional Health Care Provider

An individual who provides professional health care services and is licensed, certified or registered by the state in which the services are performed. Listing the Professional Health Care Provider below does not guarantee payment under BCBSND medical insurance plans. Provider titles or abbreviations vary from state to state and may change from time to time. The Professional Credentialing Guide will be revised as the changes are identified, with this Credentialing and Recredentialing Policy being updated with the new information during its at least annual review. Those with an asterisk (*) are not eligible for Medicare enrollment. Medicare participation is required for enrollment in the Medicare Advantage network. This is verified during credentialing and recredentialing activities.

- Acupuncturist*
- Audiologist (AUD)
- Certified Diabetic Educator (CDE)
- Certified Nurse Midwives (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Clinical Nurse Specialist (CNS)
- Dentist (DDS)
- Doctor of Chiropractic (DC)
- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatric Medicine (DPM)
- Licensed Alcohol & Drug Counselor (LADC)*
- Licensed Assistant Behavior Analyst
- Licensed Associate Professional Counselor (LAPC)*
- Licensed Behavior Analyst (LBA)*
- Licensed Clinical Social Worker (LCSW)
- Licensed Genetics Counselor (LGC)*
- Licensed Master Social Worker (LMSW)*
- Licensed Marriage Family Therapists (LMFT)*
- Licensed Professional Clinical Counselor (LPCC)*
- Licensed Professional Counselor (LPC)*
- Licensed Registered Dietician (LRD)
- Massage Therapist*
- Naturopath*
- Nurse Practitioner (NP)
- Occupational Therapist (OT)
- Optometrist (OD)
- Pharmacist (RPH)*
- Physician Assistant (PA)
- Physical Therapist (PT/RPT)
- Psychiatric Nurse Specialist (PNU)*
- Psychologists (PHD, PSYD)
- Speech Therapist (ST)

1915i Providers and Services

BCBSND partners with ND Medicaid to administer claims for Medicaid Expansion members that pay for additional home and community-based services to support individuals with behavioral health conditions. Providers are encouraged to follow the requirements set by the State of North Dakota for this program and the steps outlined below. Coverage and payment are based on benefit plan and eligibility.

Enroll as a 1915i provider with the State: 1915(i) Providers | DHS - Behavioral Health Division (nd.gov). Refer to the BCBSND provider manual for claim submission processes and procedures: https://www.BCBSND.com/content/dam/bcbsnd/documents/manuals/provider-manual-full.pdf.

In lieu of BCBSND credentialing, Peer Support Specialists I & II and Case Managers/Care Coordinators must be enrolled with Medicaid through the North Dakota Department of Health & Human Services (ND DHHS) for participation with BCBSND or Medicaid Expansion products.

Institutional/Ancillary Provider

Provides health care services. Institutional/Ancillary Providers are listed below.

- Acute Care Hospitals and subunits
- Behavioral Health Programs:
  - Freestanding Psychiatric Hospital
  - Partial Hospitalization Program (PHP)
  - Intensive Outpatient Program (IOP)
  - Residential Treatment Center
- Ancillary Providers:
  - Air and Ground Ambulance
  - Comprehensive Outpatient Rehab Facility
  - Diabetes Prevention Program or DPP
  - Freestanding Dialysis Center
  - Freestanding Outpatient Physical Therapy Facility
  - Freestanding Sleep Lab
  - Freestanding Surgical Centers/Ambulatory Surgery Center
  - Home Health Care Agency/Visiting Nurse Services
  - Home Infusion Center
  - Home Medical Equipment
  - Hospice Facility
  - Independent Orthotics/Prosthetics Supplier
  - Independent Lab
  - Long Term Acute Care Facility
  - Mobile Radiology Supplier
  - Optometric Supplier
  - Public Health Unit
  - Radiology
  - Skilled Nursing Facility

Provider titles or abbreviations vary from state to state and may change from time to time. The Organizational Credentialing Guide will be revised as the changes are identified, with this Credentialing and Recredentialing Policy being updated with the new information at least during its annual review.

Credentialing Standards

Agreements

- A signed and completed Provider Group Participation Agreement ("Agreement") must be received by BCBSND.
- Agreements will not be backdated to satisfy provider requests.
  - Exception: Evidence supports that a delay occurred on the part of BCBSND issuing an Agreement for signature.
- The Acceptance Date (effective date) of the Agreement stored in a Provider organization's file will be equal to the receipt date of the Agreement unless otherwise noted in the Agreement.
- Participation effective date of provider(s) within the group may be equal to or after the Acceptance Date of the Agreement, provided that at least one provider has been successfully credentialed.
- A copy of the business's W-9 must accompany the signed Agreement submitted to BCBSND as evidence of legal entity name.

Applications

Trained and qualified Credentialing Specialists review all credentialing/recredentialing applications for completeness, accuracy and conflicting information during the application processing. A formal audit of a sample of applications is performed by a different Credentialing staff member or Credentialing Consultant for processing accuracy. All applications, including documentation and attachments, are presented to the Chair, the Credentialing Consultant and/or Committee for review and approval.

Professional Health Care Providers

Professional Health Care Providers must meet the applicable standards to be considered for participation. It is the ultimate responsibility of the Professional Health Care Provider to ensure complete release of information from any entity queried by BCBSND or their designee. The signature included in the credentialing application cannot be dated more than 180 days prior to Committee review. The standards are as follows:

- Professional Health Care Provider will attest by date and signature to the accuracy of all information in the Credentialing Application. Substantial errors of fact involving documents discovered before or after appointment can be the basis for non-selection or, after appointment, adverse action, including termination. Electronic signatures, such as faxed, digital, electronic, scanned or photocopied, are acceptable and have the same legal effect and enforceability as a handwritten signature.
- Professional Health Care Provider will consent to the inspection of records and documents pertinent to consideration of his/her request for appointment and privileges.

- Contracted Provider shall maintain policies of general and professional liability/malpractice coverage to insure Provider against any claim for damages arising by reason of personal injury or death resulting directly or indirectly from the performance of the Provider's participation agreement. Such coverage shall be in an amount equal to the greater of the highest amount required by law or, in the absence of such law, the community standard for such coverage. Provider shall provide a certificate or proof of such coverage upon application, entitling BCBSND to receive 30 days' prior notice of any change, termination or expiration of coverage. The certificate or an accompanying letterhead must clearly state the specified Provider is covered by the policy.
  - Ambulance services providing written confirmation of coverage from North Dakota Insurance Reserve Fund (NDIRF) would not be required to include the certificate itself.
- Professional Health Care Provider must provide information related to professional claims history – defined as “cases that are settled or have resulted in an adverse judgment against the provider.”
- Professional Health Care Provider is not currently restricted from receiving payments from any state or Federal program, including, but not limited to, Medicare or Medicaid. Providers are required to notify BCBSND within 15 business days of receipt of exclusion notice from OIG.
- Professional Health Care Provider must have no unexplained chronological gaps greater than six (6) months in his/her recent professional career history. Work history for the past five (5) years is reviewed during initial credentialing, unless the provider graduated more recently than that, in which case work history is reviewed from graduation date forward.
- Professional Health Care Provider does not have an active problem with chemical substance abuse. Professional Health Care Providers who have had prior instances with chemical substance abuse may be required to provide reasonable documentation that they have been chemical substance free prior to application.
- Professional Health Care Provider must report any current or history of loss of licensure, registration or certification. Professional Health Care Providers must list all health care licenses held in any state or jurisdiction and explain licenses that are not current, have ever been voluntarily relinquished or have been subjected to disciplinary action.
- Professional Health Care Provider must currently have and maintain the necessary state health care license, registration or certification appropriate to their practice or type of service provided.
- Professional Health Care Provider must be free of physical and mental health conditions that would affect, or likely affect, his/her ability to deliver the care expected in their designated scope of practice.
- Professional Health Care Provider must not have been convicted of, or pled no contest to, any felony charges. Individual consideration may be given to Professional Health Care Providers with felony charges unrelated to health care.
- Professional Health Care Provider must report any history of the loss or limitation of hospital or other organizational clinical privileges.
- Medicare Advantage network providers may not opt-out of Medicare participation, must participate with the designated Medicare Contractor/Jurisdiction and have a signed agreement for the Medicare Advantage network.
- Medicaid Expansion network providers must be enrolled with the state’s Medicaid program.

Professional Health Care Provider specific standards

- NP, CNM, CNS and CRNA must maintain current certification by a professional organization offering certification in the specialty of practice and current licensure in the state in which they are practicing. Their scope of practice shall be consistent with the Nurse Practice Act of the state in which they are licensed to practice.
- Professional Health Care Providers who have hospital admitting privileges shall maintain current medical staff appointment and delineated clinical privileges at an eligible institution for the scope of practice for which the Professional Health Care Provider is being considered. This requirement may be waived for medical doctors practicing in rural hospitals.
- Non-board-certified physicians must have graduated from medical school, other appropriate schooling and/or completion of residency appropriate for practicing specialty and consistent with listing in the directory. Board-certified physicians must be certified by compendium: the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA) or a specialty board recognized by the National Committee of Quality Assurance (NCQA) or URAC.
- Physician graduates from a foreign medical school must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG).
- Professional Health Care Providers must hold a current DEA certificate, if applicable.
- Privileges for compact practitioners, such as nurse practitioners and physical therapists, will be verified in lieu of state license if both the license and practicing site are in compact states. Psychologists participating in PSYPACT will have their relevant license verified.
- Physician assistants must maintain current national certification as physician assistants (PA-C) by the National Commission for the Certification of Physician Assistants and maintain current physician assistant practice status granted by the state in which they are practicing. This may be in the form of a state certificate, license or registration, depending on the state.

Institutional/Ancillary Providers

Institutional/Ancillary Providers must meet the following standards to be considered for BCBSND participation:

- Acute Care Hospitals (Short and Long Term)
  - State licensure (non-provisional)
  - Provide and maintain evidence of Medicare certification OR accreditation by The Joint Commission or another CMS-approved national accreditation organization with deeming authority
  - Evidence of malpractice insurance
- Freestanding Psychiatric Hospitals
  - State licensure (non-provisional)
  - Provide and maintain evidence of Medicare certification OR accreditation by The Joint Commission or another CMS-approved national accreditation organization with deeming authority
  - Evidence of malpractice insurance
- Psychiatric Intensive Outpatient Program (IOP)
  - Evidence of malpractice insurance
  - Meets ND substance use license requirements, as ND does not issue psychiatric license

- Psychiatric Partial Hospitalization Program (PHP)
  - Evidence of malpractice insurance
  - Meets ND substance use license requirements, as ND does not issue psychiatric license
- Substance Use Disorder (Intensive Outpatient Program (IOP)
  - State licensure (non-provisional)
  - Evidence of malpractice insurance
- Substance Use Disorder (Partial Hospitalization Program (PHP)
  - State licensure (non-provisional)
  - Evidence of malpractice insurance
- Psychiatric/Substance Use Disorder (Residential Treatment Center (RTC)
  - State licensure (non-provisional)
  - Evidence of malpractice insurance
- Opioid Treatment Programs (OTP)
  - State licensure (non-provisional)
  - SAMHSA OTP certification
  - Is registered with the Drug Enforcement Administration (DEA)
  - Evidence of malpractice insurance
- Office-based Opioid Treatment (OBOT)
  - At least one practitioner on the DEA waiver list on SAMHSA site
  - Evidence of malpractice insurance
- Air and Ground Ambulance
  - State licensure (non-provisional)
  - Evidence of malpractice insurance, if applicable
- Comprehensive Outpatient Rehab Facility
  - State licensure (non-provisional)
  - Provide and maintain evidence of Medicare certification accreditation by CARF or another CMS-approved national organization with deeming authority
  - Evidence of malpractice insurance
- Diabetes Prevention Program or DPP
  - Certification by Centers for Disease Control and Prevention (CDC)
  - Evidence of malpractice insurance
- Freestanding Dialysis Center (Renal Treatment Center)
  - Provide and maintain evidence of Medicare certification
  - Evidence of malpractice insurance

- Freestanding Outpatient Physical Therapy Facility
  - State licensure (non-provisional)
  - Provide and maintain evidence of Medicare certification OR accreditation by The Joint Commission or another CMS-approved national accreditation organization with deeming authority
  - Evidence of malpractice insurance
- Freestanding Sleep Lab
  - Provide and maintain evidence of Medicare participation (receive payments) OR accreditation by a CMS-approved national accreditation organization with deeming authority
  - Evidence of malpractice insurance
- Freestanding Surgical Centers/Ambulatory Surgery Centers
  - State licensure, if applicable (non-provisional)
  - Provide and maintain evidence of Medicare certification OR accreditation by The Joint Commission, the Accreditation Association of Ambulatory Health Care (AAAHC), American Association for the Accreditation of Ambulatory Surgical Facilities (AAAASF) or another CMS-approved national accreditation organization with deeming authority.
  - Evidence of malpractice insurance
- Home Health Agencies/Visiting Nurse Services
  - State licensure as a Home Health Agency (non-provisional) or CMS designation that a Rural Health Clinic may provide Visiting Nurse Services
  - Provide and maintain evidence of Medicare certification/participation (receive payments)
  - Evidence of malpractice insurance
- Home Infusion Center
  - Provide and maintain evidence of Medicare certification/participation (receive payments)
  - Evidence of malpractice insurance
- Home Medical Equipment
  - Provide and maintain evidence of Medicare certification/participation (receive payments)
  - Evidence of malpractice insurance
- Hospice Facility
  - State licensure (non-provisional)
  - Provide and maintain evidence of Medicare certification/participation (receive payments)
  - Evidence of malpractice insurance
- Independent Orthotics/Prosthetics Supplier
  - Provide and maintain evidence of Medicare certification
  - Evidence of malpractice insurance

- Independent Lab
  - Provide and maintain evidence of CLIA certificate or waiver of a certificate
  - Evidence of malpractice insurance
- Long Term Acute Care Facility
  - State licensure (non-provisional)
  - Provide and maintain evidence of Medicare certification OR accreditation by the Joint Commission or another CMS-approved national accreditation organization
  - Evidence of malpractice insurance
- Mobile Radiology Supplier
  - Provide and maintain evidence of Medicare certification or FDA number
  - Evidence of malpractice insurance
- Optometric Supplier
  - Evidence of malpractice insurance
- Public Health Unit
  - Evidence of malpractice insurance
  - Listed on state health department website
- Radiology
  - Provide and maintain evidence of Medicare certification or FDA number
  - Evidence of malpractice insurance
- Skilled Nursing Facility
  - State licensure (non-provisional)
  - Provide and maintain evidence of Medicare certification OR accreditation by The Joint Commission or another CMS-approved national accreditation organization
  - Evidence of malpractice insurance

If the hospital or ancillary facility is not Medicare or ND Medicaid certified/participating or accredited (as specified above), and as such, a site visit has not been completed, a site visit might be completed and would be reviewed for the following:

- Physical Environment to ensure compliance with ADA regulations
- Cleanliness
- Privacy Standards
- HIPAA Compliance
- Organization plan
- Policy and procedure manuals
- Staffing ratios
- Equipment maintenance programs
- Accessibility
- Medical recordkeeping practices and system
- Quality assurance activities

- Risk management programs
- Malpractice records
- Carrier reports
- Safety records
- Emergency procedures

Erroneous information

BCBSND will contact the Provider if any information received from a primary source differs from what was disclosed on the application. The Provider has the right to correct erroneous information. Any deficiencies are documented and attached to the Provider's file. BCBSND is responsible to review the file for completeness, accuracy and conflicting information prior to submission to the Chair and/or Committee for consideration.

Time frames

Credentialing applications are processed within 180 days from the signature date (90 days from receipt date) on a completed credentialing application which must contain all required documentation including, but not limited to, an Agreement when applicable. Providers may contact the Credentialing Department by email or in person to inquire on status of credentialing application, and all inquiries will be documented.

Confidentiality Policy

BCBSND shall hold in confidence all data and information that it acquires in relation to this Policy. All documents are confidential, maintained in locked files or password-protected electronic programs and accessed by authorized personnel only.

- All credentialing staff entering credentialing information is assigned passwords to prevent unauthorized staff from accessing screens containing confidential information. Only individuals who need access to the information to perform their assigned duties will have access to the information. Credentialing leadership determines the level of authorized user access to credentialing data.
- Confidentiality training is conducted annually for all personnel accessing credentialing information including, but not limited to:
  - Credentialing committee members
  - Credentialing staff (including temporary staff)

Primary Source Verification

During the credentialing process, BCBSND primary source verifies the following Professional Health Care Provider and Institutional/Ancillary Provider credentialing information by phone, internet, fax or letter. The documentation must be dated no more than 180 days prior to Committee review.

- A valid license/certification to practice in the state(s) via state licensing agency/board
- Highest level of education and training if not primary source verified by the state licensing or certification agency or board

- Board certification, if applicable, via American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American College of Nurse Midwives (ACNM), National Commission on Certification of Physician Assistants (NCCPA), American Association of Nurse Anesthetists (AANA), American Dental Association (ADA), American Board of General Dentistry (ABGD) or a specialty board recognized by NCQA or URAC. In the absence of board certification, the highest level of education or training is verified through the American Medical Association (AMA), state licensing agency/board or academic institution.
- State and Federal sanction activity: Medicare, Medicaid, LEIE, SAM
- Medicare Opt Out
- National Practitioners Data Bank (NPDB)
- Accreditation status, if applicable
- Criminal history background checks and licensure/disciplinary screening reports for MDs and DOs

Recredentialing Standards

Recredentialing of Professional Health Care Providers/Institutional/Ancillary Providers is conducted every three years to review the last three years of history and to ensure all applicable standards are current at the time of recredentialing.

Professional Health Care Provider

BCBSND will provide a recredentialing application to Professional Health Care Providers scheduled for recredentialing. The Professional Health Care Provider is required to update and return a signed and dated recredentialing application and meet the following applicable standards for continued participation consideration. The signature included in the recredentialing application cannot be dated more than 180 days prior to Committee review.

BCBSND verifies the following information by phone, internet, fax or letter. The documentation must be dated no more than 180 days prior to Committee review.

- A valid license/certification to practice in the state(s) via state licensing agency/board
- Staff privileges, when required, including admitting privileges, are in good standing. May accept attestation in lieu of phone, internet, fax or letter verification
- Valid DEA certificate, if applicable
- Specialty changes must include verification of completion of a residency program or other clinical training and experience as appropriate for the practicing specialty and listing in the directory
- Board certification, if applicable, via American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American College of Nurse Midwives (ACNM), National Commission on Certification of Physician Assistants (NCCPA), American Association of Nurse Anesthetists (AANA), American Dental Association (ADA), American Board of General Dentistry (ABGD) or a specialty board recognized by NCQA or URAC
- Medicare/Medicaid sanction activity through National Practitioners Data Bank (NPDB) or the Department of Health and Human Services (DHHS)
- Medicare Opt Out
- Appropriate levels of malpractice insurance are maintained
- Professional liability claims history since initial credentialing, if applicable, through NPDB and malpractice carrier
- Professional Health Care Provider is compliant with BCBSND’s Quality Management Program

Institutional/Ancillary Provider

BCBSND will provide a recredentialing form to Institutional/Ancillary Providers scheduled for recredentialing. Recredentialing criteria includes the following:

- Valid copy of full, unrestricted accreditation by relevant governing organization, if required
- Valid copy of license, if required
- Valid evidence of Medicare certification, if required
- Valid evidence of malpractice/liability insurance, if required
- Provider is compliant with BCBSND's Quality Management Program

Every effort is made to complete recredentialing within 36 months of the most recent credentialed or recredentialed date. If the Provider is noncompliant with the recredentialing process, the Provider's claims will suspend and deny as provider liable until which time credentialing paperwork is received for processing as an initial recredential. When a new credentialing file is established, the original credentialing case is referenced for the credentials that do not expire or change over time, such as education.

Primary Source Verification

During the recredentialing process, BCBSND primary source verifies the following Professional Health Care Provider and Institutional/Ancillary Provider recredentialing information by phone, internet, fax or letter. The documentation must be dated no more than 180 days prior to Committee review.

- A valid license/certification to practice in the state(s) via state licensing agency/board as minimally required to engage in clinical practice
- Board certification, if applicable, via American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American College of Nurse Midwives (ACNM), National Commission on Certification of Physician Assistants (NCCPA), American Association of Nurse Anesthetists (AANA), American Dental Association (ADA), American Board of General Dentistry (ABGD) or a specialty board recognized by NCQA or URAC

Credentialing/Recredentialing Decisions

BCBSND reserves the right to deny participation to any Provider at its sole discretion during the credentialing or recredentialing process. The Committee has final authority to approve or disapprove applications by providers for organization participation status, regardless of meeting the credentialing standards.

Only completed applications will be submitted to the Committee for review.

Upon Committee determination, the Provider's practice location(s) will be loaded to the provider data system for claims and directory purposes as appropriate. The effective date for provider setup will be the later of the date the provider joined a participating organization, or the date the organization's agreement became effective. BCBSND has a general limitation of 90 days retro the date the application or request was received, but the retroactive effective date might be greater than 90 days if prior approval is received from the contracting team. This is also true for affiliations requested outside of the credentialing process (additional location requests). Providers will not display in any directory until BCBSND's Credentialing Committee or Committee Chair/designee approval date.

The Provider seeking initial credentialing will be provided a written notification, sent via mail, email or fax, acknowledging approval or denial of credentialing within 30 business days of the Committee decision recorded on the credentialing file. The Provider is considered to be recredentialed and their participation will remain active unless otherwise notified.

BCBSND reserves the right to reject the application if any information or attachments are missing, or if information received from a primary source differs from what was disclosed on the application. The Provider has the right to correct erroneous information and re-sign the attestation to validate changes to a resubmitted application. Any deficiencies are documented and attached to the Provider's file. BCBSND is responsible to review the file for completeness, accuracy and conflicting information prior to submission to the Chair for consideration.

Approved Applications

The Chair, having delegated authority, may approve clean applications meeting Policy standards.

Clean applications are defined as:

- The Provider has completed all applicable sections of the credentialing application.
- Where indicated, the Provider has signed and dated the credentialing application.
- All necessary support documentation has been submitted and is included with the credentialing application in the Provider's file.
- The Provider meets the credentialing standards and there are no significant issues to report to the credentialing committee (Section B).

The Committee reviews/approves a list of Providers approved by the Chair during their regularly scheduled quarterly meetings. The Provider's credentialing/ recredentialing is effective on the Committee or Chair approval date.

Applications with possible significant issue(s)

Significant issues identified in the application or as part of the credentialing or recredentialing processing that may impact the quality of care or services delivered may include (but are not limited to) the following:

- History of loss or limitation of privileges or disciplinary activity
- Disclosure of any physical, mental or substance abuse problems that could, without reasonable documentation, impede the Professional Health Care Provider's ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients
- Malpractice Claims History exceeding three claims in the past five years
- Provisional License or other sanctions or limitations on license
- Special Investigations, Corrective Action Plans, or other potential incidents of poor quality

A possible significant issue(s) identified by BCBSND staff is forwarded to the Chair for review. The Chair may decide one of the following:

1. Determine if additional information is required prior to consideration by the Committee.
2. Determine that the possible significant issue(s) meets or does not meet Policy standards and present to the Committee for decision.

The Committee shall review the application with possible significant issue(s) for decision. The Committee may decide one of the following:

1. Determine the application meets BCBSND Credentialing/Recredentialing standards and approve. Staff is directed to communicate the decision according to Approved Applications processes.
2. Determine the application does not fully meet standards and grant restricted or conditional participation (e.g., A provider who has been issued a provisional license due to new construction or transfer of ownership and is awaiting a licensing site visit may be granted conditional approval. The conditional approval time frame would be expected to be the same time frame specified on the provisional license).
3. Determine the application does not meet standards and deny. Provider would not be eligible under the Agreement, so would be considered non-participating and cannot be active under a Participating group. The terms of the Agreement describe the group's responsibility to ensure its providers meet credentialing requirements.

Denied Applications

The Committee will consider the following prior to issuing a denial of participation. This is not an all-inclusive list, and other factors may be considered when issuing a denial of participation. If opting into Medicaid Expansion, the North Dakota Department of Health and Human Services (ND DHHS) is notified of denied applications within10 calendar days of the decision.

- Substandard credentials
- Omission, misrepresentation or falsification of information on the credentialing application
- Noncompliance with the Policy
- Circumstances that may pose an immediate risk to members as determined by the Committee
- Provider is not compliant with BCBSND's Quality Management Program

The process for denial of BCBSND credentialing/recredentialing is as follows:

1. The Committee makes denial determination, and the findings are reported to QMC.
2. QMC communicates denial to the Quality Committee.
3. The Committee Chair will send a written notice within 10 business days to the Provider indicating the following:

    – BCBSND credentialing/recredentialing application was denied
    – Reason(s) for the denial
    – Appeal process

Appeal Process

Providers have the right to request an appeal of a denied or restricted application if the decision was due to non-compliance with the Policy. To request an appeal, the Provider will have 30 days from the receipt of notice of a restricted participation or denial of participation to submit a written request for appeal. The request outlines why the Provider disagrees with the decision and includes new information and/or highlights specific points for reconsideration. QMC will meet and review the appeal during the next regularly scheduled meeting. Upon review, QMC will provide a written notice upholding, reversing or revising the earlier decision within 10 business days of QMC's decision.

If the initial denial of participation is upheld, Health Integration may report the action to the NPDB and the appropriate state licensing board. Issues are not reported until after the appeal has been reviewed and QMC makes a final decision.

If the Provider does not request an appeal review within 30 days, the Provider is deemed to have waived their right to a review and accepted QMC's decision. The Provider may reapply for credentialing 18 months after denial. A record of appeals is kept as part of the regular QMC's minutes. These peer review materials are considered confidential and privileged.

Professional Health Care Providers Not Credentialed by BCBSND

- Professional Health Care Providers that are not licensed, certified, or registered by the appropriate state agency, professional board or organization in accordance with the laws of the state in which the services are provided.
- Professional Health Care Providers deemed non-payable by BCBSND. These providers may be set up in the system for claims processing purposes only.

Eligible Professional Health Care Providers that are not Credentialed

Hospital-based Professional Health Care Providers who practice exclusively within an inpatient setting and do not bill individually under a performing/rendering practitioner NPI.

Ongoing Monitoring

Between the credentialing and recredentialing processes, BCBSND monitors Professional Health Care Providers' and Institutional/Ancillary Providers' continuing compliance with criteria for participation by periodic review of:

- State licensing boards, minutes and websites for sanctions, restrictions and other actions taken against a provider's license, documenting in writing that this review was performed. Documentation is kept in the Credentialing department. Documentation of actions taken against a specific Provider is kept in the provider's credentialing file.
- The Office of Foreign Assets Control (OFAC) list of Specially Designated Nationals and Blocked Persons and Officials of Blocked Countries, the Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and the U.S. General Services Administration (GSA) System for Award Management (SAM), documenting in writing that this review was performed. BCBSND's Compliance Department runs the exclusion scan monthly, comparing BCBSND's provider files against these lists using software BCBSND has purchased for this purpose. If a possible match occurs, Provider Networks verifies the validity of the match and works with Compliance to further research. Upon confirmation of an exclusion, a provider will be deemed ineligible to bill BCBSND for services. Termination of a Provider resulting from an OIG match is immediate and does not require Committee review. Reinstatement requires full credentialing. In the case where the excluded Provider is a sole proprietor, a new Agreement may be required.
- Documentation of complaints and grievances.
- Monthly review of Medicare Opt Out listing. Providers on this list are removed from the Medicare Advantage network.

In instances where a Provider ceases to comply with criteria, a report is provided to and reviewed by the Committee for action up to and including termination of participation, if necessary.

Quality Management Program

BCBSND's Quality Management Program provides planned, systematic activities and processes to monitor and evaluate patient care and services for the primary purpose of assisting Providers to improve quality.

In support of the Quality Management Program, BCBSND's Corrective Action Policy ensures BCBSND implements timely, effective actions when indicators reveal a need for improved performance by a Provider. The policy outlines how BCBSND may initiate a corrective action if a Provider does not comply with BCBSND's performance standards. Documented member complaints regarding providers are followed up with a site assessment for quality management and quality improvement purposes within 60 calendar days of the complaint, if deemed required by the Quality Management Team or Medical Director.

Provider Directory

As a Qualified Health Plan, BCBSND follows CMS guidance for posting directory information to the Marketplace. Credentialing staff will update all provider directories such that:

- Within 30 calendar days of the date that both the credentialing and contracting processes are completed, a Provider initially approved for network participation is displayed in the online provider directory. A printed copy of the online provider directory is available to members upon request.
- Once it is determined that a participating Provider has not been recredentialed for any reason or no longer meets credentialing or performance standards, the Provider is removed from online versions of the provider directory within five (5) business days of the date of that determination.
- Within 30 calendar days of determining that a participating Provider is no longer participating, the Provider is removed from electronic versions of the provider directory.
- Within 48 hours of receiving updated provider information, the updated provider information is available in provider demographics data, which gets displayed in electronic versions of the provider directory. Requests for updated information are sent periodically to providers requesting confirmation of accuracy of specified data elements and any updates needed.
- The following provider types are eligible for the Medicare Advantage network. They include but are not limited to: MD; DO; DPM; DDS; DMD; OD; DC; PT; ST; OT; LRD; AUD; NP; PA; CRNA; CNM; CNS; PhD; PsyD; CDE; LICSW (ND license = LCSW), BCBA/LBA/LABA, CCGC Certified Genetic Counselor, LADC, LMSW, LMFT, LMT, LPC, ND Naturopath and RPh. These provider types will display in the NextBlue of North Dakota directory. This directory is separate from BCBSND directory and is updated weekly.

Consumer Notification Regarding Provider Status

Consumers currently enrolled with BCBSND, Medicaid Expansion or Medicare Advantage will be notified should their Provider voluntarily (includes non-renewal) or involuntarily terminate participation with BCBSND. This notification is sent within 15 calendar days of the determination or notification date to each enrollee who received services from the terminated Provider in the past 18 months. The notification includes information on how the enrollee can access information or receive customer support in selecting a new Provider. When applicable, continuity of care guidance is included in letters.

Credentialing/Recredentialing Delegation

BCBSND may delegate the credentialing and recredentialing functions to an organization that has a credentialing program that meets or exceeds BCBSND requirements and URAC standards. This is accomplished through a delegation agreement that defines both parties' responsibilities in credentialing/recredentialing of health care Providers employed by or under contract with the Delegate, or any of the Delegate's subsidiary organizations for which the Delegate provides credentialing services.

Requirements

The following requirements must be met for delegation to occur:

- The organization must be recognized as a Delegate, evidenced by a Credentialing Delegation Agreement with BCBSND and by extension, NextBlue for Medicare Advantage, as credentialing requirements are aligned for both networks.
- The Delegate organization's policies, procedures and standards for credentialing must meet BCBSND requirements as defined in this Policy.
- The Credentialing Delegation Agreement will define acceptable performance standards the organization is required to meet for credentialing/recredentialing.
- The Delegate agrees that BCBSND retains authority to approve network Providers and to terminate or suspend participation.
- The Delegate must allow BCBSND personnel access to or provide the information and documents for the purposes of auditing compliance with the agreement and BCBSND's credentialing/recredentialing requirements.
- The Delegate agrees to provide BCBSND reports, in a format that is mutually acceptable, of eligible health care Providers credentialed and recredentialed, including name, professional designation, specialty, date credentialed or recredentialed, effective date of initial credentialing, or other information as specified in the BCBSND Delegated Credentialing Agreement, within 45 days of the Delegate's approval of the Provider.
- BCBSND will review and verify the Delegate's listing of approved Providers with BCBSND's listing of Providers that have been denied, decredentialed or terminated. Notification will be sent to the Delegate upon final determination by the Committee or Chair.

Oversight

BCBSND will provide an annual report on delegated credentialing oversight, and if conducted, the report will include the findings of the oversight to the Committee. Oversight will be conducted as follows:

- BCBSND will evaluate the Delegate's capacity to perform the delegated activities prior to delegation and/or upon the initial evaluation of the Delegate's credentialing/recredentialing policy.
- The Professional Health Care Provider's credentialing/recredentialing is effective on the Delegate's approval date. The Committee retains final authority and may override the Delegate's decision if there is cause. In such an instance, the participating Professional Health Care Provider would be terminated from the network and the appropriate process followed.

- BCBSND will conduct an at least annual performance evaluation of Delegate's policies, procedures and committee minutes to evaluate the Delegate's capacity to continue to perform delegated activities. BCBSND determines whether an audit will be conducted at the Delegate's location or virtually. If not conducting the audit onsite, then randomly selected credentialing and recredentialing files are sent either by certified mail, fax or electronically or otherwise made available to BCBSND within the specified number of hours or days as outlined in the request.
- A sample of credentialing and recredentialing files will be reviewed as part of the annual performance evaluation to ensure verification of compliance with applicable state and federal laws and URAC credentialing elements. The minimum sample size is 15 of the most recent credentialing or recredentialing files, including a selection of at least seven (7) credentialing files and at least eight (8) recredentialing files. If fewer than seven (7) credentialing files or fewer than eight (8) recredentialing files were completed by the Delegate, BCBSND continues to pull files for a total of 15 files for the audit. If fewer than 15 practitioners were credentialed or recredentialed since the last annual audit, BCBSND audits the universe of files rather than a sample.
- BCBSND will review Delegate's credentialing performance reports.
- The Committee or Chair will notify the Delegate in writing of any deficiencies within 30 calendar days of the assessment.
- Delegate must submit a corrective action plan within 30 calendar days of receipt of a deficiency report.
- When the Delegate completes the corrective action plan, a re-review is conducted, and the Delegate is notified of the results or any further recommendations.
- If Delegate fails to perform delegated functions or make required corrective actions, the Chair shall have the authority to terminate the Delegate's agreement in accordance with termination provisions of the agreement.

If primary source verification is delegated to an entity that is certified as a Credentialing Verification Organization (CVO) by URAC, no oversight is required in the areas of certification.