Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross & Blue Shield Association

Credentialing and Recredentialing Policy **2026**

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Table of Contents

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 applicable accrediting body 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 and promotes consistency of interpretation and application of policy requirements.
- Issues of race, color, creed, religion, sex, national origin, marital status, disability, age, sexual orientation, or the types of procedures (e.g., abortions) or patients (e.g., Medicaid or Medicare) in which the practitioner specializes are not considered during the credentialing/recredentialing process.
- BCBSND does not discriminate against 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. Annually, the Credentialing leadership reviews Credentialing Committee denial and termination decisions to ensure that the organization does not discriminate. Contracted authorized parties with BCBSND may have access to review provider files in person at 4510 13th Avenue 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 Quality Committee of the Board and delegates the 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 sub-committee 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 to make 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, as needed
- Compliance Department Designee
- Credentialing Staff and other designees who provide support for 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.
- Reviews credentials for practitioners who do not meet established thresholds.
- Ensuring recredentialing is performed thoroughly and in compliance with policy guidelines, accrediting bodies, state, and federal requirements.
- Promoting consistency of the interpretation and application of policy requirements.

- Responding to email votes for items not reviewed during Committee meetings. The Committee will not use email to vote on any participation decisions for practitioners or providers.
- 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 documented, and a permanent, signed and dated record of meeting proceedings, findings, and actions are kept.

Credentialing Committee Chair (Chair)

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. A credentialing or recredentialing case is only considered to be complete/finalized if the maintenance user ID of the Chair or designee accompany the decision and decision date within the file.

Voting Procedure and Quorum

Participating Professional Health Care Providers, BCBSND Credentialing Consultant committee members, and the Chair make motions, speak in informal debates, and vote on motions. Fifty-one percent (51%) of all voting committee members shall constitute a quorum for the purposes of conducting official Committee business. An ad hoc meeting may be called 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 video/web 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. Each Professional Health Care member is to sign a Confidentiality Agreement form, which will survive the termination of membership on the Credentialing Committee.

Record Keeping

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. Professional Health Care Providers are listed below. Professional Health Care 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 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 Dept 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 during its at least 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 Professional Health Care Providers 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 Document Services and Contracting personnel ensure applications are routed to the Credentialing team through a secure online document storage system. 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 Quality Specialist or Credentialing Consultant for processing accuracy and to confirm directory listings are consistent with credentialing data. All applications with potential significant issues, including documentation and attachments, are presented to the Chair, the Credentialing Consultant, and/or Committee for review and approval. Under no circumstances does any employee or consultant make material changes to the attested to information within a credentialing or recredentialing application or contract.

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 one hundred eighty (180) calendar 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.

- Professional Health Care Provider applications include fields to enter race, ethnicity and language and a statement that BCBSND does not discriminate or base credentialing decisions on an applicant's race, ethnicity or language, and that providing that information is optional and BCBSND does not penalize the Professional Health Care Provider if they do not provide the information in the application.

- Contracted Professional Health Care Providers shall maintain policies of general and professional liability/malpractice coverage to insure Professional Health Care Providers 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. Professional Health Care Providers shall provide a certificate or proof of such coverage upon application, which includes the coverage amounts and effective and expiration dates. The certificate or an accompanying letterhead must clearly state the specified Professional Health Care Providers 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 fifteen (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 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 currently use illegal substances. 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 or limitation of privileges or disciplinary actions on their 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 healthcare.

- 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 and 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) and 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:

- CMS approved accreditation organizations include:
    - TJC – The Joint Commission
    - CHAP – Community Health Accreditation Program
    - CLIA Certification
    - ACHC – Accreditation Commission for Health Care
    - AAAASF or QUAD A – American Association for Accreditation of Ambulatory Surgery Facilities
    - CARF – Commission on Accreditation of Rehabilitation Facilities
    - CARF-CCAC – CARF Continuing Care Accreditation Commission
    - CIQH – Center for Improvement in Healthcare Quality
    - DNV NIAHO – Det Norske Veritas National Integrated Accreditation for Healthcare Organizations
    - AAAHC – Accreditation Association for Ambulatory Health Care, Inc.
    - TCT – The Compliance Team
    - NDAC – National Dialysis Accreditation Commission
    - URAC – Utilization Review Accreditation Commission
    - NABP – National Association of Boards of Pharmacy
    - ADA – American Diabetes Association
    - ADCES/AADE - Association of Diabetes Care & Education Specialists (formerly known as American Association of Diabetes Educators (AADE)
    - ACR – American College of Radiology
    - IAC – Intersocietal Accreditation Commission

- Acute Care Hospitals (Short and Long Term) and Critical Access Hospitals
    - State Licensure (non-provisional)
    - Provide and maintain evidence of accreditation by The Joint Commission, ACHC, CIHQ, DNV, or another CMS approved national accreditation organization with deeming authority. If not accredited, BCBSND requires a survey report or letter from CMS, DHHS,

or a copy of the CMS or DHHS report from the provider's office, indicating an onsite survey was conducted and passed inspection within the past three years. If the CMS or DHHS review is older than three years, BCBSND or its designee will conduct a site visit of the criteria outlined below.
    - Evidence of malpractice insurance

- Freestanding Psychiatric Hospitals
    - State Licensure (non-provisional)
    - Provide and maintain evidence of accreditation by The Joint Commission, CIHQ, DNV, or another CMS approved national accreditation organization with deeming authority. If not accredited, BCBSND requires a survey report or letter from CMS, DHHS, or provider's office, indicating an onsite survey was conducted and passed inspection within the past 3 years. If the CMS or DHHS review is older than three years, BCBSND or its designee will conduct a site visit of the criteria outlined below.
    - Evidence of malpractice insurance

- Psychiatric Intensive Outpatient Program (IOP)
    - Meets ND substance use license requirements, as ND does not issue psychiatric license. Survey report or letter from TJC, CMS, DHHS, or provider's office indicating an onsite survey was conducted and passed inspection within the past three years is required. If the CMS or DHHS review is older than three years, BCBSND or its designee will conduct a site visit of the criteria outlined below.
    - Evidence of malpractice insurance

- Psychiatric Partial Hospitalization Program (PHP)
    - Meets ND substance use license requirements, as ND does not issue psychiatric license.
    - Survey report or letter from TJC, CMS, DHHS, or provider's office indicating an onsite survey was conducted and passed inspection within the past three years is required. If the CMS or DHHS review is older than three years, BCBSND or its designee will conduct a site visit of the criteria outlined below.
    - Evidence of malpractice insurance
    -

- Substance Use Disorder (Intensive Outpatient Program (IOP)
    - State Licensure (non-provisional)
    - Survey report or letter from TJC, CMS, DHHS, or provider's office indicating an onsite survey was conducted and passed inspection within the past three years is required. If the CMS or DHHS review is older than three years, BCBSND or its designee will conduct a site visit of the criteria outlined below.
    - Evidence of malpractice insurance

- Substance Use Disorder (Partial Hospitalization Program (PHP)
    - State Licensure (non-provisional)
    - Survey report or letter from TJC, CMS, DHHS, or provider's office indicating an onsite survey was conducted and passed inspection within the past three years is required. If the CMS or DHHS review is older than three years, BCBSND or its designee will conduct a site visit of the criteria outlined below.
    - Evidence of malpractice insurance

- Psychiatric/Substance Use Disorder (Residential Treatment Center (RTC)
    - State Licensure (non-provisional)
    - Survey report or letter from TJC, CMS, DHHS, or provider's office indicating an onsite survey was conducted and passed inspection within the past three years is required. If the CMS or DHHS review is older than three years, BCBSND or its designee will conduct a site visit of the criteria outlined below.
    - 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 (CORF)
    - State Licensure (non-provisional)
    - Provide and maintain evidence of Medicare certification, Accreditation by CARF, or another CMS approved national organization with deeming authority.
    - State Licensure (non-provisional)
    - Evidence of malpractice insurance

- Diabetes Prevention Program or DPP
    - Accreditation by ADA, or ADCES/AADE
    - Evidence of malpractice insurance

- Freestanding Dialysis Center (Renal Treatment Center)/End-Stage Renal Disease Facility
    - Provide and maintain evidence of Medicare certification, ACHC, or NDAC
    - Evidence of malpractice insurance

- Freestanding Outpatient Physical Therapy Facility
    - State licensure (non-provisional)
    - Provide and maintain evidence of Medicare certification, AAAASF/QUAD A, 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 accreditation by The Joint Commission, the Accreditation Association of Ambulatory Health Care (AAAHC), American Association for the Accreditation of Ambulatory Surgical Facilities (AAAASF/QUAD A), Accreditation Commission for Health Care (ACHC), or another CMS approved national accreditation organization with deeming authority. If not accredited, BCBSND requires a survey report or letter from CMS, DHHS, or provider's office, indicating an onsite survey was conducted and passed inspection within the past three years. If the CMS or DHHS review is older than three years, BCBSND or its designee will conduct a site visit of the criteria outlined below.
    - 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), or ACHC, CHAP, or TJC. BCBSND requires a survey report or letter from CMS, DHHS, or provider's office, indicating an onsite survey was conducted and passed inspection within the past three years. If the CMS or DHHS review is older than three years, BCBSND or its designee will conduct a site visit of the criteria outlined below.
    - Evidence of Malpractice insurance

- Home Infusion Center
    - Provide and maintain evidence of Medicare certification/Participation (receive payments), ACHC, CHAP, NABP, TCT, TJC, or URAC.
    - 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), CHAP, ACHC, or TJC
    - 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, hospital-based exemption from CLIA, or a 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, ACR, IAC, or TJC
    - 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 accreditation by The Joint Commission, CARF, or another CMS approved national accreditation organization. If not accredited, BCBSND requires a survey report or letter from CMS, DHHS, or provider's office, indicating an onsite survey was conducted and passed inspection within the past three years. If the CMS or DHHS review is older than three years, BCBSND or its designee will conduct a site visit of the criteria outlined below.
    - 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 determination whether to contract with the facility will be done with Contracting and Credentialing and a site visit might be completed (if contracted and listed in a directory) 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, including procedures for credentialing of practitioners

- Staffing ratios
- Equipment maintenance programs
- Accessibility
- Medical records keeping 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 and to review information submitted to support their credentialing application. Any deficiencies are documented and attached to the Provider's file. BCBSND is responsible for reviewing the file for completeness, accuracy, and conflicting information prior to submission to the Chair and/or Committee for consideration.

Timeframes

Credentialing applications are processed within one hundred eighty (180) calendar 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 the 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 and contract information are assigned passwords and appropriate user access roles 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 & support staff
    - Credentialing & Contracting staff (including temporary staff)
    - Document Services personnel

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 sourced, include the name or initials of the person who verified the information, and dated no more than one hundred twenty (120) calendar days prior to Committee review and stored within the credentialing software program which systematically date-stamps all uploaded documentation. The case activity checklist also lists the user's maintenance ID:

- 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 and 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) to assess for claims that resulted in settlement or judgment paid on behalf of the Professional Health Care Provider
- Accreditation status, if applicable
- Criminal history background checks and licensure/disciplinary screening reports for MDs and DO's

RECREDENTIALING STANDARDS

Recredentialing of Professional Health Care Providers/Institutional/Ancillary Providers is conducted every thirty-six (36) months 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 notification 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 one hundred eighty (180) calendar days prior to Committee review. If a Professional Health Care Providers fails to submit a recredentialing application to BCBSND in time for processing within the 36-month period, the Professional Health Care Providers record must be terminated, and claims will be unable to process. An initial credentialing application will be required in order to reinstate the Professional Health Care Providers. Claim adjustments will not be initiated by BCBSND for noncompliance with the recredentialing policy.

An extension to the 36-month recredentialing cycle may be made if written notification is sent to BCBSND indicating active military status; medical/maternity leave; or sabbatical. Upon return from such leave of absence, recredentialing must be submitted to BCBSND with a letter indicating when the Participating Health Care Provider will return. BCBSND then has 60 days to process the application.

BCBSND verifies the following information by phone, internet, fax, or letter. The documentation must be dated no more than one hundred twenty (120) calendar days prior to Committee review:

- A valid license/certification to practice in the state(s) via state licensing agency/board
- Hospital Admitting Staff privileges, when required, including admitting privileges, are in good standing, or notation of alternative admitting arrangements for Professional Health Care Provider. May accept attestation in lieu of phone, internet, fax, or letter verification.
- DEA or CDS (copy of certificate) or notation of alternative prescribing practitioner
- 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 and 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 thirty-six (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 one hundred twenty (120) calendar 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

- Education and training at the highest level, unless verified by the licensing body
- 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 and 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 thirty (30) calendar days of the Committee decision recorded on the credentialing file. The Provider is considered to be recredentialed, they will not be notified of recredentialing continued participation, and their participation will remain active unless otherwise notified. In the event an initial credentialing case must be processed for an existing provider due to a missed 36-month recredentialing window, notification is not sent to the provider, provided there was no gap in their affiliation.

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 for reviewing 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 3 claims in the past 5 years
- Provisional License or other sanctions or limitations on license (state licensing body, OIG, or GSA). Fines paid by practitioner without a formal license sanction or limitation do not need to be reported to the Credentialing Committee
- Missing DEA/CDS (for applicable practitioners) and no alternative prescribing practitioner provided on the application
- Missing Hospital Privileges (for applicable practitioners) and no alternative admitting practitioner provided on the application
- Participation in Medicare Opt-Out program
- Any 'yes' responses to disclosure questions on the application
- 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 on one of the following:

1. Determine if additional information is required prior to consideration by the Committee.

2. Determine whether the possible significant issue(s) meets or does not meet Policy standards and present them to the Committee for a 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 are directed to communicate the decision according to Approved Applications processes.

2. Determine if 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 timeframe would be expected to be the same timeframe specified on the provisional license.)

3. Determine if the application does not meet standards and deny. Provider would not be eligible under the Agreement, so would be considered nonparticipating 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 (DHHS) is notified of denied applications within ten (10) 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 the 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 ten (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 thirty (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 ten (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 thirty (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 eighteen (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 monthly 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. Suspension of a license is grounds for immediate termination as it is unlawful to see patients without an active license. All other actions on a license are reported to Credentialing Committee where the Committee reviews details of the action and determines whether the provider will be allowed to continue to remain in-network, or if claims or license activity need continued monitoring. Documentation is kept in the Credentialing department. Documentation of actions taken against a specific Provider is also kept in the provider's credentialing file, when the disciplinary history is identified and verified against historical Credentialing Committee Minutes to determine if any changes need to be reported.

- 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 the sole proprietor, a new Agreement may be required. The next time a previously excluded/sanctioned provider is credentialed, disciplinary history and NPDB information, if applicable, is identified as an exception which is flagged for review by full Credentialing Committee.

- Documentation of complaints and grievances. The Credentialing Committee may review complaints and grievances in accordance with BCBSND policies.

- Monthly review of Medicare Opt Out listing. Providers on this list are removed from the Medicare Advantage network.

- BCBSND annually obtains written confirmation or website documentation regarding the highest level of education verified by state licensing boards; otherwise BCBSND performs this verification as part of the initial credentialing process.

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. BCBSND does not contract with or enroll providers excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act.

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. The directory is reviewed at least annually for accuracy of elements such as provider locations and phone numbers, hospital affiliations, and patient acceptance in addition to routine outreach reminding providers of the importance of timely updates.

All providers defined under Health Care Provider Definitions and Institutional/Ancillary Provider Definitions are displayed in the directory unless it's a provider type that would not be available for a Member to schedule an appointment, such as a Radiologist, or in the event a provider has requested not to be displayed in the directory, such as one who only provides routine outreach and may bill for those services but does not accept appointments at the servicing site. Credentialing staff will update all provider directories such that:

- Within thirty (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 thirty (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 forty-eight (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, include but are not limited to, being eligible for the Medicare Advantage network. Providers will display in the NextBlue of North Dakota directory: 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. 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 thirty (30) calendar days of the determination or notification date to each enrollee who received services from the terminated Provider in the past eighteen (18) months. The notification includes the provider name and effective date of the termination as well as 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 the 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 applicable accrediting body 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 forty-five (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 applicable accrediting body credentialing elements. The minimum sample size is fifteen (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 fifteen (15) files for the audit. If fewer than fifteen (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 thirty (30) calendar days of the assessment.
- Delegate must submit a corrective action plan within thirty (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 an applicable accrediting body, no oversight is required in the areas of certification.