SENTARA HEALTH PLANS

Category:	Credentials Department	**Original Date:** 11/20/97	
Specialty/Area:	Optima Health Plan and Sentara Health Plans, Inc., and its subsidiaries hereinafter Optima Health	**Revised/Reviewed Date:** 4/8/98, 2/12/99, 11/15/99, 6/28/2000, 4/25/01, 11/04, 5/05, 3/06, 4/07, 10/07, 1/08, 7/08, 12/10, 8/11, 3/12, 5/13, 9/13, 5/12/2014, 7/2015, 4/2016, 3/17, 6/19/18, 3/12/19, 8/28/19, 1/2020, 7/14/20	
Subject:	Provider Credentialing Process	Approval: Nicole Marshall	DMAS Approval Date:

Credentials Department Policy CR-2.0

Purpose

To provide guidelines for the credentialing and recredentialing of Providers in the Optima Health Plan (OHP) network.

Policy

A. Optima Health will review the education, experience and credentials of all Providers who care for Optima Health members at the time of the Provider's initial request to participate in the network and at a minimum of every 36 months thereafter. Optima Health may recredential providers after 12 or 24 months at the discretion of the Credentialing committee. No Provider will be included in the Optima Health network without being credentialed and recredentialed per the most recent NCQA standards and all applicable state and federal requirements. No individual shall be denied appointment or reappointment as an Optima Health Network Provider because of age, sex, race, ethic, religion, national origin, or disability. Optima Health operates in full compliance with all applicable state and federal laws and regulations 42 CFR 438.214 when processing all practitioners as well 42 CFR 422.204(b) (2); 42 CFR 422.202(a) and (d).

Definitions

A. Credentialing: The review of qualifications and other relevant information pertaining to a health care professional who seeks appointment or who seeks a contractor participation agreement with Optima Health Plan.

B. Hampton Roads: Defined as the cities of Williamsburg, Newport News, Hampton, Poquoson, Franklin, Chesapeake, Suffolk, Portsmouth, Norfolk and Virginia Beach, and the counties of Southampton, Surry, James City, Isle of Wight, York, Gloucester and Mathews.

C. Non-Hampton Roads: Defined as any cities not listed in the above listing for Hampton Roads located in Central Virginia/Southwestern VA, North Carolina, Maryland, Kentucky, Tennessee and West Virginia

D. Optima Health Plan (OHP) Credentials Committee Members and/or Optima Behavioral Health (OBH) Credentials Committee Members: Network Providers with Optima Health Plan and/or Optima Behavioral Health, not Optima employees, with full voting privileges.

E. Medical Affairs Committee (MAC): Committee with final approval authority for Hampton Roads Providers and OHP Credentials Committee is final approval authority for Non-Hampton Roads Providers

F. HEOPS-Centipede: Subcontractor for Optima Health responsible for credentialing and recredentialing CCC Plus LTSS Providers with oversight from Optima Health according to the delegation process defined in CR-16.0.

G. All policies are reviewed by Credentials Committee annually. All annual, policy updates, semi-annual reports and findings for Delegations are reported credentials Committte. All delegations and statistics are presented to Quality Improvement Committee as a whole quarterly.

Procedures

The Optima Health Credentialing Department oversees and tracks the credentialing process using Echo, a document management system. The Network Management Department collects provider applications and associated documentation and forwards them to the Credentialing Department. Network Management collects and maintains disclosure of ownership and control interest statements for all providers in the Optima Health Network in Echo. The Credentialing Department audits provider applications for completeness and processes them for review and approval. Optima Health will not accept applications from providers with felony convictions or OIG (LEIE) or EPLS (SAM) sanctions against them, also Social Security Administration's Death Master File is verified prior to acceptance of all new application. We adhere to the 42 CFR 422.202, CFR 438.602. All information received and acquired for and by the Provider is strictly confidential and kept in a secured area. All Credentialing staff and committee members sign a confidentiality form annually. Refer CR-38.0 creation of echo sign-on id and security.

Optima Health abides by the NCQA standard of "clean files" whereby the Medical Director can provide temporary approval for files with no issues. Temporarily approved files are returned to the Network Management Department for processing in System Administration. Any file that does not meet the criteria for clean files is classified as an issue file and must be approved by the OHP/OBH Credentials Committee or MAC. A "Clean file" may be reclassified as an "Issue file" if issues are identified during the verification process. *All issue files will have a packet prepared to be reviewed by Committee members on the components that are noted as an issue* for recommendation for approval.

Authority for final approval rests with the Credentials Committee for Non-Hampton Roads providers. Files approved by the OHP/OBH Credentials Committee for Hampton Roads providers are forwarded to the MAC for final approval, accepting the OHP Credentials Committee. The credentialing process for clean files shall be completed within 60 days of receiving a completed clean application. Credentialing for issue files shall be completed within 60 days after the provider has returned all requested information. All files will have verifications dated within 180 days of final approval. Only providers who have completed the credentialing process are eligible to contract with Optima Health, see enrollees, and will be listed in marketing materials.

Optima Health does not discriminate against providers that serve high-risk populations or specialize in conditions requiring costly treatment, or against providers who are acting within the scope of their license or certification under applicable state and federal law solely by holding such a license or certification. The Credentials Department will perform random audits of credentialing files that have been denied, as well as provider complaints to ensure discrimination does not occur, we meet monthly with Network Management and Appeals Department refer to policy NM028 regarding complaints. Optima Health maintains heterogeneous credentialing committees and requires those responsible for credentialing decisions to sign a confidentiality agreement and agree to make decisions in accordance with (IAW) policies and procedures, including conflict of interest and nondiscrimination policies. Refer to policy CR 2.B

Optima Health as well as our delegations will insure to prevent and monitor discriminatory practices in their policies and procedures to ensure credentialing and recredentialing are performed in a non-discriminatory manner.

General Application and Verification Requirements

The following general information and documentation must be primary source verified during credentialing/and ongoing monitoring for providers participating in an OHP.

Table 1: Information and documentation requiring primary source verification, by provider type.

	Provider Type			
	MD, DO, DDS, DMD, DPM	OD	NP!, PA, NM, CRNA	LCP, LCSW, LPC, RNCS, LMFT, BCBA, BCBAA, BH NP, BH PA, NC LPA/LCAS ***
Professional license for VA, NC, MD, TN, KY, WV, and all other past state licenses by state licensing board	X	X	X	X
Admitting privileges at Participating Hospital	X			
Listing of provider group coverage or covering physician for solo providers	X	X	X	X
Malpractice insurance which meets state standards	X	X	X	X (1m, 3m in VA all others follow state standard)
NTIS Verification for DEA number or Pending DEA ****	X		NP, PA (DEA)	
Education history to the highest level	X	X	X	X
ECFMG, if applicable	X			
Discrepancies on CV and any gaps of 6 months or more and five years of work history	X	X	X	X
Medicaid/Medicare Sanction OIG Form	X	X	X	X
Board Certification/Board Eligibility Letter *	X		X	X
Malpractice carrier and NPDB query for claims and sanctions**	X	X	X	X
Medicare Opt-out List Form	X	X	X	X
NPPES (NPI) for Medicare/Medicaid Validation (LPC excluded)****	X	X	X	X
Verification of Social Security Administration's Death Master file	X	X	X	X

OPT OUT FORM (notify Network if appears to remove LOB)	x	x	x	x
Verification of EPLS (SAM.GOV)	X	X	X	X

*According to timeline provided in Table 2 of this document. Requirement may be waived if provider is in an underserved area.

**Optima Health queries NPDB and the provider's malpractice carrier for claims and sanctions information during the past 7 years for providers and past 2 years for ancillary providers.

**** **Pending DEA certificates** The organization may credential a practitioner whose DEA certificate is pending if it has a documented process for allowing a practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner whose DEA is pending until the practitioner has a valid DEA certificate.

*** LPA/LCAS (Licensed Substance Abuse Provider in NC) has a license to practice independently and LCA cannot practice independently must have coverage. Note: While the LPA is not licensed to practice independently, but is trained in all BH services, and the LCAS is licensed to practice independently and is only trained in SA, the combination of these two licensures allows this provider to meet all the requirements for credentialing

****NPI Verification for Medicare/Medicaid validation (LPC excluded): https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html

***** CRNA – working in office setting must be credentialed (i.e. gastro office, etc.)

! NPs If they have restrictions from the licensing board, they don't meet criteria of an unrestricted license. However, they can practice independently, we only require that they practice the scope allowed by the licensing board and we do not monitor further.

*****Annual letter from state licensing board verifying education started in summer 2020 for the following: Practitioners – Certified with American Academy of Certified Nurses (AACN),Nurse Practitioners – Certified with American Academy of Nurse Practitioners (AANP),Nurse Midwife – Certified with American Midwifery Certification Board (AMCB),Nurse Anesthetists – Certified with the National Board of Certification & Recertification for Nurse Anesthetists (NBCRNA) Nurse Practitioners – Certified with National Certification Corporation (NCC),Nurse Practitioners – Certified with American Nurses Credentialing Center (ANCC) Physician Assistant – Certified with National Commission on Certification of Physician Assistants (NCCPA),Nurse Practitioner(Pediatrics) – Certified with Pediatric Nursing Certification Board (PNCB),Licensed Behavioral Analyst – Verified from Department of Health Professions, Commonwealth of Virginia,Licensed Assistant Behavioral Analyst – Verified from Department of Health Professions, Commonwealth of Virginia,Licensed Professional Counselor - Verified from Department of Health Professions, Commonwealth of Virginia,Licensed Clinical Psychologist - Verified from Department of Health Professions, Commonwealth of Virginia,Licensed Clinical Social Worker - Verified from Department of Health Professions, Commonwealth of Virginia,Licensed Marriage and Family Therapist - Verified from Department of Health Professions, Commonwealth of Virginia,Certified Substance Abuse Counselor - Verified from Department of Health Professions, Commonwealth of Virginia we will renew annually for verification of education.

A. The following information is required for physicians and allied health primary source verified (MDs, DOs, DPMs, DDS, DMDs):

1. Participating Hospital Privileges, Group Coverage and if solo provider, must have Covering Provider who is participating with Optima
2. Primary Medical License verifications for VA, NC, MD, TN and WV and all other past state licenses listed
3. Malpractice Insurance which meets state standards (Virginia is 2.150m/4.3m example)
4. NTIS verification for DEA number listed
5. Medical Education/Professional School Internship/Residencies/Fellowships (highest level)
6. Two references
7. Medicaid/Medicare Sanction - OIG Report Form
8. Board Certification/Board Eligibility Letter within six (6) years of residency/fellowship or Underserved Map for MDs, DOs, DMDs, DDS. Seven (7) years for DPMs based on their board policy
9. NPDB/HIPDB
10. Verification of Medicare Opt-Out List Form
11. Verification of EPLS (Excluded Parties List System)

G. The following information is required for Optometrists:

1 Current Optometry License
2. Malpractice Insurance
3. Medical Education/Professional School
4. Medicaid/Medicare Sanction - OIG Report Form
5. NPDB/HIPDB
6. Verification of Medicare Opt-Out List

7. Verification of EPLS (Excluded Parties List System

H. The following information is needed for Licensed Nurse Practitioners, Physician Assistants, Nurse Midwives, Certified Registered Nurse Anesthetist for NC and see below what is defined as a Mental Health Nurse Practitioner refer to step 10:

1. Current License (all licenses for Nurse Practitioner including license to prescribe)
2. Covering Physician (if not completed five years under supervision for NPs or Pas) if applicable
3. Liability Insurance
4. Medical Education/Professional School
5. Medicaid/Medicare Sanction OIG Report Form
6. Board certification, if applicable
7. NPDB/HIPDB
8. Verification of Medicare Opt-Out List
9. Verification of EPLS (Excluded Parties List System

10. Family Practice NPs must have at least ten (10) years of experience as a nurse practitioner in a BH setting with references from past and present MD's supervisors.

    Note: if they do not meet the criteria, they must be reviewed by Medical Director; they would then be recommended to be processed by OHP and presented to OHP Credentials Committee. Initial staff would notify OBH Network Management once approved based on above standard.

11. Physician Assistants for OBH must meet the following criteria: 2000 hours of experience or the equivalent of one year of full-time practice working in a PA specialty within six years of the date they attest to NCCPA. Minimum of 150 credits of Category I CME focused on psychiatry practice earned within two (2) years prior to the date for exam application for CAQH application, valid unrestricted license, the supervising physician must attest the PA works in the specialty and has performed patient management relevant to the practice setting. They must pass and maintain the Psychiatry CAQ Exam in order to be considered PA in the behavioral health department.

    A) Exception rule approved in June 2015 OBH Committee minutes as follows:

    Physician Assistant will be credentials as long as they meet the criteria of 1) Being certified by NCCPA or have 5 years of behavioral health experience with a professional reference from supervising physician and 2) Provider's supervising physician is a psychiatrist credentialed with Optima Behavioral Health Services.

12. Addiction medicine physicians must follow the ABAM certificate requirements, however they need to be board certified with ABMS and/or board eligible within six (6) years of ABMS. This requirement must be completed by June 30, 2014.

A. One year's full-time involvement OR one full-time equivalent (1 FTE) in the field addiction medicine in addition to, and not concurrent with, residency training. One Full Time Equivalent is equal to at least 1,920 hours over the last 5 years in teaching, research, administration, and clinical care of the prevention of as well as treatment of individuals who are at risk for or have a substance use disorder. At least 400 of these hours should have been spent in direct clinical care of patients. Hours used to meet the requirement must have been accrued between June 30, 2009 and June 30, 2014. OR

B. Successful completion of ABAM-F Approved Training Program

C. CME CREDITS 50 hours of Category I Credit toward the AMA Physician Recognition *Award. Credits must relate to addiction and substance abuse and must have been* accrued over the two years immediately prior to the date of the examination.

I. The following information is required for Clinical Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors, Registered Nurse Clinical Specialists Licensed Marriage Family Therapists, NC LPA's/LCAS, BCBA and BCBAA, Certified Registered Nurse Anesthetist (CRNA) for NC.

NOTE: As of 4/1/2014 we are changing the requirement for malpractice, for all non-physician behavioral health providers for the state of Virginia they will be required to have 1m and 3m. They do not need to meet the Virginia state cap.

1. License including license to prescribe for Nurse Practitioners
2. Group listing
3. Name and contact number of covering provider that participates with Optima for all other ancillaries that are not part of a group and are listed as solo
4. Liability Insurance - 1m/3m or where applicable by state
5. Medical Education/Professional School
6. Medicaid/Medicare Sanction - OIG Report Form
7. Board certification, if applicable
8. NPDB/HIPDB
9. Verification of Medicare Opt-Out List
10. Verification of EPLS (Excluded Parties List System)
11. LCAS (Licensed Substance Abuse Provider in NC) has a license to practice independently and LCA cannot practice independently must have coverage.
    Note: While the LPA is not licensed to practice independently, but is trained in all BH services, and the LCAS is licensed to practice independently and is only trained in SA, the combination of these two licensures allows this provider to meet all the requirements for credentialing

NOTE: LPC do not require an Opt-Out Form since they do not contract with Medicare

12. Verifying board certification for NC – CRNA, you will go to the website https://portal.nbcrna.com/credential-verification and it will also be the same for AANA and they are not required to have a DEA per Medical Director to process.

J. The following information is required for a Board Certified Behavioral Analyst and Board Certified Behavioral Analyst Assistants

1) BCBA - must possess at least a Master's Degree, have 225 classroom hours of specific Graduate-level coursework, meet experience requirements, and pass the Behavior Analyst Certification Examination. Board Certified Behavior Analyst-Doctoral must be BCBAs with doctorate degrees must have, conferred at least ten (10) years prior to applying. The field of study must be behavior analysis, psychology, education or another related field (doctoral degrees in related fields are subject to BACB approval). BACB certificates must accumulate continuing education credit to maintain their credentials.

2) BCBAA - must have at least a Bachelor's Degree, have 135 classroom hours of specific coursework, meet experience requirements, and pass the Assistant Behavior Analyst Certification Examination.

K. All Providers are recredentialed within 36 months.

L. Site visits are conducted if a service complaint is received and after review by the Medical Director. Network Management coordinates site visits which are conducted by an Educator. Results of the visit are forwarded to the Credentials Department. Site visits are followed-up within 6 months (refer to policy **NM004**).

M. All applicants have the right to review information submitted to the Credentials Committee and/or status of their application request in support of his/her application except for references, recommendations, or information that is peer review protected under HCQIA and/or HIPAA. Also refer to Network Management NM004 policy regarding the right to review as well for practitioner rights.

a. All applicants have the right to correct erroneous information submitted by another party. Within 30 days of receipt of conflicting information, the Credentials Department will notify the applicant of substantial discrepancies in information provided by the applicant and by other sources.

b. Applicant shall have fifteen (15) business days from the date of notice of the erroneous information to correct such information. Corrections shall be submitted in writing to the Credentials Analyst and Credentials Manager. Refer to Policy CR-38.0 for tracking modified information.

c. Nondiscrimination: Does not base credentialing or recredentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes.

d. All documents are in a secured document management system for confidentiality

Special Requirements for Behavioral Health and Addiction Medicine Providers

Optima Health's Community-Based Mental Health, Early Intervention, and Addiction Research and Treatment Services (ARTS) providers shall meet all applicable DBHDS certification and license standards, state and federal requirements, and requirements listed in the most current DMAS behavioral health provider manuals.

ARTS Providers

Optima Health shall use DMAS recognized licensed and credentialed treatment professionals in its CCC Plus network including:

A. Addiction credentialed physicians
B. Buprenorphine waivered practitioners licensed under Virginia law and registered with the Drug Enforcement Administration (DEA) to prescribe schedule III, IV, or V medications for treatment of pain.
C. Certified peer recovery specialists as defined in 12VAC30-130-5020.

In situations where a certified addiction physician is not available, the Contractor shall recognize physicians who are not addiction credentialed but have some specialty training or experience in treating addiction or experience in addiction medicine or addiction psychiatry. The Contractor shall credential ASAM Level 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, 4.0 and Opioid Treatment Programs using the ARTS ASAM Level 2.1 to 4.0 Uniform Credentialing Form and ARTS Staff Roster. Facility-based providers are credentialed through the Network Management department according to policies and procedures in NM007. ARTS providers contracted for Optima Health CCC Plus are credentialed by HEOPS-Centipede with oversight from Optima Health according to Compliance Policy 147.

Office-Based Opioid Treatment (OBOT) Providers

DMAS shall credential OBOT providers approved by DMAS, the CMO, and the Pharmacy Director Workgroup using the DMAS criteria.

Behavioral Health Nurse Practitioners and Physician Assistants

OBH network Nurse Practitioners (NPs) must have board certification as a mental health NP, if they fail to meet the OBH requirement they will be processed on Medical side for billing. These files are reviewed by Medical Director prior to acceptance and will sign off as issue to be processed on medical.

OBH network Physician Assistants (PAs) must meet the following criteria:

A. 2,000 hours of experience or the equivalent of one year full-time practice working in a PA specialty within six years of the date they attest to NCCPA
B. Minimum of 150 credits of Category I CME focused on psychiatry practice earned within two (2) years prior to the date for exam application for CAQH application
C. A valid unrestricted license
D. Attestation by the supervising physician that the PA works in the specialty and has performed patient management relevant to the practice setting
E. A passing score on the Psychiatry CAQH Exam

A PA may also be credentialed if their supervising physician is a participating psychiatrist and they have been certified by NCCPA with Psychiatry CAQ certification.

All the OBOT & OTP for medical must be listed on the DMAS Red Cap report. Work

Addiction Medicine Physicians

Addiction medicine physicians must follow the ABAM certificate requirements; however, they need to be board certified with ABMS or board eligible within six years of completing training. Additionally, they must have one year of full-time involvement or one full-time equivalent (FTE) in the field of addiction medicine in addition to and not concurrent with residency training. One FTE is equal to at least 1,920 hours over the last 5 years in teaching, research, administration, and clinical care of the prevention of as well as treatment of individuals who are at risk for or have a substance use disorder. At least 400 of these hours should have been spent in direct clinical care of patients. Hours used to meet the requirement must have been accrued between June 30, 2009 and June 30, 2014.

Alternatively, a provider may be credentialed as an addiction medicine physician if they have successfully completed the ABAM-F Approved Training Program and have 50 Category I CME credit hours toward the AMA Physician Recognition Award. Credits must relate to addiction and substance abuse and must have been accrued over the two years immediately prior to the date of the examination.

Board Certified Behavioral Analyst (BCBA) and Board Certified Behavioral Analyst Assistant (BCBAA)

A BCBA must:

A. Possess at least a Master's Degree, with 225 classroom hours of specific graduate-level coursework
B. Meet experience requirements
C. Pass the Behavior Analyst Certification Examination

A BCBA-Doctoral must:

A. Have received their doctorate degree at least ten years prior to applying in the field of behavior analysis, psychology, education or another related field
B. BACB certificates must accumulate continuing education credit to maintain their credentials

A BCBAA must:

A. Possess at least a Bachelor's Degree
B. Have 135 classroom hours of specific coursework
C. Meet experience requirements
D. Pass the Assistant Behavior Analyst Certification Examination

Commonwealth Coordinated Care Plus (CCC Plus) Long-Term Services and Supports (LTSS) Providers

Optima Health delegates and provides oversight for credentialing and recredentialing of CCC Plus LTSS providers to HEOPS-Centipede per requirements defined in Compliance Policy 147. Optima Health ensures that HEOPS-Centipede credentials and recredentials providers per DMAS requirements and ensures that all providers comply with provisions of the CMS Home and Community-Based Settings Rule.

Board Certification

Board eligible physicians must become board certified within the time period specified for their discipline in the table below. The Credentials Department will verify documentation of board certification verbally or by query to the relevant American Board.

Table 2: Board Eligibility Period for American Boards

American Board of -	Board Eligible Period (years)	Transition Date
Allery and Immunology	5	12/31/2017
Anesthesiology	7	1/1/2019
Colon and Rectal Surgery	7	12/31/2023
Dermatology	5	12/31/2016
Emergency Medicine	5	12/31/2019
Family Medicine	7	1/1/2019
Internal Medicine	7	1/1/2019
Medical Genetics and Genomics	7	1/1/2019
Neurological Surgery	5	12/31/2018
Nuclear Medicine	7	NA**
Obstetrics and Gynecology	7 (+1)*	12/31/2018
Ophthalmology	7	1/1/2019
Orthopedic Surgery	5	NA**
Otolaryngology	5	1/1/2019
Pathology	5	1/1/2019
Pediatrics	7	NA**
Physical Medicine & Rehabilitation	7	12/31/2019
Plastic Surgery	7 (+1)*	1/1/2019
Preventive Medicine	7	1/1/2019
Psychiatry and Neurology	7	1/1/2019
Radiology	6	1/1/2015
Surgery	7	7/1/2022
Thoracic Surgery	7	NA**
Urology	6	NA**
Podiatric Medicine	10 ***	*** see below
Foot & Ankle Surgery	7	NA

*1 year Clinical Practice required

**Board Eligibility policies already match ABMS policy

*** 5 years to take board qualification exam after residency (becomes board eligible) + 5 years to become fully certified

In addition to American Board of Medical Specialties, other acceptable Boards are: American Osteopathic Association, American Board of Oral & Maxillofacial Surgery, American Board of Podiatric Surgery (ABPS), ABPM or the American Board of Dentistry and National Chiropractic Board. The eligible period for these Boards is seven years. To be consistent with system-wide Credentials Advisory Committee, Optima Health no longer accepts the Royal Canadian Board.

The board certification requirement will not apply to recently graduated physicians, board eligible physicians, and physicians who have not practiced for at least 10 years (Network Accessibility Policy – CR-19.0). Board eligible physicians are tracked to determine when the eligibility period has been reached (Board Tracking Procedure – CR-10.A).

Optima Health allows a one-time waiver for providers who were previously board certified, giving them one additional year to sit for the boards. Providers who did not pass their boards on their expired year are

notified of the extension in December. Failure to maintain board status after the one-year waiver results in a termination review by the Medical Director and Network Management. Network Management requesting a waiver for exception after the extension has to supply a business case to the Credentials Department. Credentials Department will request a map by specialty by location, both items will then be reviewed by Medical Director and Credentials Committee for necessity, if not accepted the practitioner will be termed for failure to comply with board renewal. If accepted there board status will change to exception based on necessity in database.

Optima Health conducts annual review of board certifications and tracking of board letters. Monthly, the Credentialing Analyst updates provider files with all letters received (CR-10).

Optima Health reserves the right, at the recommendation of the COO or Senior Medical Director, for the MAC to waive the board certification requirement when it is determined that there are special circumstances warranting waiving such a requirement. Credentialing approval for a physician who is not board certified, but is working in an under-served area will be individually reviewed to comply with 12 VAC 5-408-270. (Refer to CR-19.0). This regulation applies to service areas where less than 80% of the enrolled population have access to providers within OHP/OBH time and distance standards. A map is included with the completed application for any under-served providers.

A physician requesting a board certification exception must:

A. Meet or exceed the current state CME requirements
B. Furnish a list of courses by title at the time of the application
C. Have been board-certified at least once and have a minimum of 10 consecutive years of clinical practice
D. Have been trained and certified in his/her field prior to the availability of board certification in that specialty

Physicians located outside of Hampton Roads who do not meet an exception rule based on being in an under-served area may be considered for exception if they are not Board Certified or Board Eligible and if they have a satisfactory work history for at least five (5) years.

Provisional Credentialing

Newly-graduated providers may receive provisional credentialing during the first 12 months after their graduation. Approval of provisional status requires primary source verification of current valid license to practice, listing of malpractice carriers and claims history for the past seven years, and NPDB review. Following award of provisional status, the provider will have 60 days to complete his/her file for review and final approval by the Credentials Committee.

Right to Review, Denials, and Appeals

All applicants have the right to learn the status of their application and review information submitted to the Credentials Committee except for references, recommendations, or information that is peer review protected under HCQIA or HIPAA.

All applicants have the right to correct erroneous information submitted by another party. Within 30 days of receiving conflicting information, the Credentials Department will notify the applicant of discrepancies. Applicant shall have 15 business days from the date of notice of the erroneous information to submit corrections in writing to the Credentials Analyst and Credentials Manager. Refer to directions CR-2.C regarding staff receiving updated information regarding disclosure questions and corrections.

If a provider is denied network participation, Optima Health will send the provider a letter noting the reasons for denial and providing instructions for submitting an appeal. Request for an appeal must be made in-person or in writing to the Medical Director within ten business days of receiving notice of denial (CR-17.0 Fair Hearing Policy). Results of appeals will be reported to the State Medical Licensing Board, NPDB, or DMAS, depending on the circumstances (CR-25.0). Any provider who has had a suspended or revoked license must have two years of a fully reinstated, unrestricted license before being eligible to reapply.

Ongoing Monitoring

Optima Health conducts ongoing monitoring of network providers to ensure quality and inform re-credentialing activities. In addition to requiring providers to notify Optima Health of any changes in the status of their credentialing criteria, on a monthly basis, Optima Health:

A. Conducts OIG sanction report queries and checks the EPLS listing against the provider database via CAQH License Sanction Monitoring monthly. The credentialing analyst will review error reports for OIG or EPLS (SAM) to verify they do not apply to an Optima Health practitioner, sign, date, and file the report. Also runs the Social Security Administration's Death Master File monthly.
B. Runs an expiration report listing the expired DEA, State Medical Licenses, and Insurance Certificates
C. Conducts the Disciplinary License Review Board Action procedure (CR-30.0) which notifies Network Management for action
D. Updates the provider file as necessary
E. Conducts quarterly board tracking for eligibility and one-year extension practitioners
F. Produces divisional monthly report - A report of all entities checked for sanctions is submitted to the Compliance Department (CR-11.0) and corporate
G. Overview monthly provider complaints with Network Management and Appeals Department refer to NM028
H. Download monthly opm.gov/debar and review on the 8th of each month all practitioners within Echo and claims system noting, par, non-par, no hits for reports semi-annually.

Note: A change to the policy regarding indefinite probation and/or restricted license where there is an appeal with the licensing board. In the case of an appeal to the Virginia Board of Medicine, and/or other states that have an Indefinite Probation, the practitioner may remain in network until the appeal process is complete. The OHP/OBH Credentialing Committee and Medical Director reserve the right to review every

case individually. A list of all practitioners is presented clean and or issue to Committee. Optima Health Plan would allow for a maximum six (6) month monitoring period while the Virginia Board of Medicine makes an appeal decision.

This is a case by case monitoring period will not be considered if the Findings of Fact by the Virginia Board of Medicine was directly involved in patient care and is intended for strictly educational issues.

If a member submits a site-related complaint about a provider office to the Appeals Department, the Medical Director reviews the complaint and refers it to Network Management for a provider site visit. Results of the site visit are returned to the Credentials Department and site visits are followed-up within 6 months. All documentation from site visits will be attached to the quality review form in recredentialing (refer to policy CR-22.0, NM 001).

Optima Health runs monthly reports of complaints against providers during recredentialing to monitor performance. The acceptable standard during a three-year recredentialing cycle is no more than five service complaints, no quality occurrence, and no more than one open or closed legal action of up to $75,000. All occurrences beyond the standard will be reviewed by the Credentials Department. All complaint information is supplied by the Appeals Department and the Symphony Database per Appeals Department policies and procedures.

Quality Improvement sends an email that simply states if there were any ratings for 2 or 3 ratings; if no concerns with practitioners, providers ,facilities or if we have a 2 or 3 within a quarter. Credentials department logs each month if any complaints appear and Name, Date of Occurrence and Committee review date. Refer to policy QI-2 Occurrence Guidelines and Example QI-2 Tracking Occurrence spreadsheet. We receive monthly reports from QI and notate on a grid monthly.

Terminations and Appeals

The National Provider Data Bank (NPDB), the state Medical Board, and DMAS will be notified in accordance with legal requirements regarding any quality issues, limitation in participation , or termination of provider contract.

Any provider that appears on the OIG sanction report or EPLS (SAM) is immediately reported to the Medical Director and Network Management for removal from the network (OIG Policy, CR-11.0).

Failure to maintain primary license to practice, DEA number, or malpractice is a breach of contract and grounds for termination. The Credentials department completes a Network Termination form and forwards it to Network Management after 2 warning letters, 2 follow-up calls, and a final certified letter to the provider. Refer to Network Management for their policy on the termination process request form.

If the provider wishes to appeal, they must submit a written rebuttal document to the Medical Director within ten business days (Policy CR-17.0 - Fair Hearing Policy). The Credentials Manager shall report the outcome of an appeal to the NPDB, State Medical Licensing Board, and DMAS (refer to policy CR-25.0).

Reporting

The Credentials department generates a quarterly report on progress towards credentialing goals. The report lists providers credentialed in 30, 60, goal to meet the HB 139 threshold and provides a graphical comparison of performance in each quarter to Quality Improvement Committee (QIC) as well as staff.

Any actions that seriously impact quality of care which may result in suspension or termination of a practitioner's license is immediately reported to the appropriate authorities. Optima Health submits a quarterly report of providers who have failed to meet credentialing/recredentialing standards, been denied application or terminated, or who have had program integrity-related and adverse actions, as instructed by the most recent CCC Plus Reporting Manual.

Optima Health shall provide monthly dashboard reports to DMAS by the 1st of each month on all ARTS credentialed provider organizations by ASAM Level of Care and by region in the CCC Plus network according to contract requirements. The report shall include ASAM Levels 1.0, 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, and 4.0 as well as Opioid Treatment Programs and Office-Based Opioid Treatment providers.

Process

Application Workflow

1. Network Management educators give the Credentialing Analyst the electronic copy of the CAQH Application (CR 2.1). The application includes the applicant's signature attesting to the completeness and correctness of the application and a statement regarding current physical and mental health status, lack of impairment due to chemical dependency/substance abuse, history of loss of license, felony convictions, and history of limitation of privileges or disciplinary activity.
2. If the analyst identifies issues with an application and it does not meet clean file requirements, the application must have a Medical Director Review Form prior to acceptance as an "issue" file (CR-2.2 Medical Director Review Form). If an NPDB, License, or claims history issue, Questions marked "no" and during primary source, if identified as a clean file, the analyst will fill out the Medical Director Review Form (MDR) and have the Medical Director correct from "Clean file to Issue file" and notify the applicant. The applicant will have 15 business days from notification to provide explanations or corrections.
    a. *If the analyst reviewing the application has a MDR and the Medical Director reviews the application and makes the decision to reject the application based on not meeting requirements. The application is sent back certified with explanation and Network is notified.*
    b. *If the analyst receives the MDR form signed as an issue it is processed by the Initial analyst and reviewed at Committee for approval*
    c. *If the analyst reviews the complete application and it is deemed "Clean" once the Medical Director reviews and signs the electronic file they are sent for Temporary approval every Monday via Temp Approval grid and all files Issues or Clean are all presented to Committee for final approval.*
3. Optima Health will key initial Providers into Echo within five business days of accepting the CAQH application with an Optima Health release. The received date in Echo shall be the same as the date of acceptance by the reviewer as listed on the application checklist.
4. Any primary source verification that is not sent electronically is scanned and indexed into the Echo-database. Where written documentation is not available, Credentialing staff may use a

verbal verification form (CR 2-4). The form requires the Provider's name, the verification being completed, the name of the person who is being called, the type of query, the date of the call, the signature of the person verifying, and the date of the verification.

5. Second requests and third requests are sent to the verifying party if verifications are not received within a week of original inquiry. On the final attempt, Optima Health will also notify the provider so he/she may assist if necessary.

6. Optima Health will not primary source verify professional references. However, Optima Health reserves the right to include professional references as additional information if there is derogatory information received while primary verifying the state licensing boards, malpractice carriers, sanction board, or NPDB.

7. Optima Health verifies ADA accessibility at the time of credentialing and recredentialing for all providers included in the Optima Health Network.

8. The Credentialing staff will use CertiFACTS Online to verify all specialty boards. All verification documents will be printed and scanned into Echo. The Credentials Analyst will use the Specialty Board Form if the Provider is not certified but is board eligible. The signed form will contain the type of specialty or subspecialty and the expected board exam date.

9. The Credentials Analyst will verify and update the electronic log linking documents to ensure the Provider's file is complete. The Credentials Analyst will submit the file electronically via the Provider Assessment Portal is a checklist of primary source (PAP) to the Credentials Manager/Auditor for review attesting to the accuracy of the completed file. Following review by the Credentials Manager/Auditor, it is submitted to the Medical Director.

10. Once the OHP Medical Director has signed the file in PAP (CR-24.0), the Provider has temporary approval and is included in the Active matrix for review and approval by the OHP/OBH Credentials Committees (CR-24.A or CR-24.B). Files approved by the committees for Hampton Roads providers are forwarded to the MAC for final approval. All clean files will have the date of the Medical Director's signature as the final approval date. Issue files for Non-Hampton Roads providers and Hampton Roads providers will have the Committee's meeting date or MAC's meeting date respectively as the date of final approval. The Credentials Committees and MAC meet monthly to review providers with temporary approval in the prior month.

10a. Non-clean files that need to be decided by the Committee are reviewed by Committee and they review the packet with issues.

11. The OHP/OBH Credentials Committees and MAC have the authority to review any provider at any time. Adverse or questionable information identified by the committees that may give cause for the denial or termination of a provider is subject to the appeal policy (CR-17.0). Committee-approved providers that are denied/terminated may re-apply after a two-year grace period on a case-by-case basis with the Medical Director's permission.

12. The Credentialing Department notifies Network Management staff of approvals via email. With the approval of the OHP/OBH Credentials Committees or MAC, Network management generates a change form for System Admin to set-up the provider and assign a provider number and they are

refer to Network Management policy NM0024 Provider Directory Policy. After final review by OHP Credentials Committee or MAC, all temporarily approved Providers will receive an approval letter with their effective date within sixty (60) days of approval date. *Also refer to Network Management policy for New Provider Workflow Policy NM004*

13. Within 60 calendar days of Committee decision, Credentialing staff mails and/or electronic fax an approval letter with the credential date to the Provider and places a copy in the Provider's file. Refer to NM004

References

B. CR-2.A for OHP Credentials Committee Structure
C. CR-2.B for Affirmation of Non-Discrimination for Credentialing & Recredentialing
D. CR-24.0 for Medical Director Policy for review process
E. CR-2.7 for the Credentials Committee
F. CR- 17.0: Fair Hearing Policy
G. CR-10: Board Certification
H. CR-19: Network Accessibility for Underserved and/or Exception Based Policy
I. CR-30.0: Disciplinary License Review Board Action
J. CR-11: OIG Sanction Policy
K. Compliance Policy 147: Oversight of Vendors, Subcontractors, Agents, and FDRs
L. NM001: Site Visit Policy
M. NCQA Standards and Guidelines for the Accreditation of Health Plans, Chapter CR-1 to CR-8
N. Medicare Managed Care Manual Chapter 6 on Relationships with Providers, Sections 30, 60.3 & 60.4
O. 42 CFR 422.204(b) (2); 42 CFR 422.202(a) and (d)
P. 12 VAC 5-408-170
Q. 42 CFR 438.214

Attachments

Provider Credentialing Process Time Line (Attachment A)

CREDENTIALS DEPARTMENT POLICY CR-2.0
PRACTITIONER CREDENTIALING PROCESS TIME LINE
ATTACHMENT A

TIME FRAME	ACTION
March 1997 meeting	OHP Credentials Committee recommended final approval would reside with Medical Affairs Committee (MAC), instead of the OHP Board.
Beginning April 1, 1997	Medical Affairs Committee is the final approval for credentialing and recredentialing process for Hampton Roads providers.
October 1998	OHP will use an Initial Application Credentialing Log as information arrives for Physicians which will be used to document primary source verification and signed by the analyst.
April 1, 1999	OHP Credentials Committee is the final approval body for credentialing and recredentialing process for Non-Hampton Roads providers not defined in Hampton Roads, North Carolina, Tennessee, West Virginia and Maryland.
June 6, 1999	The OBH credentialing department combined with OHP credentialing department.
July 1999	Incorporated a quarterly statistics report, to reflect the OHP/OBH progress in meeting goals for initials and recredentials. It lists providers completed in a 30, 60, 90, 120, 150 and 180 and over 180 days.
Beginning December 7, 1999	OHP will be incorporating several revised standards from the 2000 NCQA standards. OHP adopted the requirement that the applicant attest to current malpractice insurance and history of loss, limitation of privileges and/or disciplinary activity.
July 2000	Completed the recredentialing process for all OBH providers. A mechanism is now in place to ensure all providers are recredentialed within 36 months.
June 1, 2001	Will no longer primary source verify professional references.
July 1, 2001	OHP has Provisional Credentialing for newly graduated providers within the first 12 months. These providers must be completed within 60 days.
July 3, 2001	Credentials Department will no longer require hard copies of state license certificates as they expire.
May 31, 2002	Credentialing no longer accepts the Royal Canadian Board to be consistent with System-wide Credentials Advisory Committee.
January 2005	Any provider participating within the state of Virginia must maintain the malpractice with Sentara standards. However, all other states (i.e. NC, MD, WV, TN, etc.) must have the minimum of their state malpractice requirement in order to participate.
May 1, 2007	The criteria for provider's board certification process will change for Hampton Roads and Non-Hampton Roads moving forward. Refer to CR-10.0 Board Certification.
May 1, 2007	Optima Credentialing incorporated the NCQA standard of "clean files" i.e. non-issues that meet the organizational criteria.
October 20, 2007	Credentials Dept. will no longer need a current hard copy of license for VA, NC, TN, MD or WV, etc. as long as they have a current copy of their state verification attached. All licenses and out of state licenses will be maintained monthly and update any that may expire from previous states.

January 1, 2008	Credentials Department switched over to a document management system (Fortis system).
July 2008	Site visits will no longer be done at initial review, only at the time the Medical Director issues an occurrence refer to site visit policy.
December 31, 2008	All files will be scanned and indexed and will be strictly paperless all signature and dates will be in the Fortis Info log system. Completed all on this date.
August 2011	Added criteria for LCAS and standard for Mental Health Nurse practitioners, also BCBA and BCBAA criteria effective 9/19/2012.
March 2012	Per NCQA we needed a form to show that the analyst was reviewing all work gaps of six months or more, claims more than $75, 000 (more than 3 regardless of amount) underserved or cross coverage issues prior to accepting application. We then added the Medical Director form (in Echo Pre-Review Medical Director Form) which a signature page that the medical director will indicate clean or issue file prior to processing based on the findings from the analyst prior to acceptance of application.
June 2013	ACNPC (Adult Acute Care Nurse Practitioner Certification) accepted as new board to verify.
April 2014	Change in malpractice requirements for Ancillary Behavioral Health providers (Clinical Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors, Registered Nurse Clinical Specialists Licensed Marriage Family Therapists and NC LPA's/LCAS, Board Certified Behavioral Analyst and Board Certified Behavioral Analyst Assistants) they malpractice they are now required to have is 1m and 3m instead of the Virginia cap requirement. ,
May 2014	Addiction Medicine has been accepted by MAC for processing, refer to CR-10.B.
June 2014	CRNA – added for NC business new board certification website and they do not need DEAs to practice. Also if they work in an office setting i.e. gastro office
March 2017	Revised in response to requirements of the CCC Plus contract. Added ARTS credentialing criteria and DMAS reporting requirements. Added table of Board Certification periods.