POLICY AND PROCEDURE

POLICY NAME: Practitioner Credentialing & Recredentialing	**POLICY ID:** LA.CRED.01
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA:** Credentialing and Provider Data Management
EFFECTIVE DATE: 10/01/2020	**PRODUCT(S):** Medicaid ~~and Medicare~~
REVIEWED/REVISED DATE: 10/21, 10/22, 021~~1~~/23	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
This policy outlines practitioner credentialing and recredentialing.

PURPOSE:
To ensure LHCC develops and maintains a network of professional practitioners who are qualified to meet the health care needs of covered members in an efficient, compliant, safe, and effective manner.

SCOPE:
Louisiana Healthcare Connections Credentialing ("Credentialing") and the Provider Data Management Department ("PDM") on behalf of Louisiana Healthcare Connections ("LHCC"). LHCC Provider Relations, Network Contracting, and Quality Improvement Departments.

DEFINITIONS:

POLICY:
Louisiana Healthcare Connections has established standards for conducting the functions of practitioner selection and retention. These standards include practices for practitioner credentialing, recredentialing, and ongoing monitoring that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA).

Network Participation: Prior to entering into a Network Provider Agreement, LHCC shall ensure that providers have been properly credentialed to ensure provider facilities, organizations, and staff meet all qualifications and requirement for participation in the Louisiana Medicaid Program and as outlines in the MCO Manual. For consideration to participate in LHCC network, all individual practitioners who have an independent relationship with LHCC must complete an application for participation, submit copies of applicable supporting documentation, meet minimum administrative requirements, and meet the credentialing qualifications of LHCC. LHCC shall develop and implement policies and procedures for the acceptance of new providers screened, enrolled, and approved in writing by the State, and termination or suspension of providers to ensure compliance with the Contract. The policies and procedures should include, but are not limited to, the encouragement of applicable board certification(s). LHCC shall develop and implement a mechanism, subject to LDH approval, for reporting quality deficiencies, which result in suspension or termination of a Network Provider. This process shall be submitted to LDH or its designee as part of Readiness Review and annually thereafter, and prior to implementation of revisions.

Exclusion from federal procurement activities is non-compliant with minimum administrative requirements and results in exclusion from payment, except as permitted under 42 CFR 1001.1801 and 1001.1901. For currently participating practitioners, exclusion results in immediate termination of network participation. LHCC will report to LDH those participating providers who have been terminated due to exclusion within three (3) business days.

It is the sole responsibility of the applicant to produce all necessary information and documentation in a timely manner; as required to conduct a thorough examination. Failure to provide the necessary information within thirty (30) calendar days from the initial application date may result in termination of the process. If the practitioner ever seeks to join LHCC in the future once the process has been terminated, he/she must begin the process from inception.

Types of Practitioners: The credentialing/recredentialing processes apply, but are not limited to, the following practitioner types:

- Medical doctors (MD);
- Nurse Practitioners (NP);
- Oral surgeons (DDS/DMD);
- Chiropractors (DC);
- Osteopaths (DO);
- Podiatrists (DPM);

- Behavioral Health Service Providers (Licensed Mental Health Practitioners); and
- Mid-level practitioners (non-physician).

Completion of the credentialing/recredentialing process is not required when LHCC does not select or direct its members to see a specific practitioner or group of practitioners and for non-participating practitioners. This includes practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for LHCC members only as a result of members being directed to the hospital, inpatient setting, or free-standing facility. These practitioners may include, but are not limited to the following specialties:

- Anesthesiology,
- Emergency Medicine,
- Neonatology,
- Pathology,
- Radiology, and
- Telemedicine.

A locum tenens practitioner who does not have an independent relationship with LHCC and who is covering for a participating provider does not require credentialing.

Practitioner Rights: All practitioners are notified of their right to review information obtained by LHCC and/or Credentialing to evaluate their credentialing or recredentialing application upon receipt of a written and signed request submitted to the Credentialing Department. These rights do not include the right to review references, personal recommendations, or other information that is peer review protected.

Practitioners also have the right to receive the status of their credentialing or recredentialing application at any time by contacting LHCC Provider Relations and/or Contracting Department.

Should the practitioner believe any of the credentialing information to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner, he/she has the right to correct any erroneous information submitted by another party.

New practitioners who are denied participation for non-administrative reasons have the right to request a reconsideration of the decision within thirty (30) calendar days of the date of receipt of the denial letter.

Notification of these rights may occur via individual correspondence, in the provider manual, and/or on LHCC's web site.

Provisional Credentialing: LHCC Credentialing may determine the need to occasionally make practitioners available to members prior to the completion of the entire initial credentialing process. The option for provisional credentialing is only available to practitioners who are applying for the first time to the LHCC practitioner network. A practitioner may only be provisionally credentialed once and for a time-period no longer than 60 calendar days. Louisiana Healthcare Connections utilizes Provisional credentialing to meet the requirement to process expedited and temporary credentials.

Recredentialing: LHCC Credentialing formally recredentials practitioners at least every thirty-six (36) months. The recredentialing cycle begins with the date of the initial credentialing decision.

Practitioners who are terminated or voluntarily withdraw from the network and subsequently seek to be reinstated must complete the initial credentialing process if the break in service is more than thirty (30) calendar days or if it has been more than thirty-six (36) months since they were last credentialed.

If LHCC Credentialing is unable to recredential a practitioner due to military leave, maternity leave or sabbatical, the contract remains in place and the practitioner will be recredentialed upon his/her return. Credentialing will document the reason for this delay in the practitioner's file. At a minimum, the recredentialing must be completed within 60 calendar days of when the practitioner resumes practice.

Professional Competence: For health care practitioners, verification of applicable education and training upon initial credentialing and maintenance of valid professional licensure for practitioner's field of practice upon recredentialing, which includes requirements for Continuing Medical Education, are accepted as evidence of maintenance of knowledge and ability in practice area(s) for health care practitioner.

Binding Nature of Credentialing Decisions: LHCC has the right to make the final determination about which practitioners may participate within its network. Practitioners who are denied initial participation may reapply for admission into the network no earlier than one (1) year following the initial denial or end of the reconsideration process.

PROCEDURE:

I. Application Received

A. LHCC contracting secures first-signature contracts, provider applications, and associated documents from applicant practitioners and forwards to PDM. LHCC will accept and utilize the Louisiana Standardized Credentialing Application or the CAQH Application for the credentialing application.

B. Provider enrollment systems shall include, at a minimum, the following functionality:
   i. Automated interfaces with all licensing and medical boards;
   ii. Automated alerts when provider licenses are nearing expiration;
   iii. Retention of NPI requirements;
   iv. System generated letters to providers when their licenses are nearing expiration;
   v. Linkages of individual providers to groups;
   vi. Credentialing information;
   vii. Provider office hours; and provider languages spoken

C. PDM verifies existence of sufficient information needed for enrollment:
   i. Completed Provider Data Form or Provider Roster;
   ii. Completed Provider Application signed and dated not more than 150 calendar days prior to enrollment;
   iii. Applicable W-9(s);
   iv. Query of the National Plan & Provider Enumeration System (NPPES) to confirm that the practitioner has a current, valid unique National Provider Identifier (NPI) for every provider type, to the extent such provider is not an atypical provider as defined by CMS;
   v. Current Disclosure of Ownership/Interest Form, signed and dated;
      a. PDM provides Disclosure forms to the Corporate Compliance department for monitoring of exclusion checking and ongoing monitoring as specified in LA.COMP.27.
      b. Upon notification from the Corporate Compliance department of a verified exclusion status of an individual or entity with an ownership or controlling interest in the provider or a managing employee of the provider, PDM will initiate the appropriate actions specified in LHCC's contract, up to and including termination of the contracting process or participation status.
   vi. In conjunction with the enrollment process, if state requirements specify, PDM also performs additional reviews to ensure compliance to requirements in the provider contract.
   vii. Eligibility to become a Medicaid provider is verified as part of enrollment, as applicable per LHCC requirements;

D. If any of the required items needed for enrollment are missing or insufficient, PDM notifies LHCC Contracting or Provider Relations to secure needed items.

E. PDM completes enrollment into the Provider Data Management system utilizing the Provider submitted information as referenced above in Section B. This includes but is not limited to demographic information, NPI, licenses, Practice/service location information including accessibility as required by federal, state and local laws, and standards adopted by LHCC, associated groups, education/training, specialty, board certifications, cultural competency training, Panel information, etc. and forwards documentation to Credentialing. Discrepancies identified during the credentialing process regarding licenses, education/training, specialty, board certifications or other information verified by Credentialing is updated by Credentialing prior to completion of the credentialing cycle. Credentialing staff updates the Provider record to reflect the Credentialing Committee decision, PDM staff performs a review of the Provider record for practice/service location and associated group information and identified discrepancies will be updated prior to changing the status from non-participating to participating in the network. Once made par, the record is fed to both the online directory, the call center system, and the eligibility system for member cards and enrollment.

II. Verification of Items Requiring Primary Source Verification (PSV)

Credentialing verifies using primary sources the elements included in this section. Primary sources may include oral, written, and/or internet sources. Any sources used are NCQA accepted.

Query images and other documentation reviewed (including those retrieved via oral sources) during PSV are saved, date stamped, initialed, and placed in the applicant's file prior to the credentialing decision. For calculating timeliness requirements on Internet and electronic verifications, the date generated by the source when the information is retrieved is used. If the source does not generate a date, the staff person verifying the credential should note the date of receipt of verification in the credentialing file via date stamp.

The minimum verification elements needed for Provisional Credentialing are noted in the section below.

A. Current, unrestricted state license to practice, if license is required to practice (*required for Provisional Credentialing*).
   i. Validation that the practitioner has a current and valid license at the time of credentialing decision is required in all states where practitioner provides care to LHCC members and is verified directly from the state license or certification agency (or it's website).
   ii. Verification for state sanctions, restrictions on licensure and limitations on scope of practice is performed for all active state licenses and is performed through a query of the National Practitioner Data Bank or with the applicable State Licensure Board or the applicable State Certification Board or State Agency. Verification of the most recent five year period available through the data source is performed.

B. Education and Training.
   i. Credentialing verifies the highest of the three levels of education and training obtained by the practitioner (graduation from medical school, residency, or board certification).
   ii. Because medical specialty boards verify education and training, verification of board certification fully meets the requirement for verification of education and training, unless otherwise noted.
      a. Credentialing queries the current version of the ABMS Directory of Medical Specialists via CertiFacts or other NCQA-approved service.
   iii. Other approved primary sources for verifying education and training include:

Practitioner Type	Primary sources for verifying education and training
Physicians	**Graduation from Medical School** • Confirmation from the medical school • Entry in the AMA Physician Master File • Entry in the AOA Official Osteopathic Physician Profile Report or AOA Physician Master File • Confirmation from the Educational Commission for Foreign Medical Graduates for international medical graduates licensed after 1986 (ACFME is not an acceptable substitute). • Confirmation from an association of schools of health professions if the association performs primary-source verification. At least annually, Credentialing must obtain written confirmation from the association that it performs primary source verification of graduation from medical school. • Confirmation from the state licensing agency if the state agency performs primary source verification. Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification. • Sealed transcripts, if submitted in the institution's sealed envelope with an unbroken institution seal. • Confirmation from AMA that the physician's education was completed through the AMA's Fifth Pathway Program. **Completion of Residency Training** • Confirmation from the Residency training program • Entry in the AMA Physician Masterfile • Entry in the AOA Official Osteopathic Physician Profile Report or AOA Physician Masterfile • Confirmation from an association of schools of health professions if the association performs primary-source verification. At least annually, Credentialing must obtain written confirmation from the association that it performs primary source verification of residency training. • Confirmation from the state licensing agency, if the state agency performs primary source verification of residency training. Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of residency training. • FCVS for closed residency programs.

Practitioner Type	Primary sources for verifying education and training
Chiropractors	• Confirmation from a chiropractic college whose graduates are recognized as candidates for licensure by the regulatory authority issuing the license. • Confirmation from the state licensing agency, if the state agency performs primary source verification of graduation from chiropractic college. Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of graduation from chiropractic college.
Oral Surgeons	Completion of Residency • Training programs in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA) • Confirmation from the appropriate specialty board if the board performs primary source verification of graduation from a CODA accredited training program. At least annually, Credentialing must obtain written confirmation from the specialty board that it performs primary source verification of graduation from a CODA accredited training program. • Confirmation from the state licensing agency, if the state agency performs primary source verification of graduation from a CODA accredited training program. Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the CODA accredited training program or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of graduation from a CODA accredited training program.
Mid-level Practitioners	• Verification from the college or university of the highest level of education. • Confirmation from the state licensing agency, if the state agency performs primary source verification of the highest level of education. Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of the highest level of education.
Other Non-physician health care professionals	• Confirmation from professional school. • Confirmation from the state licensing agency, if the state agency performs primary source verification of professional school training. Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of professional school training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of professional school training. • Confirmation from a specialty board or registry, if the board or registry performs primary source verification of professional school training. At least annually, Credentialing must obtain written confirmation from the specialty board or registry that it performs primary source verification of professional school training.
Podiatrists	• Confirmation from the residency training program • Appropriate specialty board, if the board performs primary source verification of completion of residency. At least annually, Credentialing must obtain written confirmation from the podiatry specialty board that it performs primary source verification of completion of residency. • Confirmation from the state licensing agency, if the state agency performs primary source verification of the completion of residency. Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification completion of residency directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of completion of residency.

C. Board Certification

i. LHCC requires board certification or alternate educational and clinical pathways as outlined in LA.CRED.10. However, if a physician level practitioner claims to be board certified, Credentialing verifies current board certification.
    a. The expiration date of the board certification is documented in the credentialing file.
    b. If the practitioner's board certification does not expire, a lifetime certification status is verified and documented.
    c. If the medical board does not provide the expiration date, Credentialing verifies that the board certification is current and documents the date of verification.

D. Report(s) of malpractice settlement(s) (*required for Provisional Credentialing*).
    i. National Practitioner Data Bank (NPDB) is queried and reviewed.
    ii. Credentialing reviews of the history of all settled malpractice claims against a practitioner within the past five (5) years from date of report, or as defined by the unique LHCC look back period.

E. ~~Medicare/~~Medicaid-specific exclusions (*required for Provisional Credentialing).*
    i. OIG LEIE will be queried through the Office of Inspector General's website.

F. State Specific Exclusion Lists, as applicable. (*required for Provisional Credentialing*). The Louisiana LDH Adverse Actions List shall be queried.

G. Determination if a practitioner has been debarred, suspended, or otherwise excluded from participating in federal procurement activities (*required for Provisional Credentialing*)
    i. The System for Awards Management (SAM) website shall be queried.

~~H. To ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to LHCC members, as applicable per LHCC requirements.~~

~~I.~~H. Social Security Administration's Death Master File must be queried for determination if practitioner has deceased, a possible indicator of fraud.

~~J.~~I. CMS Preclusion list is queried.

III. Verification of Items where PSV is Not Required

The elements below may be verified via secondary sources to support completion of an application and to show eligibility of practitioner to participate in the LHCC network. Documentation reviewed during verification is saved, date stamped, initialed, and placed in the applicant's file prior to the credentialing decision. Secondary sources of information are acceptable for the below credentialing requirements.

The minimum verification elements needed for Provisional Credentialing are noted.

A. Complete application form is signed and dated by the applicant and must include attestation for correctness and completeness of the application. Attestation elements must include (*required for Provisional Credentialing):*
    i. Reasons for any inability to perform the essential functions of the position, with or without accommodation;
    ii. Physical or mental health problems that may affect the provider's ability to provide health care;
    iii. Lack of present/current illegal drug use;
    iv. History of chemical dependency/substance abuse;
    v. History of loss or limitation of license and/or felony convictions;
    vi. History of loss or limitation of clinical privileges and/or disciplinary actions; and
    vii. Current malpractice insurance coverage;

B. Current valid federal DEA certificate(s) in each state where practitioner provides care to LHCC members (as applicable) for those practitioners who are qualified to write prescriptions.
    i. Credentialing verifies through one of the following methods: Current Certificate, the DEA Diversion website, NTIS, or an AMA Profile.
    ii. In cases where a practitioner may not possess a valid DEA certificate, an attestation of DEA Coverage Plan with name of covering practitioner may be verified.
    iii. If the practitioner states in writing that they do not prescribe controlled substances and that in their professional judgement, the patients receiving their care do not require controlled substances, they are therefore not required to have a DEA certificate but must describe their process for handling instances when a patient requires a controlled substance. The practitioner's statement and process description is included in the credentialing file.

C. Current valid State Controlled Substance registration in each state where practitioner provides care to LHCC members (as applicable) for those practitioners who are qualified to write prescriptions.
    i. Credentialing verifies through one of the following methods: Current Certificate or through the issuing state agency. For example: CSR, CDS.

ii. LHCC requires verification of the LA controlled dangerous substance certificate, if applicable. A current copy of the certificate is considered a valid source for meeting the requirement or primary source verification.
iii. If the practitioner states in writing that they do not prescribe controlled substances and that in their professional judgment, the patients receiving care do not require controlled substances, they are therefore not required to have a Controlled Substance certificate but must describe their process for handling instances when a patient requires a controlled substance. The practitioner's statement and process description are included in the credentialing file.

D. Hospital privileges from the primary hospital as indicated on the credentialing application are verified.
   i. This requirement supports patient access to a hospital setting and accurate directory information.
   ii. Credentialing may verify using one of the following acceptable sources. LHCC-specific requirements may include PSV of hospital admitting privileges.
      a. application attestation;
      b. letter from facility;
      c. roster from facility;
      d. verbal confirmation from the facility; or
      e. Copy of online directory information provided by the hospital's website specifying admitting privileges.
   iii. If the practitioner does not have privileges, a statement (written or verbal) is obtained regarding the practitioner's alternate admitting arrangements through one of the following acceptable sources:
      a. the use of a hospitalist program or
      b. admitting through a colleague.

E. Proof of professional liability coverage
   i. Credentialing verifies existence, currency, and amount using one of the following acceptable sources. LHCC-specific requirements may exist.
      a. A current malpractice facesheet, application attestation or primary source verification from the carrier. If the malpractice coverage is current and provided within the application, it must be current as of the date when the practitioner signed the attestation. If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates. Coverage must be in an amount not less than $1,000,000 per occurrence/ $3,000,000 per aggregate, or as otherwise set forth by LDH; or
      b. Federal coverage through the Federal Torts Claims Act may be confirmed by a copy of the Federal Tort letter or an attestation from practitioner of Federal Tort coverage. The application does not need to contain the current amount of malpractice insurance coverage; or
      c. Evidence of compliance with state regulations.

F. Work history review is performed and the results of the review, including gaps, are documented within the credentialing file.
   i. Relevant work history is obtained through the practitioner's application or Curriculum Vitae (CV). Relevant experience includes work as a health professional.
   ii. Work history must be submitted in a month/year format for at least the preceding five (5) years.
      a. If a practitioner has had continuous employment for five (5) years or more with no gap, providing the year only is acceptable.
   iii. Work history is reviewed for gaps;
      a. Each gap in employment exceeding six (6) months is clarified either verbally or in writing and documented in the credentialing file.
      b. Each gap that exceeds one year will be clarified in writing.
   iv. If the practitioner has practiced fewer than five (5) years from the date of verification of work history, the time frame starts at the time of initial licensure. Experience practicing as a non-physician health professional within the five (5) years should be included.

G. Evidence of CLIA Certificate or Waiver for the provision of laboratory services, as applicable per LHCC requirements.

H. For non-physician mid-level practitioners, proof of collaborative agreement, protocols, or other written authorization (as required by state law or LHCC requirements) with a licensed physician who is participating with LHCC, sets forth the manner in which the mid-level practitioner and licensed physician cooperate, coordinate, and consult with each other in the provision of health care to patients and may be secondary source verified utilizing:
   i. Form completed by supervising physician;
   ii. Copy of authorization or arrangements; or
   iii. Copy of protocols.

I. An onsite review may be required of PCPs and OB/GYNs as defined by market-specific requirements. Verification process includes review of documentation from LHCC staff of completion of assessment with passing score and may be in the form of:
    i. Documented on Provider Data Form;
    ii. Logged in CRM system;
    iii. Credentialing staff review of documented site assessment results from LHCC; or
    iv. Other confirmation communicated verbally or in writing from LHCC staff.

IV. Recredentialing follows the same process as initial credentialing, with the following differences:

A. Credentialing team is responsible for collection of the Provider Application and associated documentation needed for the recredentialing process (LHCC Contracting team is responsible for collection of this documentation for initial credentialing process);
B. Credentialing secures an updated copy of the Disclosure of Ownership/Interest Form, signed and dated (LHCC Contracting team is responsible for collection of this document for initial credentialing process);
C. Review of work history is not required;
D. Verification of education and training is not required, unless one of more of the following exceptions exist:
    i. If additional education has been obtained to change specialty affecting the contractual agreement with LHCC, Credentialing will verify additional education.
    ii. If a physician level practitioner states he/she is board certified, Credentialing will verify current board certification status from the primary source.
E. The recredentialing process consider provider-specific performance data such as those collected through the quality improvement program, the utilization management system, the grievance/complaint system, satisfaction surveys, and other activities of the organization, and that includes an attestation to the correctness and completeness of the new information. The credentialing designee gathers applicable performance data from the QI Department designee for inclusion in the recredentialing file.

V. Cases of Information Variance

In cases where information obtained from primary sources varies from information provided by the practitioner, Credentialing contacts the applicant by phone and/or letter to alert the applicant to the variance and request a response.

A. At least three (3) outreach attempts are made by Credentialing. Each attempt is documented and included in the practitioner's credentialing file.
    i. Notification sent to the practitioner includes the time frame for submitting a correction or explanation.
    ii. Notification also includes the contact information for submitting the correction/explanation, including the name and phone number of the Credentialing representative, address, and fax number.
B. The practitioner must provide a written explanation detailing the error or the difference in information to Credentialing on or before the due date stated on the notification to the practitioner. LHCC Credentialing Committee includes this information as part of the credentialing/recredentialing process.
C. If requested by the practitioner, a representative of Credentialing contacts the practitioner's office to confirm receipt of the practitioner's written explanation. Credentialing representatives only speak directly to the practitioner, or a designee authorized by the practitioner, to ensure the confidentiality of information.
D. If no response is received by the stated due date in the notification to the practitioner, Credentialing, on behalf of LHCC, assumes the practitioner does not dispute the accuracy of the information collected, and the file is presented to the Credentialing Committee. Information received after the due date, but prior to the next Credentialing Committee meeting, may be accepted at the discretion of LHCC.

VI. Complete Application Criteria

A "complete application" contains all of the information needed for credentialing review, including:

A. the practitioner's correctly and fully completed application;
B. submission of all required and current credentialing documents;
C. current application attestations, aged not more than 180 days from anticipated credentialing decision, and
D. associated attestation supporting statements.

Per Louisiana State Act 358, complete application is the date on which the managed care organization has received all the information needed for credentialing, including the health care provider's correctly and fully completed application and attestations and all verifications or verification supporting statements required by the managed care organization. "Verification" or "verification supporting statement" means the documentation confirming the information submitted by an applicant for a credentialing application from a specifically named entity or a regional, national, or general data depository providing primary source verification including but not limited to a college, university, medical school, teaching hospital,

health care facility or institution, state licensing board, federal agency or department, professional liability insurer, or the National Practitioner Data Bank.

The application must be considered complete for credentialing review to occur. The date the application is deemed complete is recorded within the Provider Data Management system.

VII. Process to Secure Missing and/or Expired Information

Missing and/or expired information must be secured before an application can be considered complete.

A. Credentialing staff and/or LHCC staff contact the practitioner and/or relevant third party to secure missing and/or updated documentation (in cases of expired or soon-to-be-expired) information. At least three (3) outreach attempts are made to secure needed information.

B. If information is not secured within twenty-one (21) calendar days of first outreach attempt for initial credentialing applications or prior to recredentialing due date for recredentialing applications, Credentialing and LHCC determine course of action up to and including termination of the application process.

C. If application is terminated, notification is sent to the practitioner. LHCC will send termination notice via certified mail, effective fifteen (15) days from the date of the notice. Claims will be paid for services delivered prior to the termination date.

VIII. Minimum Administrative Requirements

Certain minimum requirements must be met for credentialing committee/Medical Director review to occur; if these requirements are not met, termination of the process results and is referred to as “administrative” termination of the application process.

A. Minimum administrative requirements that must be met include:

i. Contains the minimum elements required for verification as described in Sections II-IV of this document;

ii. Application is signed and dated not more than 180 calendar days prior to anticipated credentialing decision;

iii. Contains primary and/or secondary source verification information collected not more than 120 calendar days prior to placing into the “Ready for Committee” status in the credentialing system of record. And, not more than 180 calendar days at the time of credentialing decision;

~~iv. As applicable to LHCC requirements, does not contain information that practitioner has opted-out of receiving Medicare funds;~~

~~v.~~iv. Does not contain information that the practitioner has been excluded from participation in the ~~Medicare and/or~~ Medicaid program or state-specific exclusions; and

~~vi.~~v. Does not contain information that the practitioner has been identified as being included on the Social Security Administration’s Death Master File.

~~vii.~~vi. Does not contain information that the practitioner has been excluded from participation in the federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

B. Credentialing notifies the practitioner via certified mail of the administrative termination of the application process.

i. A copy of the letter is retained in the practitioner’s closed file and maintained in the Credentialing Department for future reference.

C. When administrative requirements (iv), (v) and/or (vi) are not met, Credentialing notifies LHCC and PDM to ensure appropriate actions are taken:

i. As applicable, PDM modifies Provider Data Management system to prohibit payment to practitioners under these programs.

ii. If practitioner is found listed on the Social Security Administration’s Death Master File and Credentialing reasonably suspects potential fraud, Credentialing engages Louisiana Healthcare Connections’ Special Investigations Unit (SIU).

iii. LHCC Compliance ensures applicable State notifications are completed. Effective February 1, 2015, Louisiana Healthcare Connections shall notify LDH of denial of a Provider credentialing application for program integrity-related reasons or otherwise limits the ability of Providers to participate for program integrity-related reasons

IX. Determination and Review of Clean Files

Applicants who meet the participation criteria and are determined to have a “clean file” are approved for LHCC participation following review by the LHCC Medical Director or chair of the Credentialing Committee.

A. LHCC defines a “clean file” as one that meets the following criteria, unless otherwise noted in LHCC-specific attachments to this policy:

i. No past or present suspensions or limitations of state licensure within a five (5) year look back period;
ii. No past or present suspensions or limitations of DEA or state controlled substance registration within a five (5) year look back period;
iii. Current Malpractice coverage in the amount required by LHCC;
iv. No past or present Federal or State sanction activity including ~~Medicare/~~Medicaid sanctions;
    a. At the discretion of the Credentialing Manager or Medical Director, sanctions over the five (5) year look back period may be presented to the Committee if the practitioner has recent sanctions and the older history may provide more information regarding an appropriate decision
~~v. Absence of information that practitioner has opted-out of receiving Medicare funds, as applicable to LHCC requirements;~~
~~vi.~~v. No malpractice claims that resulted in a settlement or a verdict in favor of the plaintiff (claims ruled in favor of the defendant are acceptable for a clean file) in a five (5) year look back period from date of settlement;
    a. At the discretion of the Credentialing Manager or Medical Director, malpractice claims over the five (5) year look back period may be presented to the Committee if the practitioner has recent aberrant malpractice claims and the older history may provide more information regarding an appropriate decision.
~~vii.~~vi. No gaps in relevant (as a health professional) work history of one (1) year or more within a five (5) year look back period. Each gap in employment history exceeding six (6) months is clarified either verbally or in writing. Gaps over one (1) year in work history must be documented in writing and reviewed by Committee. If the practitioner has practiced fewer than five (5) years from the date of credentialing, the work history starts at the time of initial licensure;
~~viii.~~vii. No current hospital membership or privilege restrictions and no history of hospital membership or privilege restrictions within a five (5) year look back period;
~~ix.~~viii. No history of or current use of illegal drugs or alcoholism;
~~x.~~ix. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
~~xi.~~x. No criminal/felony convictions, including a plea of no contest.
~~xii.~~xi. No involuntary terminations from an HMO or PPO.
~~xiii.~~xii. For those practitioners for whom site visit is required, site visit score meets appropriate threshold for passage.
~~xiv.~~xiii. No "yes" answers on attestation/disclosure questions, with exceptions of the following which do not trigger a full Committee review:
    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that is over five (5) years old from date of report, or as defined by the unique LHCC look back period;
    e. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam in a provider who is currently board certified or who remains in the five (5) year post residency training window;
    g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion; and/or
    h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

B. In cases of recredentialing:
    i. Issues, judgments, or settlements previously reviewed do not have to be resubmitted during the current phase of recredentialing; and
    ii. Issues, judgments, or settlements since prior credentialing must be considered in the determination of whether a file is considered clean.

C. If a file is determined to be clean, the practitioner is presented to the LHCC Medical Director or chair of the Credentialing Committee on a summary listing containing, at minimum, practitioner name, NPI and specialty.
    i. Information is typically presented via email but may also be presented in person.

ii. Approvals received via email are from a secure system with a unique electronic identifier with appropriate controls to ensure that only the designated medical director or qualified physician can access and use as an electronic signature.

D. If approved for network participation, a letter of acceptance is mailed to the applicant within sixty (60) calendar days of the determination, unless otherwise specified by LHCC requirements.

i. Notification of acceptance is not provided for recredentialing applications.

X. Committee Review of Unclean Files

Credentialing and/or recredentialing application files that do not meet criteria for clean file review are brought to the Credentialing Committee for review. The Credentialing Committee has been delegated the responsibility from LHCC Quality Improvement Committee to review the qualifications of each applicant presented and make approval or rejection determinations

A. The following grid summarizes file criteria and when Credentialing Committee review is required:

Credentials	Criteria	Committee Review
NPDB Profiles	NPDB Reports within five (5) years of the resolution date, per report to the committee decision/date.	Yes
	Example: Committee Date 01/2007 *NPDB Report 1 Resolution 1/2009*	*Yes*
	NPDB Report 2 Resolution 10/1991	*No*
Restricted License Adverse Activity Disciplinary Limited Supervision	State Licensure documentation within five (5) years of date of final action/order to the committee decision/date. *Please see the NPDB example for date compliance.*	Yes
Malpractice History	All Open, Pending, Discovery Claims *Committee cannot make a recommendation on these types of issues until a final judicial outcome. The Credentialing Committee will review the final outcome during the recredentialing or ongoing monitoring process.*	No [1]
	All Closed or Dismissed Claims Claims that resulted in a settlement or judgement for the plaintiff	No Yes
Federal, State Sanctions, Financial	State, ~~Medicare/~~Medicaid~~re~~ Sanctions, Fines, Discipline activity within five (5) years. Review dates for determination.	Yes
	Current ~~Medicare/~~Medicaid Exclusions File will be administratively declined for participation.	No
Work History Gap	Gaps over 1year in work history must be documented in writing and reviewed by committee.	Yes
Specialty Issues Board Certification Clinical Education Training Program	Any discrepancies found through the verification process with a final order or judgment within 10 years of the credentialing committee decision/date.	Yes
Relinquish privileges, licensure, certification	Relinquish state clinical license or certificates, malpractice insurance coverage, clinical or staff privileges, appointments, board status etc. Also any state, local, or federal agencies.	
	*Under Investigation	Yes
	Not Under Investigation – *Credentialing Manager review to determine committee file review.*	Yes or No
Quality Indicators Recredentialing Only	During recredentialing the practitioner or facility have unsatisfactory Quality indicators, which can be one or more of the following: quality of care, over/under utilization, inadequate medical records, accessibility issues, and inappropriate volume of member complaints.	Yes

* It is expected that these findings will be discovered for currently participating practitioners through ongoing sanction monitoring. Practitioners with such findings will be individually reviewed and considered by the Credentialing Committee at the time the findings are identified. These practitioners will be identified (off cycle) when they are presented to the Credentialing Committee.

B. The Credentialing Committee may utilize an exception process should it be necessary to credential certain practitioners given the needs of its membership.
    i. When there are extenuating circumstances that preclude the practitioner from meeting minimum participation criteria, but do not preclude the practitioner from providing quality care and service for LHCC members, the Medical Director/Credentialing Committee Chair /Credentialing Committee may decide to utilize an exception process to extend an offer of participation.
    ii. A complete discussion of this decision is reflected in the Credentialing Committee meeting minutes.
    iii. If such a need exists, each criterion for selection is examined on an individual basis taking into account the following:
        a. If there is a history of drug or alcohol abuse, the applicant must be involved in a credible program to correct impairment with concurrent and present monitoring by the medical society or state board. There should be no evidence of recidivism.
        b. Previous sanction activity: the nature of the sanction and remedy.
        c. Office site visit: a plan to remedy any deficiencies with provisional approval until the remedy is achieved, if LHCC requires site visits.
        d. Additional exceptions are granted and reviewed on an individual basis by the Credentialing Committee.

C. The Credentialing Committee and/or Quality Improvement Committee has the authority to require an applicant to undergo an evaluation of his/her physical and/or mental status prior to further consideration of the application or in order to retain active status within LHCC.
D. If the Credentialing Committee requires additional information prior to making a determination, application may be pended, and information is obtained, and file presented to Credentialing Committee at a future meeting.
E. The Credentialing Committee may determine that corrective action is necessary in order to credential a practitioner. The Committee decision includes a description of the steps necessary to fulfill compliance with the required action. If necessary, a work process will be created to document the specific step-by-step detail of how to complete the required tasks. Provider application should be pended, and a future date set for re-review.
F. The applicant is sent notice of his/her status in writing within sixty (60) calendar days of the Credentialing Committee decision, unless otherwise required by LHCC.

XI. Denial of Initial Credentialing/Recredentialing Application

A. LHCC Medical Director or Credentialing Committee may decide not to extend or continue to extend participation status to a practitioner.

B. The Credentialing Committee Chair or designee notifies the practitioner via certified mail of the Credentialing Committee denial decision within sixty (60) calendar days of the Credentialing Committee's decision. For those practitioners reviewed by Committee for recredentialing and denied continued participation, LHCC will send a termination notice effective fifteen (15) days from the date of the notice via certified to the last mailing and email address submitted by the provider.
    i. A letter of denial includes the reason and information on the practitioner's right to view and/or correct erroneous information.
    ii. A copy of the letter is retained in the practitioner's closed file and maintained in the Credentialing Department for future reference.
    iii. If the practitioner's current participation status is being suspended, restricted or terminated based on issue of quality of care or service, LHCC offers and informs the practitioner of the appeal process in accordance with the associated policies, LA.CRED.07 - Practitioner Disciplinary Action and Reporting, and LA.CRED.08 - Practitioner Appeal Hearing Process.
C. In order to support compliance with specific LHCC requirements, Credentialing notifies LHCC Compliance of Credentialing Committee denials as soon as reasonably possible after the committee proceedings conclude.

XII. Practitioner Requests for Status of Credentialing/ Recredentialing Application

A. Practitioner contacts LHCC Provider Relations Department to request status.
B. Upon receiving such request, LHCC Provider Relations Representative obtains information from Credentialing as needed, and provides practitioner with information such as the application approval date, status of any requests for additional information, the expected date the practitioner's file will go to the Credentialing Committee, etc.
C. LHCC Provider Relations Department relays status information to requesting Practitioner.

XIII. Practitioner Requests to Review Information Obtained During Credentials Verification

A. Practitioner submits a written and signed request for access to information obtained during the credentialing and/or recredentialing process.
B. Requested information is secured and sent to the practitioner via Restricted Delivery Certified Mail within fourteen (14) days of the receipt of the request from the practitioner.
    i. If Credentialing is unsure of the type of information that can be released, Corporate Counsel is immediately notified.
C. The written request from the practitioner and the information provided by Credentialing is documented in the provider's credentialing file.

XIV. New Practitioner Requests Reconsideration

A. A practitioner who is denied participation for non-administrative reasons requests a reconsideration of the decision.
    i. If the request is received within thirty (30) calendar days of the date of receipt of the denial letter and includes additional supporting documentation in favor of the applicant's consideration for network participation, reconsideration will occur.
    ii. The request is presented to the Credentialing Committee at the next regularly scheduled meeting but in no case later than sixty (60) calendar days from the receipt of additional information. The Credentialing Committee may recommend:
        a. Support of the original denial recommendation by the Credentialing Committee and closure of the file; OR
        b. Support of the applicant's ability to meet LHCC minimum participation criteria and approval of the applicant for inclusion in LHCC practitioner network.
    iii. The Medical Director/Credentialing Committee Chair, or designee, notifies the applicant in writing within sixty (60) calendar days of the Credentialing Committee decision.

XV. Once credentialing is complete, PDM performs a quality check and makes the provider "par" (i.e., participating) in the Provider Data Management system. Once made par, the record is fed to both the online directory, the call center system, the claims system, and the eligibility system for member cards and enrollment.

XVI: LHCC Unique Requirements for Credentialing:

A. Louisiana Healthcare Connections will accept and utilize the Louisiana Standardized Credentialing Application or the CAQH Application for the credentialing application.
B. Louisiana Healthcare Connections requires verification of the LA controlled dangerous substance certificate, if applicable. A current copy of the certificate is considered a valid source for meeting the requirement or primary source verification.
C. All changes to this Policy & Procedure shall be submitted to the DHH when a change is made and annually thereafter.
D. Louisiana Healthcare Connections requires board certification or alternate educational and clinical pathways as outlined in CC.CRED.10
E. Louisiana Healthcare Connections shall notify LDH of denial of a Provider credentialing application for program integrity-related reasons or otherwise limits the ability of Providers to participate for program integrity-related reasons.
F. Per Louisiana – Act 358. Interim credentialing requirements: Under certain circumstances and contingent upon the provisions of this Subsection being met, a managed care organization contracting with a group of physicians that bills a managed care organization utilizing a group identification number, such as the group federal tax identification number or the group National Provider Identifier as set forth in 45 CFR 162.402 et seq., shall pay the contracted reimbursement rate of the physician group for covered health care services rendered by a new physician to the group, without health care provider credentialing as described in this Subpart. This provision shall apply in each of the following circumstances:
    i. When the new physician has already been credentialed by the managed care organization and the physician's credentialing is still active with the managed care organization.

ii. ii. When the managed care organization has received the required credentialing application and information, including proof of active hospital privileges, from the new physician and the managed care organization has not notified the physician group that credentialing of the new physician has been denied.

iii. A managed care organization shall comply with the provisions of Subsection A of this Section no later than thirty days after receipt of a written request from the physician group.

G. Louisiana Healthcare Connections shall completely process credentialing applications from all types of providers within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documents and attachments, and a signed provider agreement. "Completely process" shall mean that LHC shall:

i. Provide written confirmation, electronically or by mail, of receipt to the provider within five (5) Business Days of receipt of the application;

ii. Review, approve, and load approved applicants to its provider files in its claims processing system;

iii. Submit on the weekly electronic Provider Directory to the LDH or LDH's designee, or

iv. Deny the application and assure the provider is not used by the MCO.

~~iv.~~v. If the application is deemed incomplete, send a written request within thirty (30) Calendar Days of receipt of the application to the provider for all missing information;

H. Louisiana Healthcare Connections utilizes Provisional credentialing to meet the requirement to process expedited and temporary credentials.

I. Louisiana LDH Adverse Action List shall be queried.

J. LHCC shall not contract or shall terminate contracts with providers who have been excluded from participation in the ~~Medicare and/or~~ Medicaid program pursuant to Section 1128 (42 U.S.C. §1320a-7) or Section 1156 (42 U.S.C. §1320c- 5) of the Social Security Act or who are otherwise barred from participation in the Medicaid ~~and/or Medicare~~ program. This includes providers undergoing any of the following conditions identified through LDH proceedings:

i. Revocation of the provider's home and community-based services license or behavioral health service license;

ii. Exclusion from the Medicaid program;

iii. Termination from the Medicaid program;

iv. Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41);

v. Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC 48:I.Chapter 50); or

vi. The Louisiana Attorney General's Office has seized the assets of the service provider.

K. LHC shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.

L. Louisiana Healthcare Connections understands that the State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, LHC and our subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. LCH will be given at least 90 days' notice before implementation of any CVO contract.

M. Louisiana Healthcare Connections will report to LDH those participating providers who have been terminated due to exclusion within three (3) business days.

N. Behavioral Health Services Providers - Licensed Mental Health Practitioners for Louisiana Healthcare Connections for the Healthy Louisiana contract.

O. Louisiana Healthcare Connections will provide a minimum of three (3) written notices to a contracted provider with information regarding the recredentialing process, including requirements and deadline for compliance. The first notice shall be issued no later than six (6) months prior to the expiration of the provider's current credentialing. The notice shall include the effective date of termination if the provider fails to meet the requirements and deadlines of the recredentialing process.

P. For those practitioners who fail to meet timely recredentialing requirements, Louisiana Healthcare Connections will send termination notice via certified mail, effective fifteen (15) days from the date of the notice. Claims will be paid for services delivered prior to the termination date.

Q. For those practitioners reviewed by Committee for recredentialing and denied continued participation, Louisiana Healthcare Connections will send a termination notice effective fifteen (15) days from the date of the notice via certified to the last mailing and email address submitted by the provider.

R. LHCC shall ensure ASCs have an agreement with the Centers for Medicare and Medicaid Services (CMS) in accordance with 42 C.F.R. §416.30 and that ASCs are licensed and certified by Louisiana's licensing and certification agency. LHCC shall include the directive that the ASC must have a system to transfer enrollees requiring emergency admittance or overnight care to a fully licensed and certified hospital following any surgical procedure performed at the facility.

S. LHCC shall require unlicensed staff of entities rendering and receiving reimbursement for Mental Health Rehabilitation (MHR) services to obtain and submit NPI numbers to LHCC, as well as documentation verifying the unlicensed staff meets all qualifications and requirements for providing MHR services established by applicable Federal and State laws, rules, regulations, and the Medicaid Behavioral Health Service Provider Manual, inclusive of Evidence-Based Practice (EBP) MHR services, prior to reimbursing agencies for services provided by these staff. Claims submitted for MHR services shall include rendering provider NPIs and other Contractor required identifiers regardless of whether the rendering staff is licensed or unlicensed. LHCC shall configure systems to deny claims for services when rendering providers and NPIs are denoted on claims for service that have not been credentialed and approved by LHCC. LHCC shall submit their policies and procedures associated with this requirement to LDH or its designee for approval during Readiness Review.

T. It is LHCC's responsibility to ensure its provider comply with DCFS licensing requirements as applicable and can submit proof of compliance upon request. LHCC will follow communication protocols as established by DCFS, if necessary.

~~Q.~~

REFERENCES:
Current NCQA Health Plan CR Standards and Guidelines
~~CMS Medicare Managed Care Manual Chapter 6 "Relationships with Providers"~~
42 C.F.R. § 438.214, 455.104, 455.105, 455.106, 1001.1801, 1001.1901, 1002.3(b)
LDH Model Contract

ATTACHMENTS:

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy Document	Converted corporate to local policy.	10/2020
Emergency Contract update	Added language from 16.9.2 of Emergency Contract	07/2022
Ad Hoc Review	Updated DEA language to align with NCQA Standards and added references to regulatory requirements related to exclusions & Formatting edits Edited to include language edits under new Model Contract Sections 2.9.9.2.9.29 and 2.9.30 Reformatted to latest Policy Template	12/2022
~~RFP Revision~~Ad Hoc Review	Language added to be compliant with ~~RFP's~~ MCO Manual and Model Contract Section 2.9.9.4 Removal of Medicare statements that fall under Corporate Policy Grammatical Edits	01/2023

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

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