# Credentialing

Asuris uses its credentialing process to provide members with a selection of physicians and other health care professionals who have demonstrated backgrounds consistent with the delivery of high quality, cost-effective health care. Asuris has established credentialing criteria for participation and termination that is used to evaluate a provider's credentials. The credentialing criteria serve as the foundation for determining a provider's eligibility and continued eligibility on all Asuris networks. Providers are expected to remain in compliance with credentialing criteria at all times.

Effective April 1, 2008, all physicians and other health care professionals must be credentialed before they can participate in a Asuris Northwest Health provider network. Beginning April 1, 2008, the following policy will apply to all participating providers:

- New provider agreements will have an effective date of the first day of the month in which the provider was credentialed (e.g., if credentialing was approved on June 14, the agreement will be effective on June 1).
- If Asuris does not receive a signed agreement in the same month as credentialing is completed, the agreement effective date will be the first of the month in which credentialing is approved or the signed agreement is received, whichever is later.
- A new provider joining a group or clinic agreement will have an effective date of the first day of the month in which he or she was credentialed (e.g., if credentialing was approved on June 14, the effective date of participation will be June 1).
- If a provider already participating with Asuris adds an additional network, the effective date of the new network will be the first day of the month the signed agreement is received. Asuris will no longer establish retroactive agreement effective dates.
- Claims submitted to Asuris for dates of service prior to the provider's effective date will be processed as out-of-network.

If you have any questions regarding this policy, please contact your provider consultant at **1-800-562-2156.**

For more information on credentialing, please refer to the "Practitioner Handbook for the Credentialing Process", available on the Washington Healthcare Forum's Web site at **www.wahealthcareforum.org/adminsimp/Credentialing/PractitionerHandbook_Rev8-8.pdf.**

# Credentialing

### *Individual Practitioner Credentialing*

#### Initial Credentialing

Asuris requires that all providers falling within the scope of the Credentialing Program complete the initial credentialing process prior to contracting. Asuris uses the credentialing process to evaluate each provider's qualifications and performance. Only those applicants licensed or certified in Washington and in those specialties recognized by Asuris will be considered. Providers whose credentialing approval status has lapsed more than 120 days will be required to resubmit an initial application.

Upon receipt of a completed application, the application is reviewed and elements are primary source verified before being submitted to the Asuris Credentialing Committee for final approval of participation. Incomplete submissions will delay the process.

Providers that have been denied initial participation do not have the right to submit an appeal. Refer to the participation criteria at:
**www.asuris.com/provider/credentialing/docs/200701PractitionerCriteria.pdffor** additional information.

#### Recredentialing

Recredentialing requires that all providers falling within the scope of the Asuris Credentialing Program complete the recredentialing process at least every three years. Asuris uses the recredentialing process to re-evaluate each provider's qualifications and performance. Providers whose contracting status has lapsed more than 120 days will be required to resubmit an initial application.

The recredentialing process is initiated by the Credentialing Department based on the last credentialing or recredentialing approval date. In order to streamline the recredentialing process, Asuris has developed a recredentialing profile that is populated with credentialing previously submitted to Asuris.

The recredentialing request is sent three months prior to the recredentialing due date. All providers are expected to respond to the request for recredentialing in a timely manner. Additional information analyzed at the time of recredentialing may include, but is not limited to, member complaints and quality improvement activities. All providers must be recredentialed and approved by the Asuris Credentialing Committee for continued network participation.

Providers that have been terminated from network participation do have the right to appeal. Refer to the provider contract termination appeals process for additional information. Physicians or other health care professionals leaving a delegated entity must notify Asuris and are subject to recredentialing guidelines.

# Credentialing

## Delegated Credentialing

Asuris may entrust and delegate credentialing activities to contracted provider groups whose membership includes a minimum of 350 providers. Provider groups must demonstrate the ability to meet the performance requirements of Asuris standards. Those provider groups who assume delegated credentialing activities must utilize policies and procedures that meet the credentialing policies and procedures of Asuris. Credentialing for organizational providers and facilities cannot be delegated. Asuris retains the right to approve new physicians, other health care professionals and facilities and to terminate or suspend individual physicians or other health care professionals as deemed necessary and appropriate.

## Practice Site Visits

Asuris requires that physicians and other health care professional must provide professional services to our members in an office setting located in a permanent, fixed professional office setting located in a traditional commercial office site; or in an approved health care facility with no barriers to access. For purposes of illustration, a traditional commercial office site includes a medical office building and freestanding office or clinic, but does not include home offices, health clubs, other athletic facilities, and salon or spa-based practices. The Company may, in its sole discretion, permit physicians and other health care professionals to work from a location other than a traditional commercial office site, if such physician or other health care professional receives the Company's approval.

# Credentialing

## *Locum Tenens and Temporary Practitioner Policy*

When an office has a practitioner who goes on medical leave or vacation, a *locum tenens* practitioner is identified and authorized by the practitioner to provide treatment for his/her patients while they are temporarily out of the office. Below is Asuris Northwest Health's policy for obtaining and billing for locum tenens practitioners.

### Locum Tenens Practitioner Requirements and Process

**I.** The locum tenens must be identified and authorized by the Asuris Northwest Health contracted practitioner to provide treatment.

II. To be considered for locum tenens status, the temporary practitioner must be one of the following types of provider:

- Doctor of Medicine (MD)
- Doctor of Osteopathy (DO)
- Doctor of Podiatry (DPM)
- Doctor of Chiropractic (DC)
- Doctor of Optometry (OD)
- Doctor of Naturopathy (ND)
- Advanced Registered Nurse Practitioner (ARNP)
- Physicians Assistant (PA)

III. The locum tenens must be licensed in the State of Washington and only perform services within their scope of license.

IV. All procedures performed and billed by the locum tenens must have modifier Q6 attached per CPT4 procedure code. Enter the modifier in box 24D on the CMS-1500 claim form.

V. The use of a locum tenens practitioner by a contracted provider is limited to **60** days per 12-month period. However, Asuris Northwest Health may, within its sole discretion, and under exceptional circumstances, grant an extension.

VI. The locum tenens should bill Asuris Northwest Health using the Asuris Northwest Health tax ID and rider number of the contracted practitioner for whom they are substituting.

VII. Other health care practitioners not mentioned in the list above may make their own arrangements for substitute personnel. However, if a Asuris Northwest Health member sees a non-contracted practitioner, they may receive reduced or no benefits for the services provided.

# Credentialing

### *Organizational Provider Credentialing*

#### Initial Credentialing

Asuris requires that all organizational providers that fall within the scope of the Credentialing program complete the credentialing process prior to contracting. Refer to the credentialing criteria at:
**www.asuris.com/provider/credentialing/docs/200701OrganizationalCriteria.pdf** for a listing of organizational providers that require credentialing. Organizational providers whose credentialing approval status has lapsed more than 120 days will be required to resubmit an initial application.

Organizational providers that have changed ownership and are required to complete the application and site survey process by the state and Medicare must be initially credentialed under the new ownership. If the state and Medicare allow the acquisition without the application and site survey process, credentialing is not required.

Upon receipt of a completed application, the application is reviewed using a variety of national and state data sources before being submitted to the Asuris Credentialing Committee for final approval of participation. Incomplete submissions will delay the process. When the organizational providers that have been denied initial participation do not have the right to submit an appeal. Refer to the participation criteria for additional information.

#### Recredentialing

Asuris requires that all organizational providers that fall within the scope of the Asuris Credentialing Program complete the recredentialing process at least every three years. Asuris uses the recredentialing process to re-evaluate each organizational provider's qualifications and performance. Organizational providers whose contracting status has lapsed more than 120 days will be required to resubmit an initial application.

The recredentialing request is sent three months prior to the recredentialing due date. All organizational providers are expected to respond to the request for recredentialing in a timely manner. Upon receipt of the completed application, the application is reviewed using a variety of national and state data sources for final approval. Additional information analyzed at the time of recredentialing may include, but is not limited to, member complaints. All organizational providers must be recredentialed and approved for continued network participation.

Organizational providers that have been terminated from network participation do have the right to appeal. Refer to the provider contract termination appeals process for additional information.

# Credentialing

### *Termination and Appeals Process*

In compliance with the Health Care Quality Improvement Act of 1986, Asuris Northwest Health has developed policies and procedures for reviewing the participation of practitioners and providers whose conduct could adversely affect the health and welfare of members.

All contracts will be terminated for any provider or practitioner failing to meet Asuris Northwest Health's participation criteria, recredentialing requirements, or for other substantial infractions outlined in the contract. The process is initiated upon determination that the provider or practitioner no longer meets credentialing requirements related to quality of care, competence, or professional conduct or for substantial infractions outlined in the contract.

Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, established the National Practitioner Data Bank (NPDB) to collect and release certain information related to the professional competence and conduct of physicians, dentists, and, in some cases, other health care practitioners.

As a health care entity accessing the NPDB, Asuris Northwest Health is required to report adverse actions based on a practitioner's professional competence or conduct that adversely affects, or could adversely affect, the health or welfare of patients. Reportable adverse actions include denial of panel participation and panel de-selection/ de-credentialing.

The Secretary of the U.S. Department of Health and Human Services, acting through the Office of Inspector General (OIG) and the United States Attorney General, were directed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Section 221 (a), Public Law 104-191, (the Act) to create the Healthcare Integrity and Protection Data Bank (HIPDB) to help defer fraud and abuse in health insurance and health care delivery.

As a health care entity, Asuris Northwest Health is required to report fraud and abuse and disclose certain final adverse actions taken against health care providers, suppliers, or practitioners to the HIPDB and are subject to civil money penalties for each unreported adverse action. The Healthcare Integrity and Protection Data Bank will be notified when required by applicable laws.

## Provider Contract Termination Appeal Process

### *Policy Statement*

The appeals process is intended to give practitioners as well as organizational providers (herein after known as provider(s)) an opportunity to make sure Asuris Northwest Health (hereinafter referred to as the Company) has reviewed all relevant information in making its decision regarding recredentialing of provider for continuation on a network, or for other substantial infractions outlined in the contract.

### *Appeal Definition*

A provider appeal:

(1) is a written request from a provider for reconsideration of participation on a network panel resulting from an adverse decision for substantial infractions outlined in the contract and/ or an adverse decision made at recredentialing, and

(2) contains additional, pertinent information supporting the provider's perspective of the circumstances.

### *Notification and Level of Appeal Definitions*

#### Notification letter

An initial letter informing the provider of an adverse decision.

#### Level One: (Request for Reconsideration)

A written request for reconsideration from the provider giving a detailed description of the issues in dispute, the basis for the provider's disagreement, all evidence and documentation supporting the provider's position, except in the case of audit appeals where submission of records will not be considered, and the action the provider desires from the Company. This correspondence will start a Level One Appeal.

#### Level Two: (Request for In-Person Meeting)

If the provider is not satisfied with the decision made at Level One Appeal, they can submit, via certified mail, return receipt requested, the following:

- A written request for an In-Person Meeting,

***and***

- Submits additional, pertinent information supporting the provider's perspective.

The Level One and Level Two Appeal Committees are two distinct committees. The Level One Committee comprises a panel of Asuris Northwest Health participating practicing provider peers, medical management representatives, and administrative personnel.

(Level Two: Request for In-Person Meeting, Continued)

The Level Two Appeal Committee comprises a panel of Asuris Northwest Health medical management, Chief Medical Officer, 1-2 Medical Directors (MDs), Vice President of Provider Network Management, a representative from Asuris Legal, the Assistant Vice President of Health Care Services, Manager of Credentialing and administrative personnel.

## Standards

1. Initial and all subsequent appeals must be made in writing by the provider and accompanied with pertinent documentation supporting the provider's position on the issues in question. Correspondence submitted by the provider's office staff will not be accepted as a formal request for an appeal.

2. All written requests are to be sent to: **Attn: Credentialing Appeals Coordinator**, 1800 Ninth Avenue, P.O. Box 21267, Mailstop S1234, Seattle, Washington 98111-3267.

3. All appeal requests must be received by the Credentialing Appeals Coordinator within 30 business days of receiving the letter of notification of an adverse decision, unless otherwise specified in our notification letter.

4. All correspondence regarding requests for appeal or appeal decisions must be sent via certified mail, return receipt requested.

5. Required time lines begin as follows: (a) an appeal request - counting from the date of receipt of the notification/ decision letter, (b) no appeal request - counting from the date on the notification/ decision letter, (c) Credentialing Appeal Coordinator will notify the provider in writing of the Committee's decision within 15 business days.

6. The Level One Appeal Committee and the Level Two Appeal Committee typically meet monthly. Once an appeal request and documentation is received by the Credentialing Appeals Coordinator, the appeal will be scheduled for the next available meeting. The Credentialing Appeals Coordinator will notify the provider of the date his/her appeal will be reviewed by the Committee.

7. All provider appeals and decisions are entered and tracked on the Provider Credentialing System by the Credentialing Appeals Coordinator.

8. If the provider requests an extension to submit documentation, due to extenuating circumstances, the Company may grant it at its sole discretion.

9. If the provider fails to submit a complete and timely Request for Reconsideration or a request for an In-Person Meeting, the provider will be deemed to have accepted the Company's determination of the issues raised by the provider and to have waived all further internal, external, judicial, or arbitral process regarding the issues.

(Standards, Continued)

10. If the Credentialing Appeals Coordinator does not receive the Request for Reconsideration or the Request for an In-Person Meeting within 30 business days of receipt of the adverse decision, the decision regarding the provider's participation is considered final.

11. The Company does not re-instate providers automatically. Providers requesting reinstatement must complete an application, meet current participation criteria, and be approved by the Credentialing Committee.
    a) Providers removed from network participation may not request application for participation on any network for 24 months from the end of network participation date. Any provider removed from network participation for a second time is not eligible for reapplication.

12. Practitioners removed from network participation, due to sexual misconduct, may not request application for participation on any network for five (5) years from the end of network participation date.

13. Practitioners denied initial network participation, due to sexual misconduct, may not request application for participation on any network for five (5) years from the date of the final denial letter.

14. Practitioners removed from network participation due to the results of a medical records audit, external audit or quality management findings, may not request application on any network for five (5) years from the end of network participation date.

15. A practitioner may not request network participation as an "employee" of an existing practitioner that has been removed from network participation by the Company, or that is currently in the internal provider appeals process.

16. Practitioners who have been removed from network participation or denied initial network participation more than once are not eligible for reapplication.

17. Applicants who have been denied initial participation do not have the right to submit an appeal. Denied applicants may not request an application for participation on any network for 12 months from the date of the final denial letter.

18. Providers who have been removed from network participation or denied initial network participation may not participate through a delegated group, as locum tenens coverage or as temporary provider status.

19. After the appeal process is exhausted, in cases of adverse decisions, which are not reversed by appeal, the appropriate State Boards and data banks (National Practitioner Data Bank (NPDB), Healthcare Integrity and Protection Data Bank (HIPDB)) will be notified when required to by applicable laws.

## *Process*

### Notification Letter

The initial letter informing the provider of an adverse decision made by the Credentialing Committee or the results of an External Audit and Investigations audit. The letter notifies the provider of how they do not meet the required standard(s) for participation on the panel or regarding contract infractions and informs the provider of the right to appeal. A copy of the Health Care Practitioner /Organizational Provider Criteria for Participation and Termination and a copy of the Provider Contract Termination Appeal Process is enclosed with the letter.

#### Level One (Request for Reconsideration)

The Level One Appeal is initiated when the provider submits a written Request for Reconsideration to the Credentialing Appeals Coordinator. The Credentialing Appeals Coordinator must receive the request within 30 business days of receipt of the letter of notification of the Company's action or decision for which the provider wishes to appeal. The appeal must be sent via certified mail, return receipt requested, and include, at minimum, a specific restatement of the issues in dispute, and includes additional documentation supporting the provider's position, except in the case of audit appeals where submission of records will not be considered.

Upon receipt of the Request for Reconsideration, the provider continues in their prior status and any pending action by the Company is put in abeyance until the appeal is resolved and a final decision is made.

If the Company requires additional time to review the submitted appeal documentation, the Credentialing Appeals Coordinator will notify the provider in writing and the provider will wait until the review is complete.

The Credentialing Appeals Coordinator will present the Level One Appeal before the Level One Appeal Committee for review. The Level One Appeal Committee will review the appeal. The Level One Committee comprises a panel of Asuris Northwest Health participating practicing provider peers, medical management representatives, and administrative personnel and ad hoc reviews.

If the Level One Appeals Committee requests additional documentation, the provider has 15 business days from the receipt of the written request to respond. If no documentation is received, the initial adverse decision stands and the provider will be notified in writing. If the documentation is received, the Level One Appeal Committee will review the new information and make a decision. The Credentialing Appeals Coordinator will notify the provider in writing of the Committee's decision within 15 business days.

If the decision requires the expertise of an outside specialty consultant, the Credentialing Appeals Coordinator will notify the provider that the Level One Appeal decision is pending further review and an estimated time of when the decision will be made.

### Level Two (Request for In-Person Meeting)

If the provider disagrees with the Level One Appeal decision made by the Level One Appeal Committee, the provider may request a Level Two Appeal. The Level Two Appeal is initiated when a written Request for an In-Person Meeting is received by the Credentialing Appeals Coordinator within 30 business days of receiving the Level One Appeal decision letter. The written request for an In-Person Meeting must be sent via certified mail, return receipt requested to the Credentialing Appeals Coordinator. The request includes documentation supporting the provider's position that was not previously submitted and states the specific matter with which the provider disagrees. The Credentialing Appeals Coordinator will notify the provider of the date, time and place of the meeting.

Level Two Appeals are reviewed by the Company's Level Two Appeal Committee. The Level Two Appeal Committee comprises a panel of Asuris Northwest Health medical management, Chief Medical Officer, 1-2 Medical Directors (MDs), Vice President of Provider Network Management, a representative from Asuris Legal, the Manager, Credentialing and Quality Review and administrative personnel. Committee members may designate an appropriate designee. The Credentialing Appeals Coordinator will serve as the recording secretary for these proceedings. The provider may appear in person and may be accompanied by an attorney; no other representatives will be allowed. The provider and/ or the attorney will have 30 minutes to make an oral statement and respond to questions. This meeting is not a forum to debate the issues in question but to simply give the provider the opportunity to present their case in person.

Decisions of the Level Two Appeal Committee concerning participation status on a Company network are final. Decisions regarding audit findings are final. The Credentialing Appeals Coordinator will notify the provider in writing of the Committee's decision within 15 business days.

This process is not intended to create any substantive rights for provider or guarantee them participation with the Company. Just as providers remain free to choose not to contract with Asuris Northwest Health, the Company is free to decide whether to enter into or maintain a contract with a provider.