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## Practitioner Credentialing Policy

### Purpose

Blue Cross and Blue Shield of Vermont (Blue Cross VT or the Plan) evaluates and selects licensed independent practitioners to provide care to its members through the credentialing process. Upon application and at least every three years thereafter, the Plan verifies and evaluates practitioner credentials. This process ensures that practitioners participating in the Plan's network are qualified and competent to practice in their respective specialties and that they meet the Plan's standards for performance and delivery of high-quality clinical care and services.

### Scope

This policy applies to all physician and non-physician practitioners who wish to contract with the Plan. The policy applies to practitioners credentialed by the Plan's network quality and credentialing committee or by a delegated entity. Credentialing is not required for (a) facility-based practitioners (see page 4, below); (b) practitioners that may only provide services under the direct supervision of a licensed provider; (c) students, residents, and fellows; and (d) practitioner types whose services the Plan does not cover under any member certificates.

For facility provider credentialing and ancillary provider enrollment, please see Plan's Facility Credentialing Policy and Plan's Ancillary Provider Enrollment Policy.

### Regulatory/Accreditation Links

2024 NCQA HPA Standards and Guidelines/Elements: CR 1-7

State of Vermont Rule H-2009-03 Standards: 5.2A – 5.2J

18 V.S.A. § 9408a

Medicare Managed Care Manual, Chapter 6 (Medicare Advantage)

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**Department:** Network Management, Quality Improvement

**Reference:** [S:\P\\_REIM\Enrollment Information\Active Credentialing Info\Policies\Professional Credentialing Policy](#)

**Policy Links:**

BCBSVT Provider Appeals from Adverse Contract Actions and Related Reporting policy

BCBSVT Facility Credentialing Policy

BCBSVT Ancillary Provider Enrollment Policy

BCBSVT Delegation and Oversight Policy

BCBSVT Quality of Care Risk Investigation Policy

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## Policy

Through a well-defined process, the Plan completes an initial verification of credentials before entering into a contractual relationship with providers. Blue Cross VT completes full credentialing prior to listing a health care practitioner in any marketing or member materials, such as provider directories. Blue Cross VT bases this process on standards set forth by the National Committee for Quality Assurance (NCQA), the State of Vermont in Rule H-2009-03, and the Centers for Medicare and Medicaid Services (CMS) in Chapter 6 of the Medicare Managed Care Manual.

The Plan will consider a provider a non-participating provider until the credentialing process is complete and the provider is accepted into the network. Providers joining existing, contracted groups, or individual providers entering into a contract with Blue Cross VT, are not eligible to render services to any Blue Cross and Blue Shield member (including CBA Blue, the Federal Employee Program and Vermont Blue Advantage) until they are fully enrolled and approved by the credentialing committee. Please note that for Medicare Advantage business, CMS rules apply and a provider whose credentialing has yet to be approved may not use a waiver process to bill the member directly.

Practitioners requesting participation in the Blue Cross VT network must submit a complete credentialing application provided by the Council for Affordable Quality Health Care (CAQH) and meet the Plan's criteria for participation as set out in Exhibit A (Primary Source Verification (PSV) grid) of this policy.

At least every three years after the initial approval for participation, the Blue Cross VT credentialing verification committee formally reviews the credentials of its practitioners and makes decisions about continued participation in the Blue Cross VT network. The committee includes licensed providers and the Plan's medical director. Between recredentialing cycles, the Plan monitors practitioner sanctions, member complaints about providers, and quality issues. The committee takes appropriate action against practitioners when it identifies occurrences of poor quality. Except as otherwise provided by law, Blue Cross VT confidentially maintains all information obtained in the credentialing process.

This policy may be accessed at any time at [www.bluecrossvt.org](http://www.bluecrossvt.org).

The Plan requires credentialing for the practitioners listed in Table 1, unless they are facility-based, as explained on page 4. Please note the practitioner types flagged with an asterisk (\*) are not eligible to provide services to Medicare Advantage individuals and will not be enrolled in and credentialed for the Vermont Blue Advantage network.

Table 1.

Physicians (MDs or DOs)	Certified Nurse Midwives (CNMs)	Physical/Occupational Therapists (PTs/OTs)	Audiologists (MAs, AUD)
Dentists (DDSs, DMDs)	Advanced Practice Registered Nurse (APRN, ARNP)	Speech/Language Pathologists (SLPs)	Licensed Acupuncturists* <sup>1</sup>
Podiatrists (DPMs)	Physician Assistants (PA, PA-C)	Registered Dietitians (RDs)	Licensed Clinical Social Workers (CSW, LCSW)
Chiropractors (DCs)	Certified Nurse Anesthetists (CRNAs)	Athletic Trainers (ATC)*	Psychiatric Mental Health Nurse Practitioners (PMHNP)
Optometrists (OD)	Certified/Licensed/Professional Certified Midwives (CM)*	Anesthesiology Assistants (AA)	Licensed Alcohol and Drug Counselors (LADC)*
Naturopaths (ND)*	Clinical Nurse Specialists (CNS)	International Board-Certified Lactation Consultants (IBCLCs)*	Licensed Professional Counselors (LPC)*
Psychologists (MA*, PHD)	Board Certified Behavioral Analysts (BCBA, BCBA-D, BCaBA)*	Licensed Marriage and Family Therapists (LMFT)	Licensed Mental Health Counselors (LMHC)
Certified Diabetic Educators (CDE)	Pharmacist Performing Medication Therapy Management Outside of a Retail Pharmacy Setting*	Certified Nurse Practitioner (CNP)	License Genetic Counselor (LGC)*
Hearing Instrument Specialist (HIS)* or Hearing Aid Dispense*			

### Locum Tenens

Plan does not credential locum tenens who participate with the Plan for a period of less than sixty (60) days. The Plan permits locum tenens to provide services to members, subject to the requirements above. Plan will require credentialing of individual locum tenens whose services extend beyond sixty (60) days.

<sup>1</sup> For Medicare Advantage, acupuncture services for lower back pain may be provided by (1) a licensed physician; or (2) a physician assistant, nurse practitioner, or clinical nurse specialist; or (3) “auxiliary personnel” who has a masters or doctoral level degree in acupuncture or Oriental Medicine and has a current, full, active and unrestricted license to practice acupuncture and is under the appropriate level of supervision of a licensed physician, physician assistant, nurse practitioner or clinical nurse specialist. If a Vermont-licensed acupuncturist is not also a physician, physician assistant, nurse practitioner, or clinical nurse specialist, or working under the supervision of one of these clinician types, that acupuncturist is not eligible to participate in the Medicare Advantage network.

## Facility-Based Providers

Plan does not require credentialing for facility-based providers. In general, “facility-based providers” are health care professionals who provide services to members incident to hospital services unless those health care professionals are separately identified in members’ literature (i.e., listed in the directory) as available to members.

A provider is not “facility-based” if:

- The provider is enrolled with Plan and bills under a tax identification number that is different than that of the facility; or
- Members are referred directly to the provider from another physician or organization.

Services provided by facility-based providers are generally billed by the facility, under the facility’s tax identification number, on a UB-04 claim form. Facility-based providers typically fall into the categories below, but this is not an exhaustive list; if the criteria above are met, Plan may treat the provider as facility-based:

- Hospitalists
- Radiologists
- Emergency practitioners
- Pathologists
- Anesthesiology practitioners
- Neonatologists
- Audiologists
- Physical Therapists/Occupational Therapists/Speech Language Pathologists
- Mental Health and Substance Use Disorder (MHSUD) practitioners

For Blue Cross VT commercial business only, Blue Cross VT does not require individual credentialing for practitioners providing services at Vermont designated agencies.<sup>2</sup> For Medicare Advantage business, however, Blue Cross VT does require individual credentialing for those practitioner types that are eligible to participate with Medicare that work at designated agencies.

Certain MHSUD programs (including, but not limited to, intensive outpatient programs or facility programs such as partial hospitalization or residential or inpatient) may qualify to be credentialed at the facility level, and these programs may employ the use of clinicians that are not otherwise eligible for credentialing (including but not limited to, state-certified qualified mental health practitioners (QMHPs) that perform crisis assessments). In those instances, credentialing for those individuals is not required as the services are billed at the facility level.

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<sup>2</sup> See 18 V.S.A. § 8907 (Designation of agencies to provide mental health and developmental disability services); “Designated and Specialized Service Agencies,” Vermont Agency of Human Services, Department of Health, <https://mentalhealth.vermont.gov/individuals-and-families/designated-and-specialized-service-agencies>

Please note that Plan individually credentials clinicians working at urgent care centers. These clinicians are not considered to be facility based.

The Plan does not permit provisional credentialing for any practitioners applying for participation with the Plan. The Plan requires full credentialing for all network practitioners and will consider these practitioners as non-participating until the Plan approves the practitioners' credentials.

The Plan does not credential practitioners with provisional or interim licenses. A practitioner must meet all requirements for full licensure (including, for example, completion of any required clinical fellowship) before applying to enroll in Plan's networks.

### **Physician Assistants**

Blue Cross VT will enroll and credential physician assistants (PAs), which are defined and governed by V.S.A. Title 26 Chapter 31. To be eligible, the PA must enter into a qualifying Practice Agreement with a supervising physician prior to engaging in practice as a PA. The supervising physician must practice in the same field as the PA and be appropriately licensed with no current disciplinary action or disciplinary proceedings ongoing.

If the supervising physician is not also credentialed with Blue Cross VT, the PA is obligated to notify Provider Contracting at [providercontracting@bcbsvt.com](mailto:providercontracting@bcbsvt.com) if:

- a. The supervising physician's license is revoked or suspended, and/or
- b. The supervising physician is subject to any other form of disciplinary action by their licensing body.

### **1. Credentialing and Recredentialing Criteria**

The following requirements apply to all practitioners applying for credentialing with Blue Cross VT. The Plan requests additional credentialing elements for individual, specific practitioner types based on their scope of practice, training and licensure requirements. Please refer to Exhibit A for a complete list of credentialing elements required to complete an application. Unless otherwise noted, the listed elements are needed for both initial credentialing and recredentialing within the three-year period. The credentialing and recredentialing criteria are available to practitioners in this policy, in the provider manual via [www.bluecrossvt.org](http://www.bluecrossvt.org) or upon written request. For inclusion in the Medicare Advantage network, in addition to the requirements below, the provider must also be eligible to enroll as a Medicare provider.

- a) All practitioners (as outlined in scope of this policy) must complete a CAQH credentialing application electronically.
- b) All credentialed practitioners must keep their CAQH application current and periodically re-attest to the accuracy of the data. The Plan conducts recredentialing verifications at least every three years.
- c) The completed application must include the following:

- Current state license(s) in each state where the practitioner provides care to Blue Cross VT members
- If applicable to the practitioner's specialty, current hospital privileges at a network facility and the identified primary admitting facility on the CAQH application. If the practitioner does not have admitting privileges at a network facility, practitioner submits evidence of admitting arrangements through another Plan-credentialed physician.
- Current copy of valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate in each state where the practitioner provides care to Blue Cross VT members.
- Board certification information if the practitioner reports that he or she is board certified, and the certification is applicable to the intended field of practice. Note that effective May 15, 2021, MDs and DOs must supply proof of board certification or board eligibility as part of the application. Exceptions to this requirement will be considered on a case-by-case basis at Plan's discretion.
- Education and training information if the practitioner does not report board certification (initial credentialing only). Note that effective May 15, 2021, MDs and DOs must supply proof of board certification or board eligibility as part of the application. Exceptions to this requirement will be considered on a case-by-case basis at Plan's discretion. Plan reserves the right to defer to the appropriate Vermont State licensing board to confirm education and training of some practitioner types where the state law requires the board to confirm education before issuing a license.
- An application or curriculum vitae illustrating at least five years of relevant work history; if a practitioner has practiced fewer than five years, then the work history must encompass the period from initial licensure to application. (Applies to initial credentialing only.)
- Copy of professional liability insurance coverage current at the time of committee decision, with a minimum of \$1 million per occurrence and \$3 million in the aggregate, or evidence of federal or state tort immunity.
- Any history of professional liability claims that resulted in settlement or judgments paid on behalf of the practitioner for at least the last five years
- Professional disclosure statements (see application) which include the following:
  1. Reason for any inability to perform the essential functions of the position with or without accommodation
  2. Lack of present illegal drug use
  3. History of loss of license and felony convictions
  4. History of loss or limitation of privileges or disciplinary activity
  5. Attestation to the correctness and completeness of the application
- Method for meeting the Plan's after-hours availability requirement

## 2. Verification Process

The Blue Cross VT credentialing process uses the information listed in Exhibit A of this policy to define the criteria and method of verifying a particular practitioner's credentials. Practitioner credentials must be current for at least 180 days prior to the network quality and credentialing committee's review. Blue Cross VT uses primary sources accepted by accreditation and regulatory bodies to verify submitted information as indicated in Exhibit A.

The Plan expects all credentialed practitioners to keep their CAQH applications current and periodically re-attest to the accuracy of the data. The Plan conducts verifications for recredentialing at least every thirty-six (36) months.

If any information on the CAQH application varies substantially from the information the organization receives from other resources, such as primary verification entities, the Plan alerts the practitioner directly. The credentialing analyst notifies the practitioner either in writing or by telephone of the findings. The correspondence includes the following information:

- The timeframe for changes
- The format for submitting corrections
- The person to whom the corrections must be submitted

The credentialing analyst may provide a copy of the application to the practitioner in order to clarify the inconsistent information. The notice to the practitioner does not include copies of confidential, peer-review protected information, such as National Practitioner Data Bank reports, or information received from primary verification agencies.

The Plan may ask the practitioner to update the CAQH application or return a written response to the credentialing analyst to reconcile conflicting information. The credentialing analyst reviews information from the practitioner against the information collected from the primary source once again to verify that the discrepancy no longer exists. The Plan documents the corrections in the electronic files and evaluates the corrected responses against the criteria set forth in this policy. Corrected applications may require a review from the network quality and credentialing committee if they do not meet criteria.

When Blue Cross VT finishes the verifications, the Chief Medical Officer (CMO) or an equally qualified designee may approve the credentialing files that meet the established standards outlined below. Evidence of the CMO's or designee's approval includes a unique electronic signature, or in the case of a designee, a handwritten signature on a list of all practitioners who meet the established criteria.

### **3. Medical Director**

The CMO, or a practitioner designated by the CMO, assumes the following responsibilities within the credentialing program:

1. Chair the network quality and credentialing committee
2. Approval of the credentialing files independent of network quality and credentialing committee consideration if the application includes all required elements and meets the following standards:
  - a. Practitioner possesses an unrestricted license to practice in the state where the practitioner sees, or plans to see, Blue Cross VT members
  - b. Practitioner possesses an unrestricted, current, Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) license to prescribe or administer medications within the state the practitioner sees, or plans to see, Blue Cross VT members. If the practitioner's DEA registration is pending, they must provide

- documentation of an alternative arrangement with an in-network practitioner with a valid DEA registration who will write all prescriptions requiring a DEA number for them until they have a valid DEA registration.
- c. Practitioner possesses unrestricted hospital privileges at a network facility if the practitioner's specialty requires such privileges
  - d. No affirmative responses to inquiries about professional review actions and other adverse findings present on the application
  - e. The absence of licensure sanctions and adverse findings on NPDB report
  - f. No adverse findings identified during primary source verification
  - g. One of the following findings on the primary source verification:
    - ✓ Adverse events that occurred more than 10 years from the next scheduled network quality and credentialing committee meeting, or
    - ✓ Adverse findings that have been dismissed, or
    - ✓ Adverse finding that have judgments or settlements within 10 years of less than \$10,000
3. Designate a clinician of equal qualification to approve credentialing and recredentialing files that meet the criteria outlined above
  4. Request additional information from the practitioner required to make an informed credentialing decision
  5. Recommend incomplete credentialing applications and applications needing further consideration to the network quality and credentialing committee
  6. May independently make any of the following decisions on applications that remain incomplete despite outreach to the practitioner for more information:
    - a. The Plan does not enter into a contract with the practitioner upon initial application
    - b. The Plan terminates its contract with the practitioner for failure to provide information adequate for a recredentialing decision
    - c. The Plan terminates its contract for failure to cooperate with the credentialing process upon initial credentialing or recredentialing
  7. If the Plan takes action against a practitioner for quality reasons, report the actions to the appropriate legal authorities, in conjunction with the Plan's legal department. The Plan's *Practitioner Appeals from Adverse Contract Actions and Related Reporting* policy outlines the range of actions available for reporting to authorities.

#### **4. Network Quality and Credentialing Committee**

The Plan maintains a network quality and credentialing committee consisting of at least six Blue Cross VT-credentialed practitioners, including the Plan's medical directors. These practitioners represent a variety of practice areas and provide the Plan with meaningful advice and expertise on credentialing decisions. Committee members meet monthly and require a quorum of four members, no more than two of whom must be Plan medical directors. The role of the network quality and credentialing committee is to conduct quality reviews of individual practitioners to ensure ongoing member safety and quality care for Blue Cross VT members.

The network quality and credentialing committee reviews applications and supporting documentation referred by the Plan's medical director. The network quality and credentialing committee makes



credentialing, recredentialing and quality action decisions in a confidential, non-discriminatory manner. Annually, each member of the network quality and credentialing committee signs a confidentiality and affirmative statement attesting to review and provide thoughtful consideration to the credentials and quality information of each practitioner applying to participate in the Plan's network.

The network quality and credentialing committee bases its recommendations on a quality review, of practitioner specific complaints and adverse events, recognizing that its recommendations apply for all Plan products. Blue Cross Vermont investigates all complaints and adverse events referencing the Quality of Care Risk Investigation Policy. A more detailed investigation occurs when the volume of complaints or adverse events within the reporting period exceeds our thresholds. Per the referenced policy, the thresholds are any quality of care complaint or issue/concern that ranks in the yellow or red categories, OR the subject of three cases within 18 months ranking in the green or blue categories (See Quality of Care Risk Investigation Policy for breakdown of the risk categories). The biannual Complaint and Adverse Event Report is presented to the Credentialing Committee by the Clinical Quality Consultant every six months, and pending the thresholds mentioned above, practitioner intervention is implemented as needed. If complaints or adverse events involving practitioners do not exceed the thresholds, the data is tracked and trended for future monitoring. It is not the role of the network quality and credentialing committee to deny a practitioner's participation based on anything except quality concerns. The network quality and credentialing committee may not recommend participation in one Plan product, but not another.

*Committee member responsibilities include:*

1. Review and thoughtfully consider the credentials, performance appraisal, and other quality-related information of each practitioner, making recommendations with regard to initial or continued participation in the Plan's networks.
2. Request information not specifically described herein if the committee determines that such information would assist the committee in verifying the credentials of the applicant.
3. Interview applicants as it deems appropriate.
4. Engage a practitioner in the same specialty as the applicant when questions arise about an applicant's qualifications. The committee may request, as it deems appropriate, that the same specialty practitioner review the applicant's file, interview the applicant, or meet with the network quality and credentialing committee.
5. Recommend approval of credentialing or recredentialing of practitioners for a period of up to three years. Alternatively, the committee may recommend, based on quality concerns, approval for a shorter period, with a follow-up review by the committee for later consideration.
6. Recommend denial of credentialing or recredentialing, as appropriate, for reasons that may include:
  - a. Failure to cooperate with the Plan's care management or quality improvement programs and policies
  - b. Loss, relinquishment, or limitations of clinical privileges
  - c. Lack of privileges at a network facility if the committee determines the lack of facility privileges at the facility may compromise the ability of the physician to deliver the full range of services included in the physician's specialty

- d. Lack of facility privileges at a network facility that may unduly burden Blue Cross VT members financially
  - e. Failure to meet the Plan's selection criteria related to their specialty
  - f. Reasons found, by the sole discretion of the committee, that inclusion of the practitioner in the Plan's network might harm the Plan or Plan members.
7. Review quality information (and recommend corrective action as appropriate, up to and including termination) related to a network practitioner outside of the regular credentialing cycle including but not limited to:
- Adverse events or licensure restrictions identified through the Plan's ongoing sanction monitoring process
  - Practitioners having three or more complaints within an eighteen-month period as identified in the Plan's routine complaint monitoring
  - Any quality-of-care issues identified through the Plan's member complaint, chart review, claim denial process, or other activities
  - Failure to meet the Plan's requirements for specialty practice

The Plan does not make credentialing decisions based on applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type. The Plan does not deny network status because the applicant treats a substantial number of expensive or uncompensated care patients. The committee does not consider any of these factors when making a credentialing decision. All network quality and credentialing committee members sign a participation agreement pledging non-discrimination when making credentialing decisions. The credentialing analyst ensures this non-discriminatory policy by comparing the approval listing report against any denial and assessing for trends based on applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type. The Plan also monitors provider complaints to determine if there are complaints alleging discrimination in the credentialing process and acts on them as appropriate. Annually, the credentialing analyst will report on credentialing process outcomes, including denials and provider complaints, to quality council.

## **5. Acceptance to the Network**

For practitioners approved by the CMO or by recommendation from the network quality and credentialing committee, the effective date in the network is typically the date of the approval. However, should the approval date be prior to the date the practitioner signs his/her participation contract, the effective date will be the date the Plan executes the contract.

Upon credentialing approval, the credentialing analyst forwards practitioner information to [providerfiles@bcbsvt.com](mailto:providerfiles@bcbsvt.com) within the network management department. Network management sets up the practitioner in the claims payments system and in the provider directory as a network practitioner.

The Plan notifies practitioners in writing of all initial credentialing decisions and any recredentialing denials within sixty (60) days of the decision date, to include, if applicable, the reason for denial and their right to appeal the decision. We provide recredentialing approval notifications upon request. Credentialing timeliness is reported annually to the accreditation team to ensure completion of the credentialing and recredentialing process and notifications in a timely manner. The credentialing analyst

makes recommendations for process improvements when the Plan does not meet thresholds. Providers on a military assignment, maternity leave or sabbatical must notify the Plan of their expected length of leave. During the time of sabbatical, the Plan will not market the provider in any directories and will have members temporarily reassigned to another Plan provider if a covering provider within the affected practice is not identified.

If recredentialing occurs during the provider's absence, Blue Cross VT places the credentialing file on hold and extends the recredentialing date to sixty (60) calendar days after the expected date of return. Upon return from the practitioner's leave of absence, the credentialing analyst verifies that the practitioner possesses a valid license to practice before the practitioner rejoins the network. Recredentialing begins and the practitioner's continued participation in the network depends on the practitioner's continued compliance with the recredentialing process.

## **6. Delegation**

The Plan may delegate the credentialing and recredentialing process to a Plan-approved delegate. If the delegate is NCQA-certified for credentialing and recredentialing, the Plan requires notification of such certification annually as part of the delegate oversight audit. The Plan's delegation oversight policy describes the process used to manage delegation.

Credentialing delegates submit an electronic report to the Plan following completion of credentialing. The report includes, but is not limited to, whether the practitioner is board certified, the type of board certification held, and various other information required for comprehensive credentialing analysis and reporting. Note that effective May 15, 2021, MDs and DOs must supply proof of board certification or board eligibility as part of the application. Exceptions to this requirement will be considered on a case-by-case basis at the Plan's discretion. Practitioners approved for participation in the Plan's networks via a delegated credentialing process become effective in the Plan's network the day the Plan receives all information it needs to complete the set-up. The Plan's delegation oversight policy describes the reporting process.

## **7. Primary Source Verification**

The Plan delegates its primary source verification (PSV) function to a credentialing verification organization (CVO) certified by NCQA in credentialing. Annually, the CVO must provide the Plan with its current NCQA certification to qualify for continued delegation of PSV functions.

## **8. Ongoing Monitoring**

In addition to checking sanctions for any new providers during the initial credentialing process (including a review of the Office of Inspector General (OIG)/ General Services Administration (GSA) exclusion list, the Office of Foreign Assets Control (OFAC) sanctions list, the CMS preclusion list, the Medicare Opt-Out list, and the Vermont, New Hampshire, New York and Massachusetts physician, and non-physician

licensing boards, the Plan also monitors all network practitioner sanctions, complaints about practitioners, and quality issues on an ongoing basis between recredentialing cycles. The Plan's delegates (contracted physician-hospital organizations (PHOs) and CVO) query the Office of Inspector General (OIG)/General Services Administration (GSA) exclusion list, the Office of Foreign Assets Control (OFAC) sanctions list, the CMS preclusion list, and the Vermont, New Hampshire, New York and Massachusetts physician, and non-physician licensing boards monthly. The Plan receives any adverse events or licensure restrictions identified by the delegates within thirty (30) calendar days of release. Each delegate and CVO must inform the Plan of the date of the query, practitioner name, and sanction identified. The non-CVO delegate must include actions taken, follow up and corrective action plan if applicable.

The credentialing team lead or business analyst requests additional documentation from the licensing board pertaining to reported adverse events or licensing restrictions. The quality review and credentialing committee then reviews this information and acts on the information as outlined in the responsibilities section above.

To the extent a monitoring report shows that a provider has been excluded or terminated from Federally funded health care programs, including Medicare, or is otherwise unable to accept federal funds, Plan will initiate termination of that provider's contract immediately.

The network quality and credentialing committee also reviews instances of possible poor quality and member safety issues identified by the Plan through its regular business activities. The committee takes appropriate action against practitioners when it identifies safety issues or occurrences of poor quality. The Blue Cross VT *Quality of Care and Risk Investigation Policy* describes this process. This applies to all practitioners in the network independent of the credentialing entity.

The Plan uses a standardized site-visit survey tool that incorporates office-site criteria used to address complaints about an office environment. The Plan follows set performance standards and thresholds for physical accessibility, physical appearance, adequacy of waiting and examining room space and adequacy of medical/treatment record keeping. The Plan monitors member complaints and implements appropriate interventions as outlined in the Blue Cross VT *Quality of Care and Risk Investigations Policy*. Plan delegates in the credentialing process do not perform this function.

The Plan reserves the right to terminate any Plan network practitioner based on the ongoing sanction monitoring reports or because of proven instances of poor quality of care to members, regardless of whether the Plan or the Plan's delegate made the initial or subsequent credentialing decision.

## **9. Confidentiality and Information Security**

Blue Cross VT keeps all information obtained in the credentialing and review process confidential, except as otherwise provided by law. Electronic records are only accessible by approved user groups set up within the user application. All Plan employees and committee members sign a confidentiality statement as a condition of employment and participation on the committee. All materials and processes are subject to the standards outlined in the corporate confidentiality and security policies. The Plan retains all credentialing information, whether paper or electronic, for a minimum of two

credentialing cycles or for six years, whichever is longer. For providers enrolling in the Medicare Advantage network, Plan will follow retention requirements of CMS.

The minutes and records of the quality review and credentialing committee are confidential and privileged under 26 V.S.A. §1443, except as otherwise provided in Vermont Rule 09-03.

Customer Resource Management (CRM) is housed on Blue Cross VT server that is secured in a locked room. Access to the room that houses Blue Cross VT server is governed by ID card access badges and pins, two factor authentication.

Credentialing system access: The network management (NM) manager is the only authorizing agent who can grant access to new users. The credentialing team lead will email the NM manager a request to submit a system access request to the CRM consultant for approval and appropriate access. Access to credentialing application and data are classified into a secure credentialing user group. User groups are defined based on the user's job function and level of authority to access, modify, or delete information. Access to the credentialing applications and secure credentialing database is limited to the CRM consultants, chief medical officer (or designee) and the credentialing team lead or business analyst. CRM consultants customize user groups by making appropriate information visible for a specific user group, the credentialing team lead or business analyst. CRM consultant will assign user role as requested by the NM manager to ensure an appropriate level of access. User roles within the groups are read, write and or modified capabilities. The chief medical officer (or designee), credentialing team leader or business analyst and CRM consultants have read, write and modification access to the credentialing records. CRM consultant is also responsible for terminating user credentials immediately upon notification of employee's departure from the organization.

Only the credentialing team lead or business analyst have access to download the completed primary source verification PDF report from the CVO's secure portal and upload it into the Plan's secure credentialing database. To maintain an accurate credentialing file, modifications to PSV documentation and recording of credentialing and recredentialing dates, may be required. The credentialing function of the CRM system has an audit log which tracks all historical additional, modifications, changes and deletions. The audit log feature includes the following elements:

- Table name (item or element being modified)
- Action taken (Insert, update, delete)
- User making the change
- Change date and time
- Reason for change
  - Staff documents reason for change in the credentialing system controls notes section of the providers credentialing record

The credentialing team leader and business analyst are authorized to review, modify, or delete appropriate credentialing information before a credentialing decision is made. Examples of appropriate modifications or deletions include, but are not limited to:

## **Modifications**

- Updates to verification of expired credentials
- Corrections to inaccurate or out of date data

## **Deletions**

- Remove erroneous data including duplicate data

The credentialing team leader and business analyst records a description of the error in the notes section of the practitioner's credentialing record, and emails notification to the CVO with the error description and the course of action the CVO needs to take to fix the error. The credentialing team staff downloads the corrected PSV report from the CVO's portal and retains both documents in the credentialing database, identifying the corrected document in the system. Credentialing and recredentialing dates are modified from the original recording when a data entry error or a system glitch occurs that creates erroneous dates. As noted above, the CRM system audit log records all entries, including the change made, who made the change and when the change was made to the record. The credentialing team leader and business analyst records a description of the error in the notes section of the practitioner's credentialing record to explain the reason why the change was made. CRM consultants have authority to delete records.

Access to CRM is obtained through the network single sign on password. Users are required to change their network password every 90 days using complex standards of a minimum of 8 characters or when staff suspects their password is compromised:

- Uppercase characters (A-Z)
- Lowercase characters (a-z)
- Numbers (0-9)
- Non-alphanumeric characters (e.g. -, !, \$, #, %)

In addition to standard corporate security and system audits, the Plan will audit credentialing files at least annually. The credentialing team leader or business analyst will pull a report from CRM that identifies modifications made to credentialing reports from their original recording. The credentialing team lead will conduct of a random sample of 5% or 50 files (whichever is less) of initial and recredential files approved in the previous year with modifications. The audit consists of assessing whether modifications in credentialing files meets the requirements in this policy, including making the modification for an acceptable business reason by authorized individual who documents the reason for the modification. If the audit reveals modifications that do not comply with policy requirements, the credentialing team leader will analyze the factors contributing to modifications not allowed under this policy, so that appropriate corrective action can be implemented. Once the audit is complete, the director of network management and the accreditation team will review the results, taking any needed actions, if any.

When the audit reveals modifications not allowed under this policy, that will trigger the credentialing team leader, along with the clinical quality consultant from quality improvement and the HIRM divisional portfolio manager to implement a quarterly monitoring process. They will conduct an audit of

a random sample of credential files approved in the previous quarter. Sample will be minimum of 5% or 50 files (whichever is less) approved in the previous quarter that were modified. Results of these audits will be recorded internally and shared with the director of network management and the accreditation team. The quarterly monitoring process will remain in place for three consecutive quarters until findings demonstrate improvement.

#### **10. Practitioner Rights in the Credentialing Process**

The Plan informs practitioners of their rights regarding the credentialing process in the cover letter that accompanies the practitioner enrollment and credentialing packet and is available online at [www.bluecrossvt.org](http://www.bluecrossvt.org). These rights are as follows:

- a. Receive information about the status of their credentialing application no later than sixty (60) days after the Plan receives the completed credentialing application; and every thirty (30) days thereafter until the Plan makes a final credentialing determination; or on request at any time during the credentialing process.
- b. Review the credentialing file. Practitioners may request to review the information submitted in support of their credentialing applications. A practitioner may be granted access, during regular business hours at an agreed upon appointment time, to review his or her credentialing information in the presence of the credentialing analyst.
- c. Correct erroneous or inaccurate information. The practitioner must correct erroneous information received from verification sources directly with the verifying source.
- d. Notify the Plan of any changes in the status of any of the items enumerated in this policy at any time.
- e. Receive the status of their credentialing or recredentialing applications, upon request to the Plan.
- f. In the event the Plan takes action against a practitioner for quality reasons and is required to report the action to the appropriate authorities, the Plan offers the practitioner the right to a formal appeal as outlined in the *Blue Cross VT Provider Appeals from Adverse Contract Actions and Related Reporting* policy.

#### **11. Annual Review**

The Accreditation Team will review this policy annually to ensure that it is consistent with current business practice and to incorporate the latest re Annual Review