

## Section 2 – Participating Provider Credentialing Process

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## Participating Provider Credentialing Process

Once a payer has agreed to *consider* the LHD as a participating provider, the credentialing process begins. This process is designed to evaluate required qualifications and verify the provider is legally authorized to provide services to the plan’s members. CMS programs, Medicare and Medicaid, use the term “validation” and “revalidation.” There are various standards that may apply to credentialing.

### Key Concepts:

#### Standards

NCQA

URAC

Medicare Advantage

WI statute

#### Credentialing preparation & process

Medicare (included revalidation project)

Medicaid

Commercial plans

CAQH plans

## Standards

### National Committee on Quality Assurance (NCQA)

Homepage: <http://www.ncqa.org>

NCQA has credentialing standards (**Appendix 4**) that are part of their accreditation process. Through its Healthcare Effectiveness Data and Information Set (HEDIS) tool, it also evaluates health plan activities that ensure each doctor is licensed and trained to practice medicine and that the health plan's members are happy with their doctors. *For example:* Does the health plan check whether physicians have had sanctions or lawsuits against them? How do health plan members rate their personal doctors or nurses? To evaluate these activities, NCQA uses records of doctors' credentials, interviews health plan staff, and grades the results from consumer surveys. In 2013, 22 payers participated in the HEDIS survey, which included provider evaluation (**Appendix 5**).

### URAC (formerly called Utilization Review Accreditation Commission)

Homepage: <http://www.urac.org>

URAC is the largest accrediting body for health care. Originally it accredited only utilization review organizations, but today any organization that meets the standards, including hospitals, HMOs, PPOs, TPAs and provider groups can seek accreditation. URAC standards are recognized by the following to satisfy applicable requirements:

<b>CMS</b>	Medicare Advantage Health Plan Deeming Accreditation
<b>OPM/FEHP</b>	All URAC Accreditation Programs
<b>TRICARE</b>	Health Network Accreditation
<b>States<sup>1</sup></b>	26 states including Wisconsin Medicaid

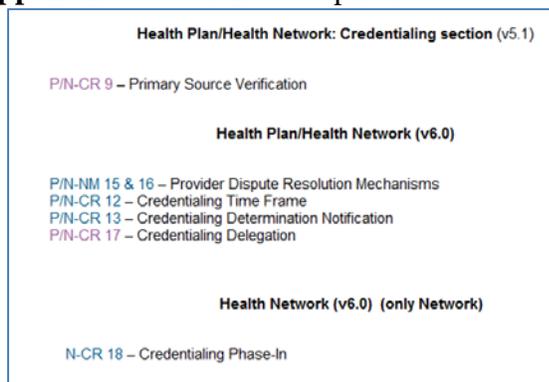
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<sup>1</sup> <https://www.urac.org/policyMakers/resources/State%20URAC%20Health%20Plan%20Recognitions.pdf>

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URAC has several credentialing standards that apply to various accreditation programs.

**Figure 1** lists these standards. See **Appendix 6** for a full description.



**Figure 1 - URAC Credentialing Standards**

### Medicare Advantage Plans – 42 CFR 422.204

Provider selection and credentialing: It is the responsibility of the MA organization to ensure through written arrangements that all applicable laws, regulations, and other instructions are followed.

**(a) General rule.** An MA organization must have written policies and procedures for the selection and evaluation of providers. These policies must conform with the credential and recredentialing requirements set forth in paragraph (b) of this section and with the antidiscrimination provisions set forth in § [422.205](#).

**(b) Basic requirements.** An MA organization must follow a documented process with respect to providers and suppliers who have signed contracts or participation agreements that—

(1) For providers (other than physicians and other health care professionals) requires determination, and redetermination at specified intervals, that each provider is—

(i) Licensed to operate in the State, and in compliance with any other applicable State or Federal requirements; and

(ii) Reviewed and approved by an accrediting body, or meets the standards established by the organization itself;

(2) For physicians and other health care professionals, including members of physician groups, covers—

(i) Initial credentialing that includes written application, verification of licensure or certification from primary sources, disciplinary status, eligibility for payment under Medicare, and site visits as appropriate. The application must be signed and dated and include an attestation by the applicant of the correctness and completeness of the application and other information submitted in support of the application;

(ii) Recredentialing at least every 3 years that updates information obtained during initial credentialing, considers performance indicators such as those collected through quality improvement programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, and other plan activities, and that includes an attestation of the correctness and completeness of the new information; and

(iii) A process for consulting with contracting health care professionals with respect to criteria for credentialing and recredentialing.

(3) Specifies that basic benefits must be provided through, or payments must be made to, providers and suppliers that meet applicable requirements of title XVIII and part A of title XI of the Act. In the case of providers meeting the definition of “provider of services” in section 1861(u) of the Act, basic benefits may only be provided through these providers if they have a provider agreement with CMS permitting them to provide services under original Medicare.

(4) Ensures compliance with the requirements at § [422.752\(a\)\(8\)](#) that prohibit employment or contracts with individuals (or with an entity that employs or contracts with such an individual) excluded from participation under Medicare and with the requirements at § [422.220](#) regarding physicians and practitioners who opt out of Medicare.



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Not all provider types are credentialed by all payers. Each has their own standards, policies and procedures. For instance, **Network Health Plan (NHP)**, Menasha, WI, only credentials the following that would be relevant to immunizations:

- Doctor of Medicine, (M.D.)
- Doctor of Osteopathic Medicine (D.O.)
- Nurse practitioners (NP)
- Physician’s Assistants (PA)
- Advance Practice Nurse Prescriber (APNP)

Some payers may credential LHDs as a total entity, instead of individual providers. This is the best scenario because there is less paperwork and maintenance.

### Process

#### Medicare

The credentialing process can be lengthy because much of the information must be verified and be reviewed by a committee or panel of physicians. Average timelines for a Medicare application are as follows:

##### **Initial Enrollments and Reactivations**

**Paper Applications:** 60 – 180 calendar days from receipt

**Paper Applications IDTF:** 90 – 180 calendar days from receipt

**Internet-based (Web) PECOS Applications:** 45 – 90 calendar days from receipt

##### **Reassignments/Change Requests**

**Paper Applications:** 60 – 120 calendar days from receipt

**Internet-based (Web) PECOS Applications:** 45 – 90 calendar days from receipt

\*Processing times will vary contingent upon the number of development requests.

There are three (3) ways find the status of your application in PECOS:

- 1) Check the Ordering and Referring Report on the CMS website found in the "Downloads" Section at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html>. If you are listed on that report, you have a current enrollment record in PECOS.
- 2) Use Internet-based PECOS to locate your PECOS enrollment record. For Internet-based PECOS, visit <https://pecos.cms.hhs.gov/pecos/login.do> on the CMS website. If a record is displayed, you have a current enrollment record in PECOS.  
**Note:** An approved Security Consent Form is required in order for an organization’s existing Medicare data to display in Internet-based PECOS. For more information on the Security Consent Form please refer to “The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations” at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedEnroll\\_PECOS\\_ProviderSup\\_FactSheet\\_ICN903767.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf) on the Centers for Medicare & Medicaid Services (CMS) website.
- 3) Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS. A list of Medicare enrollment contractors and their contact information can be found

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at [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact\\_list.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf)

### Medicare Revalidation Project

Providers and suppliers are required to **revalidate their information every five years**, while certain suppliers, including physicians who furnish durable medical equipment (DME), are required to revalidate their information every three years.

CMS is currently undertaking an "off-cycle" revalidation process now for **all providers**, meaning a revalidation request could happen sooner than five years. This project is an effort by CMS, mandated by Section 6401(a) of the Affordable Care Act, to verify all information on file for existing Medicare providers, and to ensure they meet all standards associated with the new screening criteria. Approximately 1.5 million providers and suppliers must be revalidated by **March 25, 2015**. Providers and suppliers should take action to revalidate their enrollment when requested to do so by their Medicare Administrative Contractor via a letter.

Sample of the letter can be found in **Appendix 7**.

### Medicaid

Wisconsin Medicaid allows providers to track their enrollment application through the Portal. Providers will receive an Application Tracking Number (ATN) upon submission. After providers submit their enrollment application to ForwardHealth, they can check on the status of an enrollment application through the Portal by:

- 1) From the ForwardHealth Home Page (<https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>) click on the Provider icon (**Figure 3**);

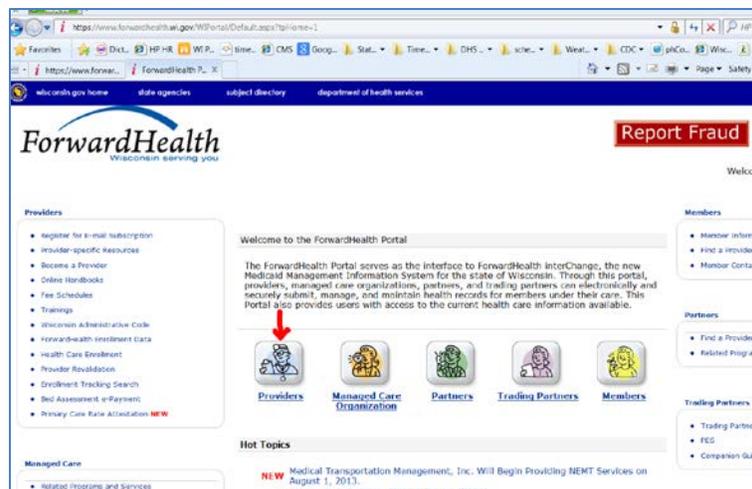


Figure 3 - Forward Health (Medicaid) home page

- 2) On the right side of the Provide Page is a Quick Links box
- 3) Click on “Enrollment Tracking Search” (**Figure 4**)

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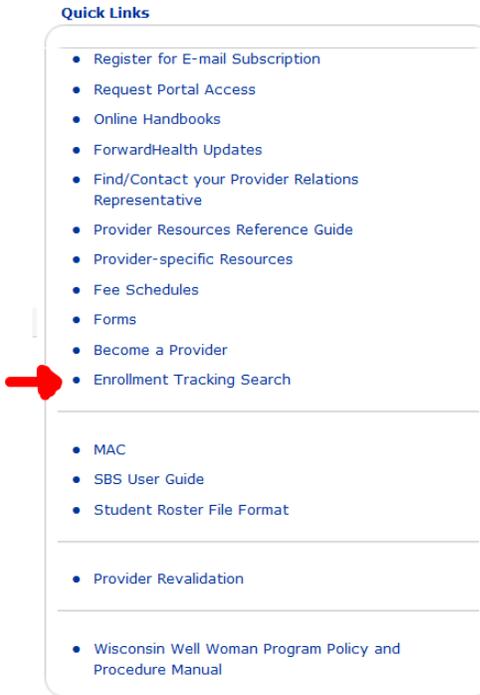


Figure 4 - Medicaid Provider Enrollment Tracking Search

4) Enter the ATN (**Figure 5**) received when the enrollment was submitted.



Figure 5 - Application Tracking Number entry screen

5) Providers will receive current information on their application, such as whether it is being processed or has been returned for more information. Providers may still call Provider Services to check on the status of their application but are encouraged to use the Portal.

### Medicaid Effective Date Determination

The initial effective date of a provider's enrollment will be based on the date ForwardHealth receives the complete and accurate enrollment application materials. The date the applicant submits his or her online provider enrollment application to ForwardHealth is the earliest effective date possible, and will be the effective date if both of the following are true:

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- The applicant meets all applicable screening requirements, licensure, certification, authorization, or other credential requirements as a prerequisite for Wisconsin Medicaid enrollment on the date of submission.
- Supplemental documents required by ForwardHealth that were not uploaded as part of the enrollment process are received by ForwardHealth within 30 calendar days of the date the enrollment application was submitted. To avoid a delay of your certification effective date, uploading documents during the enrollment process is encouraged.

If ForwardHealth receives any applicable supplemental documents more than 30 calendar days after the provider submitted the enrollment application the provider's effective date will be the date all supplemental documents were received by ForwardHealth.

### Medicaid Revalidation

All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formally known as recertification.

**Note:** Providers should note that the Centers for Medicare and Medicaid Services require revalidation at least every five years. However, Wisconsin Medicaid will continue to revalidate providers every three years.

### Commercial Payers

Assuming you have submitted exactly what the payer has asked for (as stated in Section 1, most of the requested data is contained in a professional providers curriculum vitae – see **Appendix 8**), it can take anywhere from 60 days to several months to achieve participating status. The basic flow of your applications is as follows:

- 1) Verification of application details is the first task.
  - a) **Primary Source Verification** is accomplished by contacting the source of a credential or license *directly*. In the case of physician, this includes getting verification directly from their medical school, residency program, state medical license board, etc. Verification is done by mail, fax, telephone, or electronically in order to make sure there was no interference in the communication by an outside party. There are some standard items that are subject to primary source verification:
    - i) Previous education, training and board certification (as applicable)
    - ii) Professional state appropriate licensure
    - iii) State appropriate registered DEA certificate or verification of state appropriate registered DEA via National Technical Information Service (NTIS) query or CDS via copy of current certificate (as applicable)
    - iv) Sanctions by Medicare or Medicaid via the National Practitioner Data Bank (NPDB) query
    - v) Sanctions or disciplinary actions on licensure via state appropriate licensing board and the NPDB query
    - vi) History of malpractice claims or denial of professional liability
    - vii) Current, adequate malpractice insurance per health plan policy and contract specifications via completed provider application or copy of malpractice face sheet
    - viii) Gaps in work history greater than six months identified through review of application and/or CV
  - b) **Secondary Source Verification** is documented verification of a credential through obtaining a verification report from an entity listed below as acceptable on the basis of that entity having performed the primary source verification. Information received from any of these sources must

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meet the same transmission and documentation requirements as outlined above for primary sources:

- American Medical Association Physician Master Profile
  - Association of American Medical Colleges
  - American Association of Colleges of Nursing
  - American Academy of Physician Assistants
  - Accreditation Council for Graduate Medical Education
  - Federation of State Medical Boards
  - American Osteopathic Association
  - American Board of Medical Specialties
  - American Osteopathic Information Association
  - American Nurses Credentialing Center
  - Educational Commission for Foreign Medical Graduates
  - National Commission on Certification of Physician Assistants
- c) Again, the timeline for verification differs with each organization, but the following apply to those plans that are accredited:
- i) NCQA standards allow 180 days for license, malpractice history, Medicare/Medicaid sanctions, license sanctions, board certification and no limit for DEA/CDS or education/training
  - ii) URAC is 6 months for verifications for license (including sanctions), board certification and 180 days for application/attestation
  - iii) Neither have time limits for DEA/CDS or education/training verification.
- 2) The next step is application review. The file is assembled in an order dictated by policy. Some plans will have their medical director review the file initially and he/she may also have the authority to make an approval in certain circumstances. The medical director might just comment and pass on to the credentialing committee.
- 3) Files are then submitted to the credentialing committee. This peer-review process is designed to “verify the professional qualifications of all participating providers and facilities that provide services to consumers, with the senior clinical staff person overseeing the clinical portion of the program. The credentialing program has a committee consisting of at least one practicing provider who has no other role in the organization. The committee provides, among other things, guidance to the organization on credentialing matters and votes on applications for participation status<sup>2</sup>.” The following (**Figure 6**) is an example of Security Health Plan of WI’s definition of their credentialing committee make-up and mission.

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<sup>2</sup> URAC definition

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### *Credentialing Committee*

The Credentialing Committee is a standing committee that meets twice a month. Members are nominated by Security Health Plan management and approved by the president of Security Health Plan's Board of Directors. The committee is responsible for establishing and implementing credentialing and recredentialing policies and procedures. In addition, the committee is responsible for reviewing provider credentialing/recredentialing applications that do not meet Security Health Plan's administrative and professional criteria. The committee also monitors provider performance. The committee, per Security Health Plan Board delegation, has authority to approve/disapprove provider credentialing/recredentialing.

The Credentialing Committee consists of physicians practicing in family practice, behavioral health, obstetrics, and medical and surgical subspecialties, along with Security Health Plan staff including credentialing staff, legal services and administration. The Credentialing Committee and medical director or his or her designee will use good faith discretion in reviewing applications and making credentialing decisions. The committee and medical director or his or her designee will base its decisions on any facts and circumstances it deems appropriate and relevant. Annually, each voting member of the Credentialing Committee attests that all credentialing decisions will be made in a non-discriminatory manner, without regard to age, race, gender, national origin, religion and without consideration of the types of patients treated by the applicant or the types of medical/surgical procedures provided.

Figure 6 - Security Health Plan of WI Credentialing Committee definition

- 4) If approved by the credentialing committee, you will be notified of the decision. While each payer has their own requirements, the NCQA standard for initial credentialing notification is 60 calendar days and URAC's standard is 10 calendar days.
- 5) If the application is denied, the notification should include the appeal process. Plan must offer a formal appeal process when taking any actions for quality reasons. At a minimum, the notice should meet the requirements of the Health Care Quality Improvement Act (HCQIA) of 1986 Notice of Proposed Action. This notice must state:
  - a) that a professional review action has been proposed to be taken against the physician;
  - b) the reasons for the proposed action;
  - c) the physician has a right to request a hearing;
  - d) any time limits to request a hearing (not less than 30 days); and
  - e) a summary of the physician's hearing rights that comply with HCQIA. [42 U.S.C. Section 11112(b) (1)].
- 6) Also included would be any applicable state requirements and should state the objective evidence and consideration of patient care in the decision.
- 7) Recredentialing is required, by most payers, every 3 years (which is also the standard of both URAC and NCQA).
  - a) Recredentialing is similar to initial credentialing, but with less required documents and verification. Care Wisconsin (**Figure 7**) and Unity Health Plans (**Figure 8**) both send the provider a recredentialing application when it is time for the provider to be recredentialed. Note that Unity uses an outsourced credentialing organization, Rural Wisconsin Health Cooperative (RWHC), to handle their applications.

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### **Practitioner Re-credentialing**

Care Wisconsin and/or its credentialing delegates will re-credential plan providers at least every three years. Any provider not re-credentialed within 36 months of the previous credential approval is considered to be out of compliance with our policy.

Care Wisconsin and/or its credentialing delegates send each Network Provider a re-credentialing application requesting updated professional information. The re-credentialing application must contain all required information and must be signed before it is returned to Care Wisconsin. Incomplete applications will be returned to applicants.

**Figure 7 – Care Wisconsin Health Plan Recredentialing**

### **Recredentialing**

Recredentialing takes place every three years. Practitioners who are due for recredentialing will receive their recredentialing packet from RWHC approximately five to six months in advance. This enables Unity to complete the process within the required time frames and will prevent termination of Network participation. The same process that is used for credentialing is followed for the recredentialing process.

**Figure 8 - Unity Health Plan Recredentialing**

### **CAQH Affiliated Payers**

Several WI payers use the CAQH Universal Provider Datasource (UPD) as a repository for credentialing and re-credentialing documentation. This allows you to enter the data once, under a unique ID number, and then simply give that number to other payers who also use the UPD so they can access the data without you having to re-submit. UnitedHealthcare (**Figure 9**) is one of these providers.

#### **When can I start the credentialing process for a new provider?**

If you are new to CAQH, please contact UnitedHealthcare to have a CAQH ID created (or contact another health plan to initiate the request; CAQH IDs can only be generated if the request comes from a participating organization). The credentialing request can commence more than 30 business days prior to your physician's start date. However, please ensure that all necessary parts of the application are available for completion, including malpractice insurance, Drug Enforcement Agency (DEA) numbers and state licenses. If this information is not present, UnitedHealthcare cannot complete the credentialing process.

**Figure 9 - UnitedHealthcare CAQH directive**

If you have attested to all of the data in the Universal Provider DataSource (**Figure 10**) on the regular interval required by CAQH, **you do not need to do anything**. The payer simply pulls your information from CAQH to review for updates and changes. To re-attest<sup>3</sup>:

<sup>3</sup> CAQH UPD <https://upd.caqh.org/pmm/>

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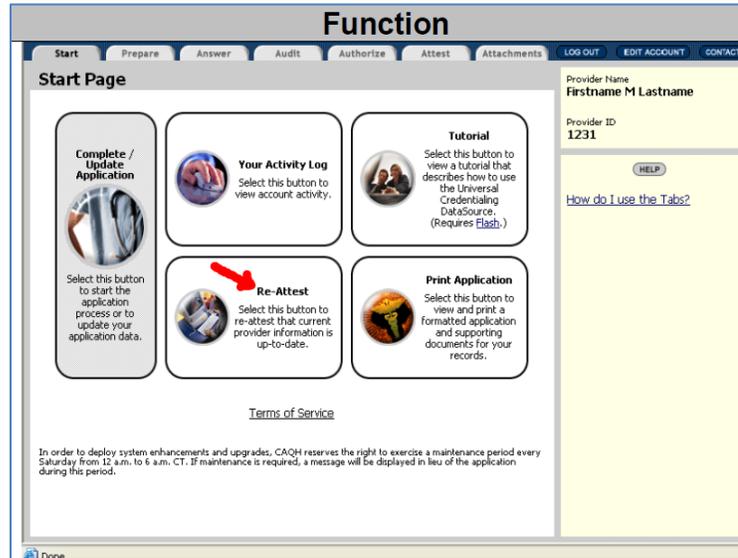


Figure 10 - CAQH UPD Re-Attest page

1. Log in to the Universal Provider Datasource.
2. If you have updates to make to your data, select the Answer tab and use the –Go to Specific Sections dropdown box to select the section where the data needs to be corrected. When you scroll down and click on the section, that page will be displayed.
3. Make the corrections to the page. Be sure to click NEXT or AUDIT to save your changes.
4. If other sections need to be changed, repeat the above process. When all changes have been made and you have clicked NEXT or AUDIT the final time, click on the Audit tab and follow the three steps to review and attest to your information.
5. If your data has not changed since your last attestation, click on the Re-Attest bubble on the Start Page. Follow the three steps to review and attest to your information.
6. In either case, please review your supporting documents.
7. On the Attachments page, scroll down and review the Supporting Documents Received. Click on the link for each document that is renewable to ensure the current document is posted. If it is, you are done.
8. If not, you will need to update the appropriate section in the application (i.e., if you have an updated state license, be sure to update the issue and/or expiration date fields) and re-attest to your changes. And, you will need to print the Fax Cover Sheet and send in a copy of the updated supporting document.

Once you are credentialed, you will move to the next step which is “Contracting.” Contracting is the point that you receive a provider agreement to execute [see **Section 3 - Participating Provider Agreements – the Agreement**]. You can review the contract and attempt to negotiate favorable language and reimbursement before signing. When you sign and submit your contract, the carrier representative does the same and then sends you a “Welcome to the network” letter. Expect this process to take 30 – 60 days.

