Credentialing and Contracting

Provider Authorization, Submitting Claims and the Corporate Credentials Committee

PROVIDER REFERENCE GUIDE

A Reference Manual for Blue KC Practitioners

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Credentialing and Contracting

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Credentialing and Contracting

Registration Steps

1. Register at the Council for Affordable Quality Healthcare (CAQH) website (see Contact Resource Directory for website). Please authorize Blue KC access to the providers' online credential information.
2. Ensure the Provider's information is updated in the National Plan & Provider Enumeration System (NPPES).
3. If the provider is registered with CMS, ensure the Provider information is updated in the Medicare Provider Enrollment, Chain and Ownership System (PECOS).
4. Submit Blue KC's Network Interest Application located here under the **Joining the Blue KC Network** section.
   a. Current Providers interested in adding networks should select Current Providers Request to Add Network button
5. Blue KC's Network Interest Committee will evaluate the Network Interest Application and determine if there is a need for the Provider and if there is a need, a Credentialing form will be forwarded to the Provider.
6. If all the CAQH information is accurate and complete, the credentialing process will take approximately 45 to 60 days. Any claims submitted by the Provider to Blue KC during this time will be processed as out-of-network and, unless otherwise required by law, any payment will be sent to the member.
7. Completed applications are presented to the Blue KC Corporate Credentials Committee for review and final approval. The Credentials Committee meets on a monthly basis. Please contact the appropriate **Account Executives** (see Contact Resource Directory) for more information.
8. After Committee approval, the Provider may be offered Blue KC contracts for network participation.
9. Upon contract execution, the Provider services staff loads the providers' applicable networks into the claims processing system.
10. Once contract set up is complete, Blue KC will send a notification and then submitting claims can begin.

Credentialing Overview

1. Registering with Council for Affordable Quality Healthcare (CAQH).
2. Submitting the Blue KC Networking Interest Application.
3. Being successfully evaluated by the Blue KC Corporate Credentials Committee.
4. After committee approval, the Provider may be offered a contract for review and signature.

Blue KC will not process credentialing applications older than 180 days.

Contracting

Terms of the Provider Agreement shall begin on the effective date and extend for one year, which will then automatically renew for successive one year terms. Providers must give written notice of non-renewal at least 90 days prior to the end of term to terminate this Agreement.

Providers must hold all accreditations required by local, state or federal laws to conduct business and perform obligations within the Provider Agreement. Providers shall cooperate and provide all credentialing requirements in a timely manner. Any licensing investigation against a Provider or affiliated Provider must be reported to Blue KC. If Blue KC delegates credentialing to the Provider, the above information shall be superseded.

Credentialing

Initial verification that a Provider's credentials meet the criteria established by Blue KC for education, training, licensure and experience.

Recredentialing

Occurs at a minimum of every 3 years following initial credentialing.

Under an Existing Provider Group

If a Provider is employed or contracted with a physician entity that previously signed a Blue KC Employed Physician Group Agreement, the Provider is not required to sign individual Blue KC contracts. In this instance, the Provider participates in the same networks selected by the physician entity. The network effective date of the Provider participation coincides with the credentialing approval date.

Even though the providers' effective date is the date on which the Provider's application is complete and the Provider meets all licensure and certification requirements, the Provider will need to verify the Provider setup is complete in the Blue KC system before filing claims. Otherwise they will process as an out-of-network Provider until the setup is completed.

Blue KC performs credentialing on all providers to ensure that its members have their health care needs met by appropriately qualified providers.

Without an Existing Provider Group

If a Provider is not employed by a physician entity (signing individual Agreements), contracts may be emailed to the Provider after the credentialing application has been approved by the Credentials Committee. The effective date is the credentialing date as long as Blue KC receives e-signed contracts from the Provider within 30 days.

Contracting Location and Tax IDs

The enrollment and contracting process is specific to the location and configuration of the Provider entity at the time of contracting. A Provider will continue to be subject to the terms of the Network Agreement associated with that location and configuration unless Blue KC gives its prior written consent.

If a Provider desires to add a service, location or Tax ID to the Provider Agreement, Blue KC must be contacted to negotiate this amendment. Depending on the service, location, or Tax ID being added, additional credentialing and configuration may be required.

Credentialing

Credentials Committee

Credentials must be valid at the time of the Committee review and must be verified within the 180-day time limit. An applicant shall be evaluated in accordance with the process and criteria established by the Blue KC Corporate Credentials Committee. The Blue KC Corporate Credentials Committee is responsible for establishing the corporate credentialing Policies and Procedures and for initial credentialing and recredentialing decisions. These govern Provider participation in the networks and all subsidiaries and affiliates, Policies and Procedures are reviewed at least annually and revised and approved as needed. All applicable Blue KC Policies and Procedures must be followed by Provider and all affiliated providers. Such reviews or revisions are reported to the appropriate governing bodies.

The committee meets monthly or as often as necessary. To obtain a copy of the meeting calendar, please contact the credentialing department (see Contact Resource Directory).

Policies and Procedures

Means the Provider Reference Guide, all Blue KC, delegate, and payor guide(s), medical and Medical Necessity policies and policies related to billing (including, but not limited to, coding, mutually exclusive and incidental or included procedures), Utilization Review, Quality Improvement, peer review, credentialing, recredentialing, Covered Individual and Provider appeal and grievance procedures, other administrative guidelines, and any other similar Policies and Procedures as may be set forth in the Blue KC Provider Manual, Provider newsletters or bulletins, or otherwise communicated to Provider.

Provider Minimum Criteria

- Current valid license.
- Clinical privileges in good standing at a Blue KC participating facility or arrangements with hospitalists, if required for practitioner type.
    - CLIA
    - KS Lab Permit
    - MO Lab Permit
- Valid DEA certificate (the DEA must reflect the current practice location address).
- Valid BNDD certificate (Missouri only) (the BNDD must reflect the current practice location address).
- Education, training and residency or special training of physician (Practitioner only).

- Board certification, as applicable (practitioner only).
- Proof of current malpractice insurance Network Providers must maintain professional liability insurance with minimum coverage limits of $1 million per claim with an aggregate limit of $3 million and in addition, Providers must comply with any State insurance coverage requirements where the practice is located.
- Advanced Practice Providers must include an In-Network Blue KC Provider as their Collaborating/Supervising Physician and submit a copy of the Collaboration Agreement.
- Laboratories, Durable Medical Equipment, Physical Therapists; Home Health Agencies; must provide at initial enrollment and recredentialing a "CMS Approval Letter" with a PTAN Number. The letter must reflect the current practice location and name must match as it appears on W-9 and NPPES.
  - Groups in general should have at least 1 Rendering Provider Affiliation
- Physical Therapy Group Providers must have NPI's that are site specific; and must have at least one affiliated provider at the site-specific location.
  - CMS Facility Survey
  - Certificate of Need for New Facilities

Verifying the Correctness and Completeness

As a part of the Council for Affordable Quality Healthcare (CAQH) registration process, the applicant is required to sign and date an attestation/authorization verifying the correctness and completeness of the application and indicating authorization for primary source verification.

The standard application includes a statement by the practitioner regarding the following:

- Any inability to perform the essential functions of the position.
- Lack of impairment due to chemical dependency and/or substance abuse.
- History of loss of license and /or felony convictions.
- History of loss or limitation of privileges or disciplinary activity.
- Current malpractice insurance coverage Network Providers must maintain professional liability insurance with minimum coverage limits of $1 million per claim with an aggregate limit of $3 million and in addition, Providers must comply with any State insurance coverage requirements where the practice is located.

Application Review

The Blue KC Credentialing department will make a reasonable effort to complete primary source verification within

45 to 60 days of receiving a completed application from the Provider.

In addition to the minimum criteria, credentialing department and Credentialing Committee will consider other factors relevant to the Provider's qualification for inclusion in the newtwork, including, but not limited to:

- History of professional liability claims history.
- Medicare/Medicaid sanction activity.
- Sanctions or limitations on licensure.
- Criminal history
- Past 10 years of work history with verification of gaps greater than 6 months (include month and year) (practitioners only).
- National Practitioner Data Bank query.
- Accreditation Certificate (facility only).
- State Survey completed within the past 36 months (facility only).
- Sanctions or limitations on licensure from either a State Board, hospital or other network.

A Provider has the right to review information obtained by Blue KC to evaluate his/her credentialing application. This review may include information from any outside primary source (for example, malpractice insurance carriers or state-licensing boards). The Provider has the right to correct erroneous information and, upon request, to be informed of the status of his/her credentialing or recredentialing application.

Notification of Decision

Providers applying for initial credentialing will be notified by letter within 10 business days from the Credentials Committees decision that their application has either been approved or denied. If approved, the Provider will need to verify the Provider's setup is completed before filing claims for in-network claims processing. If the application is denied, the notification will include explanation of the reason for denial and any appeal rights available to the Provider.

Recredentialing and Changes to Credentialing

All Blue KC providers are recredentialed at a minimum of every 3 years or more often as needed. The recredentialing process is initiated by Blue KC. Practitioners need to keep their Council for Affordable Quality Healthcare (CAQH) application up-to-date and reconfirm that the information profile is correct. A Provider may also be subject to additional credentialing review in the event the Provider notifies Blue KC of a change in services, location, or Tax ID.

Review of Application

The recredentialing process assures that the Blue KC Corporate Credentials Committee has access to all pertinent information from quality improvement and risk management. The Provider's recredentialing application will be reviewed by the Credentialing department and Credentials Committee, including minimum criteria and provider qualifications, similar to the process for new applications discussed above.

Quality Improvement and Risk Management Monitors

Blue KC monitors performance of all providers on an ongoing basis. Quality Improvement is the process that oversees the process and outcomes of member services to ensure care is efficacious current and consistent with generally accepted medical practices.

In addition to the review process for new applications, the Credentials Committee will be given additional quality information for consideration including, but not limited to:

- Member complaints and grievances.
- Performance in Blue KC quality programs.

Notification of Decision

Based on the Credentialing Committee's review of the recredentialing application, a Provider may be approved, placed on a corrective action plan or revoked. The Provider is considered to be recredentialed unless otherwise notified in writing. The Provider will be notified of any adverse decision within 10 business days of such decision, including the reason for the adverse decision and any appeal rights available to the Provider.

Revocation of Credentials

In reviewing a Provider's credentialing application, the Blue KC Corporate Credentials Committee may conduct such investigation as it deems necessary to make a decision and to determine whether the applicant is qualified for network participation, as described above.

If, at any time, the Credentialing Committee receives information on the Provider which results in a determination by the Credentials Committee that the Provider no longer meets the criteria to participate in Blue KC networks, the Credentials Committee may recommend corrective action, up to and including revocation of the Provider's credentials. In the event of an adverse decision by the Credentials Committee, the Provider will be notified of the decision in writing within 10 business days. Notification to the provider will include explanation of the reason for the revocation and information regarding any appeal rights the Provider may have.

Termination

Provider Agreements are for a one year term, which automatically renews in absence of any action by Blue KC or the Provider. A Provider Agreement may be terminated or non-renewed by the Provider or Blue KC per the terms of the Provider Agreement. In the event of a termination by Blue KC, the Provider will be given written notification of such termination, consistent with requirements under the Provider Agreement and applicable state or federal law. Where required by law, a Provider will be notified of the reason for termination and applicable appeal rights.

Termination can be either immediate or partial. For detailed information on these two types of termination, please reference the Provider Agreement.

Upon termination of the Agreement, the rights and obligations of both parties shall be immediately ceased. Until termination, Provider must continue all responsibilities. Provider shall continue providing covered services to members until the patient is discharged or transferred to another network Provider as part of the hold harmless provisions of the Provider Agreement. Following any termination, Blue KC shall continue to have access to Provider records in accordance to the Provider Agreement.

Providers must prepare, maintain and protect all medical health record in accordance to the Provider Agreement. These records shall be preserved for the longer of 6 years after termination of the Agreement or following the

completion of any audit.

Scheduling Administrative Terms

For providers who have not submitted claims in over a year Blue KC will conduct administrative terminations of provider agreements for providers who have not submitted a claim for a period of one year. Blue KC will also review provider agreements with multiple affiliations and terminate any individual affiliation where a claim has not been submitted for a period of one year. Administrative terminations take place twice a year, on September 1 and March 1, and look back at the previous year. Prior to termination, Blue KC will provide a 90-day written notice to impacted providers. Providers will be allowed a maximum of one 6-month extension upon request. If the provider is still inactive in the next administrative termination cycle, they will be termed. Providers who are terminated due to inactivity must reapply to become a participating provider through Blue KC's standard credentialing processes.

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