SUBJECT:	**Facility Credentialing Policy**	**Policy No.** **Reference: S:\QI\Policies\2012**
BUSINESS OWNER:	Quality Improvement	**Page 1 of 4**
APPROVED BY: Quality review and credentialing committee	**Date: November 13, 2012**	
APPROVED BY Executive Committee:	**Date: January 8, 2013** **_____** **Robert Wheeler MD** **Chief Medical Officer** **BCBSVT**	**EFFECTIVE: 08/2/04** **REVISED: 12/01/08, 10/2/12** **NEXT REVIEW DATE: 1/2014 by Clinical Quality Committee**
DATE DISTRIBUTED TO COMMUNICATION DESIGNEES:		**APPLIES TO: All Lines of Business**
REGULATORY / ACCREDITATION LINKS: **2013 HP Standards and Guidelines/Elements: CR 8**		

I. Policy:

Blue Cross and Blue Shield of Vermont (BCBSVT) requires hospitals, home health agencies, skilled nursing facilities, free standing surgical centers and behavioral health care facilities (providing mental health or substance abuse services in inpatient, residential and facility based outpatient settings) to be qualified, competent and meet the Plan(s)' standards for performance and delivery of high quality clinical care and service.

All facilities requesting participation with any of the Plan's products must complete the credentialing process and be approved for participation before entering into a contractual relationship with the Plan.

Facility applicants must provide evidence of the following information in order to be considered for network participation:

- An active, unencumbered state license to operate
- A CMS or state review less than three years old at the time of application. The report from the institution must show evidence of substantial compliance or an acceptable corrective action plan with current state regulatory requirements or;
- Accreditation by one of the following accrediting bodies:

Facility Type	Acceptable Accrediting Bodies
Hospital	JCAHO*, HFAP*, DNV*
Home Health Agency	JCAHO, CHAP*
Skilled Nursing Facility	CHAP*
Ambulatory Surgical Center	JCAHO, AAAHC*

- Certificate of current malpractice insurance coverage with a minimum of $1 million per occurrence and $3 million in the aggregate, or, evidence of federal or state tort immunity

The Plan does not credential facilities that do not meet the criteria for participation as outlined above.

BCBSVT confirms network facilities are in good standing with state and federal regulatory and/or accrediting bodies at least every three years thereafter.

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

BCBSVT's facility credentialing guidelines are based on the standards set by the National Committee for Quality Assurance (NCQA). The Plan's clinical quality committee reviews this policy at least every three years or more frequently if necessary.

A. Credentialing Application Requirements

All facilities, as outlined above, must complete a facility credentialing application and go through the credentialing process to become a network facility. The facility credentialing application must include the following information:

a) Copy of current valid state license.
b) Copy of professional liability insurance coverage current at the time of committee decision
c) A copy of most recent site survey by Medicare or the appropriate state oversight agency for that facility, or certificate of accreditation from one of the acceptable accrediting bodies noted above
d) A signed and dated attestation/release to obtain primary source verification

B. Credentialing Procedure

Verification of Credentials Process

The Plan, its delegate, or its agent, completes primary verification of credentials using recognized sources in the following areas:

a) Current state license in the state where the facility provides care to BCBSVT members via the states department of health and human services website or a current copy of the facility license as displayed to the public.
b) 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.
c) Verification of sanctions or exclusions from Medicare/Medicaid, or other Federal Healthcare Programs via query of The Office of the Inspector General (OIG).

Review and Approval Process

The Chief Medical Officer (CMO), designee or quality review and credentialing committee review the facility credentialing application for recommendation and approval into the Plan's network.

The CMO or a designee may approve facility credentialing files without quality review and credentialing committee review if they meet the following criteria:

a. The facility application is complete and the required documentation meets the Plan's standards as outlined above.
b. The facility state review shows substantial compliance or a corrective action plan that is accepted by the state
c. The absence of affirmative responses to inquiries about professional review actions and other adverse findings on the application

The CMO may, at his/her discretion, submit any credentialing or recredentialing file for quality review and credentialing committee discussion, even if the file meets the criteria outlined above.

The effective date for approved facilities is typically the date of CMO or quality review and credentialing committee's approval. However, should the approval date be prior to the date the facility's authorized representative signs the participation contract, the effective date will be the date the Plan receives the signed contract.

The facility does not qualify for network participation if the credentialing criteria outlined above are not met or the quality review and credentialing committee denies the request based on quality concerns.

The facility may reapply for participation once the Plan's credentialing criteria is met or the facility meets the quality review and credentialing committee's recommendations.

Notification Process

Once credentialing is complete, the network quality coordinator forwards the approval to the provider contracting department. Provider contracting executes the contract and forwards the enrollment information to the network management department for entry into the claims payment system and provider directory as a network facility.

The Plan notifies the facility in writing of the credentialing decision within sixty days of the decision date, to include, if applicable, the reason for denial and their right to appeal the decision.

*JCAHO- Joint Commission on Accreditation of Healthcare Organizations
* HFAP – Healthcare Facilities Accreditation Program
* DNV – Det Norske Veritas
* CHAP- Community Health Accreditation Program
* AAAHC- American Association for Ambulatory Health Care