BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois
Provider Manual

Credentialing Standards

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

TABLE OF CONTENTS

Overview
Credentialing is the process by which BCBSIL reviews the professional qualifications of physicians and certain other providers who apply for participation in our networks, helping to ensure that they meet the professional standards as outlined in our Credentialing Policy. BCBSIL credentialing requirements and processes are derived from and are in compliance with the State of Illinois, National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services credentialing standards.

Network Eligible Providers
The following provider types must complete the credentialing process and be recredentialed every three years:

- **Professional providers:** MD, DO, PsyD, PHD, AUD, BCBA, OD, DC, CNM, DPM, LCSW, LCPC, LMFT, PA, APN, APRN ANP and CNP, CNS, RD, LAC and DN.
- **Institutional providers:** Hospitals and Ancillary

Refer to the Network Eligible Specialists list in the Network Participation/Credentialing section of our Provider website.

Credentialing Process
BCBSIL contracts with the Council for Affordable Quality Healthcare (CAQH®)* to collect the data required for our credentialing and recredentialing process. CAQH uses ProView to electronically collect the data. The ProView online credentialing application process supports our administrative simplification and paper reduction efforts by producing quality credentialing and demographic information that improves the accuracy and integrity of our provider database. Providers may utilize CAQH ProView at no cost.

CAQH ProView Registration
Network providers are required to have a CAQH Provider ID to begin the credentialing process for any network.

Providers Not Registered with CAQH
Providers must self- register with CAQH ProView at https://proview.caqh.org . CAQH will email the provider a Welcome kit with registration instructions. Providers receive a personal CAQH Provider ID, allowing them to register on the CAQH website at proview.caqh.org and obtain immediate access to the ProView database via the Internet.

After successfully authenticating key information, providers can create their own User Name and unique password to begin using the system, and to log in at any time.

Providers Registered with CAQH
Providers registered with CAQH will be rostered by BCBSIL to allow access to their data. Providers can log in to the ProView database and add BCBSIL as one of the health plans authorized to access their information. Providers can also choose “global authorization” so that all of their affiliated health plans can access their data.

Completing the Application Process

The CAQH ProView standardized application is a single, online form used uniformly by all providers in the credentialing process. When completing the application, providers will indicate which participating health plans and health care organizations they authorize to access their application data. All provider data submitted through the ProView service is maintained by CAQH in a secure, state-of-the-art data center.

Providers can enter their data by logging in to the ProView database at proview.caqh.org / with their User Name and password. After completing the online application, providers will also be asked to:

1. Authorize access to information – List organizations they would like to receive their information.
2. Verify data entry/Attest – Review a summary of their data for completeness and make any necessary changes.
3. Submit supporting documents.

The CAQH Help Desk can be contacted for assistance via live chat or by calling 1-888-599-1771. Live chat can be accessed by logging in to your account and clicking the chat icon at the top of the pages.
Chat hours are:

- Monday – Friday: 8:30 AM to 6:30PM (EST)

Phone hours are:

- Monday – Thursday: 7 AM – 9 PM (EST)
- Friday: 7 AM – 7 PM (EST)

The following materials and documents are helpful to reference while completing the application:

- Previously completed credentialing application (for reference)
- List of previous and current practice locations
- Various identification numbers (UPIN, NPI, Medicare, Medicaid, etc.)
- State medical license(s)
- Curriculum Vitae
- Drug Enforcement Administration (DEA) certificate
- Controlled and Dangerous Substances (CDS) certificate
- IRS Form W-9(s)
- Malpractice insurance face sheet with the provider's name on it.
- Summary of any pending or settled malpractice cases
- Hospitals where the provider has admitting privileges or a Hospital Coverage Letter, if applicable.

Providers have the opportunity to review and verify all data before completing the application process. BCBSIL may need to supplement, clarify or confirm certain responses on the application with a provider. Therefore, in some situations providers may be required to submit supplemental documentation to us in addition to the information submitted through the ProView service.

The CAQH Provider Credentialing Application is available in the Network Participation/Credentialing section of the BCBSIL Provider website. Providers can visit the CAQH website at www.caqh.org/ucd.php for more information about CAQH ProView and the application process.

HMO Practitioners

For practitioners affiliated with one of our HMO contracted Medical Group/IPAs, BCBSIL must receive the following documents to initiate the credentialing process:

1. Signed HMO written service agreement with the Medical Group/IPA
2. HMO Credentialing Pre-application Form.

Credentialing Cycle/Time Frames

Initial Credentialing Cycle

Initial credentialing is the process of reviewing and verifying a licensed provider/professional credentials consistent with NCQA and the State of Illinois requirements to determine eligibility for network participation. The initial credentialing process occurs once and may be applied for any network.

Time Frames to Credential or Recredential

Health care entities and health care plans normally complete the process of credentialing/recredentialing within 60 days after the submission and verification of all credentials data. Health care plans may collect recredentialing data once and not more than every three years except as noted below.

Once recredentialing begins in accordance with the State of Illinois Single cycle, a health care entity or health care plan may continue to request data from a health care professional outside of the published recredentialing cycle if it is not submitted by the deadline date published in the schedule.

All health care entities and health care plans may monitor, on an ongoing basis, in between recredentialing cycles, information on sanctions, limitations on licensure, and complaints against health care professionals, consistent with guidelines issued by NCQA.

Process Workflow

Recredentialing

The process of recredentialing is identical to that of credentialing. Providers must register with CAQH and complete the ProView credentialing application in support of the recredentialing process to conform with network contract requirements.

CAQH requires that providers review and attest to their data once every 120 days. At the time a provider is scheduled for recredentialing, BCBSIL will send their name to CAQH to determine if they have already completed the CAQH ProView credentialing application. If so, BCBSIL will be able to obtain current information from the CAQH ProView database and complete the recredentialing process, in most instances, without having to contact the provider.

The State of Illinois recredentialing cycle requires health care entities to obtain data on physicians according to an established single cycle, which is on an anniversary basis so that it is performed only once within a three-year period. Data collection will coincide with the recredentialing cycle that:

- Will be based on the variable of the last digit of each health care professional's Social Security Number
- Provides for a one-month notification period for each digit during which each health care entity and health care plan notifies those health care professionals being recredentialed of the time period during which data is expected to be submitted.
- Provides for a two-month collection period for each digit during which each health care entity and health care plan receives data from those health care professionals being recredentialed
- Reflects a six-month "OPEN" period when health care entities and health care plans cannot collect data from a health care professional, except as noted below. This period coincides with the Illinois Department of Public Regulation's licensing schedule of physicians.

The following situations represent exceptions to this ruling:

- When a health care professional submits initial credentials data to a health care entity or health care plan;
- When a health care professional's credentials data changes; or
- When a health care entity or health care plan requires recredentialing as a result of patient or quality assurance issue(s)

State of Illinois Recredentialing Single Cycle

Note: Based on last digit of physician's Social Security Number

Year	**2019**	**2020**	**2021**	**2022**	**2023**
Month					
January	N: **4**'s	N: 8's	N: 0's	N: **4**'s	N: **8**'s
February	C	C	C	C	C
March	C	C	C	C	C
April	N: **5**'s	N: 9's	N: 1's	N: **5**'s	N: **9**'s
May	C	C	C	C	C
June	C	C	C	C	C
July	N: **6**'s	OPEN	N: **2**'s	N: **6**'s	OPEN
August	C	OPEN	C	C	OPEN
September	C	OPEN	C	C	OPEN
October	N: **7**'s	OPEN	N: **3**'s	N: **7**'s	OPEN
November	C	OPEN	C	C	OPEN
December	C	OPEN	C	C	OPEN

N: Notification is sent to provider with the SSN ending in that specified number based on year/month (one-month notification period is allocated)

C: Collection of data process starts to receive information from re-credentialed party (60-day collection period is allocated)

OPEN: The Health Plan cannot collect re-credentialing data, except as noted in subsection (a) (6-month period)

Appointment/Reappointment Reports

Appointment is the action taken by a specific network that affects a practitioner participation in any network.

Practitioners seeking to participate in certain BCBSIL networks may require appointment to that network. Management staff reviews the credentialing information, along with any additional information required for the appointment determination and makes a decision about appointment. A list of practitioners appointed is brought to the Provider Selection Committee (PSC) by the network for review. Medical Groups/IPAs and practitioners are usually notified of the appointment decision within 30 calendar days. If the network's decision is not to appoint, the practitioner may have the opportunity to appeal the decision using the appeals policy for that network.

Information relating to credentialing elements and requirements are reviewed by the PSC or the Medical Director, and a credentialing determination is made regarding the practitioner's eligibility for participation in a credentialed network.

Reappointment is the action taken by a specific network that affects continued participation in any network. The PSC reviews and makes a recommendation based on information obtained through the recredentialing process. The PSC either recommends reappointment or non-reappointment. The management staff of the network has final responsibility for making a determination as to whether the practitioner is reappointed to the network for non-credentialed practitioners. Medical Groups/IPAs and practitioners are notified via the BCBSIL website of the reappointment decision usually within 30 calendar days.

Practitioners may have the opportunity to appeal a determination not to reappoint using the appeals policy for that network.

Reports

BCBSIL applies a single credentialing process so that a provider is credentialed once and may then apply for any managed care network that requires credentialing prior to participation.

A monthly report of credentialed and appointed providers is posted in the Network Participation/Credentialing section of our Provider website to provide notification of the effective date with Blue Choice PPO, PPO, Blue HPN℠ and the HMO products. For details, select a report from the list below.

- The **Blue Choice PPO product report** lists providers in alphabetical order and includes the effective date of their appointment/reappointment and contracting group name.
- The **HMO product report** is sorted by HMO Medical Group/IPA affiliation and lists the effective date of each practitioner's appointment/reappointment date. This report includes those providers appointed/reappointed for HMO products.
- The **Blue Advantage HMO report** is sorted by HMO Medical Group/IPA affiliation and lists the effective date of each practitioner's appointment/reappointment date. This report includes those providers appointed/reappointed for HMO products.
- The **Blue Precision HMO report** is sorted by HMO Medical Group/IPA affiliation and lists the effective date of each practitioner's appointment/reappointment date. This report includes those providers appointed/reappointed for HMO products.
- The **Blue Focus Care HMO report** is sorted by HMO Medical Group/IPA affiliation and lists the effective date of each practitioner's appointment/reappointment date. This report includes those providers appointed/reappointed for HMO products.
- The **PPO product report** lists providers in alphabetical order and includes the effective date of their appointment/reappointment and contracting group name.
- The **Blue HPN product report** lists providers in alphabetical order and includes the effective date of their appointment/reappointment and contracting group name.

The report includes information for providers who complete the credentialing process after Jan. 1,of each calendar year. The data is updated weekly.

Provider Updates

It is the responsibility of the health care professional to keep their information current by notifying BCBSIL and CAQH of any changes in information, corrections, updates and modifications to their credentials data on file. This is in accordance with the time frames outlined in the Health Care Professional Credentials Data Collection Act. Providers will be sent automatic reminders to review and attest to the accuracy of their data.

Practitioners must provide updated information within five business days as it relates to the following:

- Licensure actions, including but not limited to sanctions, censures, reprimands, suspensions and/or revocation
- Federal Drug Enforcement Agency license revocation
- Medicare or Medicaid sanctions
- Revocation of hospital privileges
- Any lapse in professional liability coverage required by a health care entity, health care plan or hospital
- Conviction of a felony

Any other changes to the information provided on the credentialing application must be sent within 45 days from the date of the change.

Providers can enter their changes into CAQH ProView for authorized participating plans such as BCBSIL to access. Only plans that participate and authorized by the practitioner may access their changes.

Network Departicipation/Termination

Departicipation means termination of participation of a practitioner from a network. When performance by a practitioner does not meet network standards, the network may place the provider on monitoring and/or undertake corrective action. Monitoring persists until the issues creating the action have been resolved, or the network takes other action, including involuntary/voluntary departicipation. For providers participating in Blue High Performance Network℠ (Blue HPN℠) this may include maintenance of performance on certain quality measures.

IL Network Management/Enterprise Credentialing or the Special Investigations Dept. (SID) may report to the Provider Selection Committee (PSC) any practitioner placed on monitoring/corrective action or departicipated as a result of conduct or practice that could impair the integrity of other networks or is deemed to be unprofessional, unethical or illegal. Such conduct or practice includes, but is not limited to:

- Loss, suspension or probation of license or hospital privileges
- Felony charges
- A quality of care or member satisfaction issue
- Failure to meet site visit requirements.
- Refusal to cooperate with BCBSIL and/or contracted network policies and procedures.
- Suspected fraud
- Abusive billing practices
- Financial insolvency

A provider that receives a network departicipation/termination may have appeal rights, as determined by the PSC in the PSC's sole discretion. Providers may timely submit appeal requests along with supporting documentation, if applicable, for PSC's consideration per the instructions and within the designated appeal period stated in the departicipation/termination correspondence.

When a provider is terminated for administrative and/or performance issues related to network performance standards and unrelated to the physician's or professional provider's ability to practice, reporting is not required. In cases that involve suspected fraud by a physician or provider, the individual is reported to the SID, who may report the situation to the appropriate authorities.

The Council for Affordable Quality Healthcare (CAQH) is an independent third party not-for-profit collaborative alliance of the nation's leading health plans and networks. The mission of CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staffs. CAQH is solely responsible for its products and services, including the Universal Provider Datasource (UPD).