

**EVOLENT HEALTH LLC  
POLICY AND PROCEDURE**



POLICY NUMBER: NVR.010.E.KY  
 REVISION DATE: 05/30/2019  
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**POLICY TITLE:** Practitioner Credentialing and Recredentialing  
**DEPARTMENT:** Provider Credentialing  
**ORIGINAL DATE:** February 2017

**Approver(s):** Sharlee LeBleu, Director, Credentialing Operations

**Policy Review Committee Approval Date:** May 30, 2019

**Product Applicability:** mark all applicable products below:

<b>COMMERCIAL</b>	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <i>Products:</i> <input type="checkbox"/> Small <i>Exchange:</i> <input type="checkbox"/> Shop <input type="checkbox"/> All <input type="checkbox"/> Indiv. <input type="checkbox"/> Indiv. <input type="checkbox"/> Large
	States: <input type="checkbox"/> GA <input type="checkbox"/> MD <input type="checkbox"/> OH <input type="checkbox"/> TX <input type="checkbox"/> _____
<b>GOVERNMENT PROGRAMS</b>	<input type="checkbox"/> MA HMO <input type="checkbox"/> MA C-SNP <input checked="" type="checkbox"/> MA D-SNP <input type="checkbox"/> MSSP <input type="checkbox"/> Next Gen ACO <input type="checkbox"/> MA All <input checked="" type="checkbox"/> Medicaid <i>States:</i> <input type="checkbox"/> DC <input checked="" type="checkbox"/> KY <input type="checkbox"/> MD <input type="checkbox"/> _____
<b>OTHER</b>	<input type="checkbox"/> Self-funded/ASO

**Regulatory Requirements:** Medicare Managed Care Manual Chapter 6 and National Committee for Quality Assurance (NCQA).

**Related Documents:** NVR.011.E Practitioner Credentialing Rights, NVR.013.E Ongoing Monitoring of Sanctions and Complaints, NVR.014.E Provider Sanctioning and Reporting Policy, NVR.019.E Aperture Credentialing LLC Primary Source Verification and Provider Enrollment Policy and NVR.021.E Responsibilities of the Chief Medical Officer and the Credentialing Committee

**PURPOSE**

A highly qualified Provider Network is a cornerstone to assuring that the most cost-effective and evidence base care is available to members. This policy provides guidance for validating a practitioner’s credentials and a timely Credentialing/Peer Review decision to ensure providers are Credentialing or Recredentialled within ninety (90) calendar days of receipt of all relative information from the Provider or within forty-five (45) days if the Provider is providing substance use disorder services.

**DEFINITIONS**

**Credentialing:** The process by which Evolent Health reviews and evaluates the qualifications of licensed independent practitioners to provide services to its’ clients

## Practitioner Credentialing and Recredentialing

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members. Eligibility is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability, and accessibility, as well as, for conformity to the utilization and quality improvement requirements.

**Medicare Opt-Out:** A physician or other practitioners, who has opted out of Medicare, may not accept Federal reimbursement during the Opt-Out period. Opt-Out providers are not eligible to participate in Health Plan Medicare provider networks.

**Medicaid Practitioner:** Includes, but is not limited to, Medical Doctor (MD), Doctor of Osteopath Medicine (DO), Doctor of Dental Science (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatry Medicine (DPM), Doctor of Chiropractic (DC), Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Advanced Practice Register Nurse (APRN), Certified Register Nurse Anesthetist (CRNA), Family Nurse Practitioner (FNP), and, Physician Assistant (PA), Certified Nurse Midwife (CNM), Audiologist (AUD), Optometrist (OPT), Family Planning Providers, Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Psychological Practitioner (LPP), Licensed Psychologist (LP), Licensed Art Therapist (LPAT), Licensed Certified Behavior Analyst (LBCBA) and LCADC, Licensed Clinical Alcohol and Drug Counselor. Practitioners who do not require credentialing are not considered practitioners for the purpose of this policy.

**Medicare Practitioner:** Includes, but may not be limited to, Medical Doctor (MD), Doctor of Osteopath Medicine (DO), Doctor of Podiatry Medicine (DPM), Optometrist (OPT), Doctor of Dental Medicine (DMD), Doctor of Dental Science (DDS), Doctor of Chiropractic (DC), Physician Assistant (PA), Advanced Practice Register Nurse (APRN), Certified Register Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM), Licensed Clinical Social Worker (LCSW), Licensed Clinical Psychologist (LP), Audiologist (AUD), Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST). Practitioners who do not require credentialing are not considered practitioners for the purpose of this policy.

**Primary Source Verification:** The process by which Evolent Health validates credentialing information from the organization that originally conferred or issued the credentialing element to the practitioner.

**Type I Practitioners:** Practitioners meeting all credentials verification guidelines with no history of malpractice suits and/or adverse professional action.

**Type II Practitioners:** Practitioners not meeting all credentials verification guidelines and/or have a history of malpractice suits and/or adverse professional action.

## POLICY

It is the policy of Evolent Health (Evolent) to develop a systematic method for assessing practitioner applicants against the credentialing standards. Evolent enrolls providers in the network in accordance with Center for Medicare & Medicaid Services (CMS) provider eligibility requirements. A Provider cannot enroll, re-enroll or otherwise remain active in the provider network if the Provider has active sanctions imposed by Medicare or Medicaid, if required licenses and certifications are not current, if money is owed to the Medicare or Medicaid Program, if Provider has opted out of Medicare program or if the Office of the Attorney General has an active fraud investigation involving the provider or the provider otherwise fails to satisfactorily complete the credentialing process.

## PROCEDURE

### I. Confidentiality of credentialing information

- A. Information received through the credentialing process is considered confidential and utilized only for the purpose of reviewing prospective Provider applicants for participation in the network.
- B. All written documentation received is placed in the practitioner applicant's file and stored in a locked cabinet or are scanned in secure electronic folders.

### II. Identification/Notification to Credentialing of prospective practitioners

- A. Upon receipt of a complete practitioner application packet from enrollment, contracting or a provider's office, within two business days, providers who require credentialing will be put onto Aperture Start Work file and place on Aperture secure FTP move it site for Aperture to pick up and begin process. Aperture Credentialing, Inc. is an NCQA Credentialing Verifications Organization.
- B. Aperture Credentialing, Inc. picks up the start work file on the Secure FTP site and begins PSV services in accordance Evolent policies.

### Credentialing Verification

#### **NCQA Element A: Verifications of Credentials**

- 1) A current and valid license to practice.
- 2) A valid DEA and CDS certification, if applicable.
- 3) Education and training as specified in the explanation.
- 4) Board certification status, if applicable.
- 5) Work history.
- 6) A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner.

#### **NCQA Element B: Sanction Information**

1. State sanctions, restrictions on licensure or limitations on scope of practice
2. Medicare and Medicaid sanctions.

#### **NCQA Element C: Credentialing Application**

Applications for credentialing includes the following:

1. Reasons for inability to perform the essential functions of the position.
  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 actions.
  5. Current malpractice insurance coverage
  6. Current and signed attestation confirming the correctness and completeness of the application. Information collected on the application must be no more than six (6) months old on the date the provider is approved the plan.
- C. Aperture makes available, via Secure FTP site, a weekly Credentialing Data Transfer (CDT) and provides access to their system, both to include the profile and all supporting PSV documentation. In addition, Aperture places CDT transfer files onto the Secure FTP site. The IT department picks up CDT transfer data and places in the secure Credentialing folder.
- D. Each day, a provider credentialing coordinator checks credentialing folder for new Aperture provider profiles and prepares them for the Health Plan's CMO, or designated MD and/or Credentialing/Peer Committee review.
- E. The provider credentialing coordinator forwards all Type I and Type II Aperture provider profiles to the Health Plan's CMO, or designated MD, for review.
- F. Prior to inclusion in the next Credentialing Committee agenda, the Health Plan's CMO or designated MD, reviews Type II provider profiles and identifies any in which additional information would be needed for the committee's review.
- G. CMO, or designated MD, can make an independent decision, on any Type II provider profile, deemed by CMO, or designated MD, as a Type I profile.
- H. The provider credentialing coordinator develops the Health Plan's Credentialing Committee's packet and includes, at a minimum, an agenda and listing of all Type I practitioners. To ensure a nondiscriminatory review, all Type II practitioner files are de-identified prior to inclusion in the committee packet. The packet is placed out on an Evolent Extranet SharePoint site at least five business days prior to the committee meeting.

### III. Recredentialing

- A. All practitioners, who required credentialing, will be recredentialed at a least every 36 months. 36-month cycle is to the month, not to the day. Practitioners may be recredentialed earlier than 36 months if other quality or service data has identified the need for an earlier review.
- B. The provider credentialing coordinator notifies Aperture via start work file, ninety (90) to one hundred and eighty (180) days prior to each recredentialing due date.

**IV. Practitioner Reinstatement**

- A. In the event a credentialed practitioner leaves the provider network for greater than 30 days, they must complete the entire credentialing process in order to be reinstated.

**V. Decision Making Process**

- A. The Health Plan's Credentialing/Peer Review Committee is composed of participating practitioners in the network and chaired by the Health Plan's CMO or designated MD. The Committee reviews each applicant and votes for acceptance for participation, denial for participation, request additional information, provider corrective action plan and/or a modifying provider's participation status, i.e. a recredentialing date of less than three years.
- B. The Health Plan's Credentialing/Peer Review Committee will not vote for acceptance or denial based on a practitioner's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed or types of patients.
- C. The committee may request additional information from a practitioner if there are areas in which further clarification is needed prior to making a decision. Practitioners being reviewed and in need of additional information are considered non-participating until a final decision is reached by the committee. The committee may not grant temporary privileges for any reason.
- D. The Health Plan's CMO or designated Medical Director (MD) may implement immediate administrative restrictions with regard to any Provider where the Health Plan's CMO or MD believes such restriction is necessary to protect the health and safety of members. Examples of such circumstances include but are not limited to: Emergency Orders of Restriction and Licensure Board Disciplinary Orders. For approved practitioners, the effective date commences with the date the application was deemed complete.

**VI. Following Participating Network Approval**

- A. Once approved for network participation, the provider credentialing coordinator puts the credentialing approval date in Evolent's credentialing database.
- B. Within 60 days of the credentialing decision date, the provider credentialing coordinator sends a plan decision letter to the provider.
- C. A letter is sent to all practitioners denied participation with the plan.
- D. The provider credentialing coordinator provides notice to the State Medical Licensure Board of any adverse actions taken based on a determination by the Health Plan's Credentialing Committee. Reporting is conducted in accordance with the National Practitioner Data Bank (NPDB) requirements outlined in the NVR.014.E Practitioner Sanctioning and Reporting Policy.

- E. The provider credentialing coordinator ensures a complete copy of the Credentialing/Peer Review Committee minutes and listing of practitioners reviewed are maintained in a secure committee Folder.

## RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

## REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE REVISED
New Policy	11/16
Language added to allow CMO/Designated Medical Director to review and downgrade a TYPE II provider to a Type I and make the plan decision without need to present to Credentialing Committee.	09/17
Language changes to align with new systems, process Change of Ownership	5/18
Wording added to the Medicaid Practitioner definition	9/18
Added turnaround time per IPRO state audit request	1/19
<ul style="list-style-type: none"> <li>- Annual Review &amp; Structural Adoption</li> <li>- Change of Policy Ownership from Joel Scott to Sharlee LeBleu</li> </ul>	05/30/2019