INTRODUCTION

The Plan credentials the following contracted health care practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, doctors of optometry, chiropractors, Licensed Clinical Social Workers, Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, Psychiatrists, Psychologists, Audiologists, Physician Extenders wishing to include their name in provider directory publications and doctors of dentistry providing services covered under the medical benefits plan, including oral maxillofacial surgeons.

Overview

All credentialing determinations are made by the Credentials Committee (CC), which reports to the Anthem governing board. The CC is authorized, under authority from the governing body of Anthem and under the direction of the Chief Medical Officer of Anthem, to evaluate all health care practitioners and Health Delivery Organizations (HDOs) applying for participation or seeking continued participation in the Anthem network, within the scope of the Anthem Credentialing program.

These applicants are reviewed for issues related to Anthem’s established credentialing criteria. On review, the CC may accept or deny those practitioners or HDOs initially applying for participation, and retain or terminate practitioners or HDOs requesting continued participation in Anthem programs or networks.
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Anthem’s verification of credentials is ongoing and up-to-date, and the recredentialing process is implemented at least every three years. Continued participation is dependent on successful completion of the recredentialing process.

The Plan notifies practitioners that they have the right to review information submitted to support their credentialing applications. In the event that we cannot verify credentialing information, or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner within 30 calendar days of the identification of the issue.

This communication specifically notifies the practitioner of his or her right to correct erroneous information or provide additional details regarding the issue in question. This notification also includes the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing.

If the communication is verbal, we send written confirmation at a later date. We clearly document all communication on the issues in question, including copies of the correspondence or a detailed record of phone calls, in the practitioner’s credentials file. We give the provider no less than 14 calendar days in which to provide additional information.

The Plan may request and accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC reviews the information and rationale presented by the applicant to determine if a material omission occurred or if other credentialing criteria are met.
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CREDENTIALS COMMITTEE

The decision to accept, retain, deny or terminate a practitioner’s participation in the Plan’s programs or networks is conducted by a peer review body, known as the Anthem Credentials Committee (CC).

The CC meets, at a minimum, four times each calendar year. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy, chairs the CC and serves as a voting member.

The CC includes at least two participating practitioners, including one who practices in the specialty type that most frequently provides services to the Plan’s members and who falls within the scope of the credentialing program, having no other role in Anthem network management. The Chair of the CC may appoint additional participating practitioners of such specialty type, as deemed appropriate for the efficient functioning of the Anthem Credentials Committee.

The CC accesses various specialists for consultation as needed to complete the review of a practitioner’s credentials. A committee member discloses and abstains from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the provider; or (ii) feels his or her judgment might otherwise be compromised. A committee member also discloses if he or she has been professionally involved with the practitioner.

Determinations to deny an applicant’s participation, or terminate a practitioner or HDO from participation in one or more of the Plan’s programs or networks, require a majority vote of the voting members of the CC in attendance, the majority of whom are participating providers.

The CC, which meets on a predetermined basis, may have additional meetings called by the Committee chairperson on an as-needed basis.
During the credentialing process, all information that is obtained is highly confidential. We store all CC meeting minutes and professional practitioner files in locked cabinets or file rooms. This information can be seen only by appropriate Credentialing staff, medical directors and CC members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes consistent with Section 1128 or 1128A of the Social Security Act.
CREDENTIALING CRITERIA

Eligibility Criteria

All health care practitioners applying for initial participation in Anthem programs or networks must meet the following criteria, within the scope of the Anthem Credentialing Program, in order to be considered for participation:

• Possess a current, valid, unencumbered, unrestricted and nonprobationary license in the state(s) where he or she provides services to Anthem members.

• An exception to this requirement may be made for those applicants whose licensure action was related to substance abuse and who have demonstrated a minimum of two years of successful participation in a treatment and/or monitoring program; should this exception be entertained, the Plan may request specific documentation from the treating physician and/or program as it deems appropriate.

• Possess a current, valid and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to the specialty in which he or she will treat Anthem members.

• Must not currently be debarred or excluded from participation in any of the following programs: Medicare, Medicaid or the Federal Employees Health Benefits Program (FEHBP).
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Applicants for initial participation in the Plan’s programs or networks who do not meet the above criteria will be notified of this failure to meet criteria and their applications will not proceed through the credentialing process. However, networks not serving Federal programs may review applicants debarred from Medicare, Medicaid and FEHBP on a case-by-case basis.

Those applying for continued participation in the Plan’s programs or networks who do not meet the above criteria will be considered on an individual basis by the CC, pursuant to Credentialing Policies.

Additional Eligibility Criteria for All Applicants (Initial or Recredentialing)

If an applicant for initial participation or continued participation in the Plan’s programs or networks does not meet one or more of the following criteria, the applicant’s history must not raise a reasonable suspicion of future substandard professional conduct and/or competence. The CC will consider the applicant’s history on an individual basis. Review categories include the following:

- Application and supporting documentation must not contain any omissions or falsifications, (including any additional information requested by Anthem) or, in the absence of omissions or falsifications, must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

- Education, training, and certification must meet criteria for the specialty in which the applicant will treat Anthem members or, in the absence of such, must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

- Applicants who are medical doctors (MDs) and doctors of osteopathy (DOs) must be board certified [as defined by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada] in the clinical discipline for which they are applying, or, in the absence of such certification, must not raise a reasonable suspicion of future substandard professional conduct or competence.
Individuals will be granted five years after completion of their residency program to meet the board certification requirement.

As alternatives to meeting the board certification requirement, MDs and DOs meeting any one of the following criteria will be viewed as meeting the requirement:

- Previous board certification (by an Anthem-approved board), in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of 10 consecutive years of clinical practice; or

- Training which met the requirements in place at the time it was completed in the specialty or subspecialty field prior to the availability of Board Certifications in that clinical specialty or subspecialty; or

- Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a Faculty Appointment of Assistant Professor or higher at an Academic Medical Center and Teaching Facility in the Plan Network and the applicant’s professional activities are spent at that institution at least 50% of the time.

The Credentialing Committee will assess unique situations, when issues of limited access to care may dictate special consideration to the board certification requirement.

- For Doctors of Podiatric Medicine (DPMs) (podiatrists) the applicant must be certified by either the American Board of Orthopedic and Primary Podiatric Medicine or the American Board of Podiatric Surgery or in the absence of such certification must not raise reasonable suspicion of future substandard conduct or competence.

Individuals will be granted five years after the completion of their residency to meet the board certification requirement.

The Credentialing Committee will assess unique situations, when issues of limited access to care may dictate special consideration to the board certification requirement.

- For oral and maxillofacial surgeons, the applicant must be certified by the American Board of Oral and Maxillofacial Surgery or in the absence of such
certification must not raise reasonable suspicion of future substandard conduct or competence.

Individuals will be granted five years after completion of their residency to meet this requirement.

The Credentialing Committee will assess unique situations, when issues of limited access to care may dictate special consideration to the board certification requirement.

- MD and DO applicants must have unrestricted hospital privileges at a Joint Commission on Accreditation of Health Care Organizations (JCAHO) or AOA-accredited hospital, or at a network hospital previously approved by the committee; or, in the absence of such privileges must have acceptable arrangements and must not raise a reasonable suspicion of future substandard professional conduct or competence.

- Site visit and medical record review results, if applicable must meet Anthem standards or, in the absence of meeting such standards, must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

- Complaints from members and/or other providers must be at levels deemed acceptable to Anthem or, if such complaints exist and/or exceed such levels, must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

- Explanations for gaps in work history must be documented and meet Anthem standards or, in the presence of gaps that do not meet such standards, must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

- History of professional liability lawsuits, arbitrations or settlements must be within established Anthem standards or, in the presence of lawsuits not meeting such standards, must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

- Performance indicators obtained during the credentialing or recredentialing process must meet Anthem’s standards or, if not meeting such standards, must
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not raise a reasonable suspicion of future substandard professional conduct and/or competence.

- No physical or mental impairment, including chemical dependency and substance abuse, that would affect the health care practitioner’s ability to practice within the scope of his or her license, or pose a risk of imminent harm to members. In the presence of a history of physical or mental impairment, the nature of the impairment and other information obtained during the credentialing or recredentialing process must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

No history of disciplinary actions or sanctions against the applicant’s license; DEA and/or CDS registration; Medicare, Medicaid or FEHBP participation; or actions or sanctions of such nature as to raise a reasonable suspicion of future substandard professional conduct and/or competence. A determination will be based on the nature of the disciplinary action or sanction and other information obtained during the credentialing or recredentialing process.

No history of disciplinary actions, sanctions, or revocations of privileges taken by hospitals and other health care facilities or entities, professional societies, Health Maintenance (HMOs), Preferred Provider Organizations (PPOs), Physician-Hospital Organizations (PHOs), and so on; or, in the presence of such actions or sanctions, nothing that raises a reasonable suspicion of future substandard professional conduct and/or competence. A determination will be based on the nature of the disciplinary action or sanction and other information obtained during the credentialing or recredentialing process.

- No open indictments or convictions, or pleadings of guilty or no contest to a felony; and no open indictments or convictions to any offense involving moral turpitude, fraud, or any other similar offense; or, in the presence of such history, nothing to raise a reasonable suspicion of future substandard professional conduct and/or competence.

- No other significant information that might indicate a reasonable suspicion of future substandard professional conduct and/or competence.
HEALTH DELIVERY ORGANIZATIONS (HDOS)

The term HDO includes, but is not limited to acute care hospitals, home health agencies, skilled nursing facilities, nursing homes and free-standing surgical centers as well as behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

To assess whether participating Anthem network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, all participating HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare or the appropriate state oversight agency for that HDO.

HDOs that lack accreditation are subject to individual review by the CC, and are credentialed or recredentialed only when a committee review indicates that there are no deficiencies noted by Medicare or state oversight review that would adversely affect quality of care or patient safety.

The Plan will consider accreditation from the following oversight organizations. Acceptable standards are noted after each type.

Medical Facilities

<table>
<thead>
<tr>
<th>Facility Type (Medical Care)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
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<tbody>
<tr>
<td>Acute Care Hospital</td>
<td>JCAHO, HFAP</td>
</tr>
<tr>
<td>Ambulatory Surgical Centers</td>
<td>JCAHO, HFAP, AAPS, AAAHC, AAAASF</td>
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</tbody>
</table>
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<table>
<thead>
<tr>
<th>Facility Type (Behavioral Health Care)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital—Psychiatric Disorders</td>
<td>JCAHO</td>
</tr>
<tr>
<td>Residential Care—Psychiatric Disorders</td>
<td>JCAHO, CARF</td>
</tr>
<tr>
<td>Partial Hospitalization/Day Treatment—Psychiatric Disorders</td>
<td>JCAHO or CARF for programs associated with an acute care facility or Residential Treatment Facilities.</td>
</tr>
<tr>
<td>Intensive Structured Outpatient Program—Psychiatric Disorders</td>
<td>JCAHO for programs affiliated with an acute care hospital or health care organization that provides psychiatric services to adults or adolescents. CARF if program is a residential treatment center providing psychiatric services.</td>
</tr>
<tr>
<td>Acute Inpatient Hospital—Chemical Dependency/Detoxification and Rehabilitation</td>
<td>JCAHO</td>
</tr>
<tr>
<td>Acute Inpatient Hospital—Detoxification Only Facilities</td>
<td>JCAHO</td>
</tr>
<tr>
<td>Residential Care—Chemical Dependency</td>
<td>JCAHO, or CARF</td>
</tr>
</tbody>
</table>

Behavioral Health
## Partial Hospitalization/Day Treatment—Chemical Dependency

| JCAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; | CHMPUS or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents. |

## Intensive Structured Outpatient Program—Chemical Dependency

| JCAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; | CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents. |

New HDO applicants will submit a standardized application to Anthem for review. If the candidate meets Anthem’s screening criteria, the credentialing process will commence. Recredentialing of HDOs occurs at least every three years, unless otherwise required by regulatory or accrediting bodies.

Each Health Delivery Organization (HDO) applying for continuing participation in the Plan’s programs or networks must complete and submit Anthem’s applicable recredentialing application, along with all required supporting documentation. Supporting documentation includes:

- The application materials sent by Anthem include, at a minimum, the following:
  - Cover letter
  - Application
  - Attestation form
• In completing the application, each HDO must disclose the existence of, and provide explanations for, the following:
  - Instances in which the HDO has been the subject of any disciplinary review or action by any state licensing board
  - Instances in which the HDO’s malpractice insurance has been terminated, denied, suspended or limited
  - Convictions of HDO officers, whether as a result of a guilty plea, a plea of no contest or a verdict of guilty, of a felony, any offense involving fraud, or any offense related to the practice of healing arts
  - Instances in which the facility has been sanctioned or debarred from Medicare, Medicaid, or the FEHBP
  - Additional information requested by Anthem to explain or provide details regarding responses obtained on the credentialing application

• All HDO applications must include a signed and dated Attestation Statement that contains information, including, but not limited to:
  - History of loss of license and felony convictions
  - Current liability insurance coverage
  - The correctness and completeness of the application

• Each HDO must submit, along with the application, the following at a minimum:
  - Current state licenses and certificates
  - Current malpractice insurance face sheet
  - Medicare certification
  - Department of Health survey results, if applicable, or recognized accrediting organization certification

• On request, HDOs will be provided with the status of their credentialing application

• Anthem may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information.
The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.
The recredentialing process incorporates re-verification and the identification of changes in the provider’s licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the provider’s professional conduct and competence. The Plan reviews this information in order to assess whether network practitioners and Health Delivery Organizations (HDOs) continue to meet Anthem’s credentialing standards.

All applicable practitioners and HDOs in the network must be recredentialed at least every three years, unless otherwise required by contract or state regulations.

The following performance indicators are incorporated into the recredentialing process for Primary Care Physicians:

- Information from quality improvement activities (as applicable)
- Member complaints (as applicable)
- Other plan specific data as available and applicable

**Nondiscrimination Policy**

The Plan will not discriminate against any potential candidate on the basis of race, gender, color, religion, national origin, ancestry, sexual orientation, age, veteran status, marital status, service to high-risk populations or specialization in the treatment of costly conditions.
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REDUCTION, SUSPENSION OR TERMINATION OF HEALTH CARE PROFESSIONAL STATUS

A practitioner’s or HDO’s participation in the Plan’s programs or networks may be suspended or terminated for any lawful reason, including, but not limited to: failure to meet standard eligibility criteria due to a lapse in basic predetermined credentialing criteria.

Additionally, a practitioner’s or HDO’s participation in the Plan’s programs or networks may be re-assessed if we receive information regarding professional misconduct and incompetence, including, but not limited to a history of professional disciplinary actions, malpractice history, sanctions under Medicare, Medicaid, or the FEHBP; unprofessional conduct; moral turpitude; criminal convictions; reportable malpractice actions; loss or reduction of malpractice insurance; or other events reasonably calling into question the practitioner’s or HDO’s ability, capacity or intent to deliver efficient, quality patient care.

Actions adverse to a practitioner’s or HDO’s continued participation in the Plan’s programs or networks that are not based on concerns related to professional qualifications are not addressed in this policy, except to the extent that such practices may have been determined to be unprofessional conduct and/or incompetence by the CC. Examples of such actions are unsatisfactory business or billing practices.

Additionally, whenever a practitioner’s or HDO’s conduct requires that immediate action be taken, as the practitioner’s or HDO’s continued participation in the Plan’s programs or networks poses an imminent risk of harm to our members, or if the practitioner’s license is suspended or revoked, a process for immediate suspension may be invoked.
In such instances of imminent danger, the Chair of the CC and/or the brand medical director or designee, after consultation with legal counsel, may terminate the practitioner’s participation in the Plan’s programs or networks, effective immediately on the date of notice to the practitioner or HDO and pending investigation. The investigation may occur in an expedited time frame. The practitioner or HDO will be sent a written statement, by certified mail, of this decision. The practitioner or HDO has the right to appeal, but participation may not be reinstated during the appeals process.

If, on a recredentialing review or off-cycle review, the CC renders a decision of suspension or termination for cause, we will notify and advise the practitioner or HDO of the right to appeal the determination. If the practitioner or HDO invokes the right to appeal, we will provide the practitioner or HDO an appeal, in accordance with procedure set forth in the Credentialing Policies. If the practitioner or HDO does not invoke the right to an appeal, or the appeals process upholds the CC’s decision to suspend or terminate, the practitioner or HDO, along with appropriate internal Anthem departments, will be notified. The practitioner’s or HDO’s termination will become effective within 90 days of the date of the notification of termination.

It is the intent of the Plan to give each previously credentialed participating provider the opportunity to contest any decision of the CC to suspend or terminate that provider’s participation in one or more of Anthem’s networks or programs, and to provide an appeal and review process. Summary suspensions may be imposed due to the provider’s suspension or loss of licensure; criminal conviction; Anthem’s determination that the provider’s continued participation poses an imminent risk of harm to Anthem members or if the provider is convicted of fraud, and may be subject to the appeal process—to the extent that the suspensions deal with issues of professional conduct and competence.

The practitioner has the right to request the initiation of the appeals process when denial, termination or nonrenewal of the agreement is made for one of the following reasons:

• Medical disciplinary cause or reason: an aspect of a practitioner’s competence or professional conduct may be detrimental to patient safety or the delivery of patient care
• Conduct or professional competencies of the practitioner affect, or could adversely affect, the health or welfare of a patient

**Notice and Request for First-Level Review**

**Notice**

On decision by the CC to terminate a provider’s participation with the Plan’s programs or networks, the Credentialing staff notifies the provider by certified letter of the decision.

• The letter contains the reason for the decision, a statement that the provider has the opportunity to appeal the decision, and a summary description of the review process described below.

• The letter also states that if the provider desires an appeal, the provider must submit, within the 30-calendar day period immediately following the date of receipt of the letter (unless otherwise required by state regulation), a written request to the CC for a review of the decision, along with any additional information the provider wants to be considered.

• The CC may afford additional privileges to the practitioner or HDO, such as by way of example only, an opportunity to discuss the decision telephonically or in person with the Credentialing Committee.

**Request for First-Level Review**

The provider may request a first-level reconsideration/informal review of the CC’s decision, if it is adverse to the provider.

This request must be in writing and be received by the Credentialing Department within the 30-calendar day period immediately following the date of the provider’s receipt of the letter from the Plan (unless otherwise required by state regulation) with its determination based on the CC’s results.
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First-Level Review

As a reconsideration, any additional information provided by the practitioner or HDO subsequent to the initial decision of the CC will be presented to the committee for its consideration. The CC will review the information obtained during the credentialing process and the basis for its initial decision, along with any additional information submitted by the practitioner. This review may take place at regularly scheduled CC meeting or at a special review meeting. The Plan may have credentialing staff, network service representatives and legal representatives present for the first-level review as non-voting members.

Review Results

The CC reports its decision on the first-level review to the Credentialing department within 5 business days of its decision. The Credentialing staff notifies the provider, through certified mail, within 14 calendar days of receiving notification of the CC’s decision.

For practitioners or HDOs requesting reconsideration/informal review of a denial for initial participation in the Plan’s networks this is the final level of review, unless the Plan action is to be reported to the National Practitioner Data Base (NPDB). Whenever an action is to be reported to the NPDB, the practitioner will be afforded the right to a Formal Hearing.

Second-Level Appeal Process

The Second-Level Appeal Process includes a Formal Hearing, the Hearing Procedures, Review Results, any Additional Review Processes and Reporting Final Adverse Actions.

Formal Hearing, On Request

As a second level of review, the provider who has been terminated from the network may request a formal hearing. This request must be in writing and received by the Credentialing Department, by certified mail, within the 30-day period immediately following the date of the provider’s receipt of the letter from the Plan
with its determination, based on the first-level review results. If a provider requests a hearing in a timely fashion, then follow the procedures below:

- The Credentialing staff notifies the Plan’s medical director and the Plan’s legal counsel of the provider’s request for a hearing

**Hearing Panel**

The Plan’s medical director, or designee, selects the members of the hearing panel.

- The hearing panel is comprised of at least three practitioners not involved in the original decision
- No person who is in direct economic competition with the provider may serve on the hearing panel
- At least one of the hearing panel members is a participating provider who is a clinical peer
- The hearing panel is chaired by the Plan’s medical director, or designee, who is entitled to vote and be counted as a member of the hearing panel

**Hearing Notice**

Within 30 business days of receipt by the Plan of a provider’s request for a Formal Appeal, the Credentialing staff sends a certified letter notifying the provider of the date, time and place of the formal hearing, summarizes the hearing procedures and includes a list of the witnesses (if any) expected to testify at the hearing on behalf of the Plan. Such notice also states that the provider forfeits (that is, waives) his, her, or its right to a hearing, if the provider fails to attend the hearing (either in person or by telephone) without good cause.

- In advance of the hearing, the Credentialing staff gives each hearing panel member a copy of the suspension and/or termination letter originally sent to the applicable provider; the panel members will also be provided with any other material deemed relevant by the Plan at or in advance of the hearing.
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Hearing Date

The hearing date will not be less than 30 nor more than 60 calendar days after the date of the notice, which will provide the date, time and place of the formal hearing, given to the provider; or as otherwise agreed to by the Plan and the affected provider.

Hearing Procedures

• The chairperson of the hearing panel, who is the Medical Director or his/her designee, opens and runs the hearing by stating the purpose of the hearing and the procedure that will be followed

• During the hearing, the provider has the right to:
  ■ Representation by an attorney or other person of the provider’s choice
  ■ Call, examine, and cross-examine witnesses
  ■ Present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law
  ■ Submit a written statement at the close of the hearing
  ■ Have a record made of the proceedings, copies of which may be obtained by the provider on payment of any reasonable charges associated with the preparation thereof
  ■ Receive, on completion of the hearing, the written recommendations of the panel, including a statement of the basis for the recommendations and a written decision from the Plan, with a statement of the basis for the decision

• A representative of the Plan presents the reasons for the CC’s decision to suspend or terminate the applicable provider

• The provider presents reasons why his or her participation should not be suspended or terminated

• Before the close of the hearing, each side may briefly summarize its position for the hearing panel, if it chooses
The hearing panel meets privately after the hearing to reach a decision
- The hearing panel has the authority to uphold, reject, or modify the original decision based on the preponderance of evidence presented at the hearing
- The decision must be reached by a majority vote

The hearing panel prepares a written account of its decision, stating the reasons for its decision.

Review Results

The Plan’s medical director reports the decision of the hearing panel to the Credentialing department within 5 business days of receipt of the decision; the Credentialing staff notifies the provider, by certified mail, return-receipt requested, within 10 calendar days of receiving notification from the medical director of the hearing panel's decision, including a statement of the basis for the decision.

Additional Review Processes

If additional review processes, beyond the initial hearing, are mandated by state regulation or accreditation organizations, the same process for the second-level review will be followed; however, the appellate review body will be held to the standard of review described below.

Standard of Review

For any subsequent reviews following the initial hearing, the appellate review body reviews the Initial Hearing Panel Report and all subsequent results and actions thereon; the appellate review body also considers any written statements submitted by the provider to determine whether the adverse determination was justified and not arbitrary or capricious.

Reporting Final Adverse Actions

The Plan reports any final adverse actions to the state licensing board or other appropriate agency, in accordance with the Credentialing Policies.
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Notification

The provider making the appeal is notified, through registered mail, within 15 calendar days of the final determination.

If, at the final level of appeal, the determination is made to uphold the adverse action, the provider, and appropriate internal Anthem departments, will be notified of the action. Except in cases of immediate suspensions the action will be effective 90 calendar days from the date of the determination.
THE CAQH UNIVERSAL CREDENTIALING DATASOURCE

The Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource is a Web-based service that streamlines the credentialing process and simplifies administration for physicians and other health care practitioners. CAQH, in collaboration with Anthem Blue Cross and Blue Shield (Anthem) and other health plans and health care organizations, developed Universal Credentialing DataSource to reduce the redundancy and administrative work associated with the credentialing process.

Types of Practitioners Included in this Service

Currently, the service is available to all licensed practitioners. The service is not available to HDOs.

Only non-delegated, non-hospital-based practitioners are included at this time (that is, practitioners who are credentialed directly by the health plan).

The Benefits of this Service to Practitioners

Benefits of this service to practitioners include the following:

- The service is a one-stop shop for credentialing submissions; practitioners only need to enter their credentialing information once for all initial and recredentialing events with Anthem or any other participating organization
- The service is free of charge to the provider
- The credentialing application submission process includes sophisticated security and confidentiality procedures, including passwords and powerful 128-bit Secure Socket Layer (SSL) encryption; this is the same type of security features used in the banking industry
CAQH will not disclose data to anyone without the practitioner’s permission

- The Practice Administrator Module will help the practitioner’s office staff enter information that may be redundant across multiple practitioners in a single practice location (such as, practice location details, hospital privileges, and malpractice policy information)

**Universal Credentialing DataSource Contact Information**

The CAQH Help Desk provides telephone service support Monday through Friday, 5 a.m. to 5 p.m. to provide assistance with any questions the practitioner may have. The CAQH Help Desk can be contacted by calling 888-599-1771 or by e-mail at help@caqh.geoaccess.com. Practitioners may also contact the Anthem Network Development Department at 800-455-6805 for assistance.
CREDENTIALING POLICIES AND PROCEDURES

This list includes the names and policy numbers (for reference purposes) of the pertinent policies for the credentialing process:

- **Credentialing Program Structure**: This policy describes the Anthem National Credentials Committee, composed of brand medical directors and chaired by the VP of Medical and Credentialing Policy; this group has oversight of matters relating to the policies used in the Credentialing Program (Credentialing Policy 1)

- **Credentialing Program Scope**: This policy specifically details which providers fall within the scope of the Credentialing Program (Credentialing Policy 2)

- **Credentials Committee (Geographic)**: This committee describes the geographic composition of the Credentials Committees that perform individual peer review of all applicants for initial and continued network participation; the policy also relates the operational rules for the committees (Credentialing Policy 3)

- **Professional Competence and Conduct Criteria**: This policy outlines the various standards of conduct and competence, and the data elements required for network participation (Credentialing Policy 4)

  **Behavioral Health Practitioner (non-physicians)–Education Criteria**: This policy establishes eligibility criteria related to education and training for Behavioral Health practitioners (Credentialing Policy 4.1)

- **Initial Application**: This policy establishes the elements needed in the initial application, as well as the attestation requirement (Credentialing Policy 5)
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• **Verification of Data Elements**: This policy details the acceptable sources for verification of the various elements required to complete the credentialing process (Credentialing Policy 6)

Distribution of Appropriate Information Regarding Specialty: This policy outlines the process for accurate information flow regarding provider training and specialty (Credentialing Policy 6.1)

• **Site Visits**: This document relates the site visit process and comments on the providers for which this process applies (Credentialing Policy 7)

• **Criteria for Selecting Practitioner–Credentialing Leveling and Committee Presentations**: This policy provides the specific criteria that dictates applicants for both initial and continued participation will be presented for individual review by the CC; it also outlines the process for off-cycle review (Credentialing Policy 8)

• **Health Delivery Organizations**: In this policy, the criteria and scope of the credentials processes, relative to HDOs, are outlined (Credentialing Policy 9)

• **Recredentialing**: Recredentialing issues, including requirements, frequency and the decision-making processes, are relayed in this document (Credentialing Policy 10)

• **Termination and Immediate Termination**: This policy discusses the process for summary suspension and other terminations (Credentialing Policy 11)

• **Reporting of Adverse Actions**: This policy describes the mechanisms for compliance with regulatory requirements and reporting to appropriate agencies (Credentialing Policy 12)

• **Ongoing Monitoring**: In order to support the maintenance of standards of professional conduct and competence, ongoing, continuous monitoring of sanctions and complaints occurs; the principles and mechanisms governing this activity are described in this policy (Credentialing Policy 13)

• **Appeals**: This policy establishes the mechanism available to providers who want to appeal a CC’s determination (Credentialing Policy 14)

• **Appeals for HDOs**: Establishes a mechanism available to providers who want to appeal a Credentialing Committee determination (Credentialing Policy 15)
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• **Re-Application After Adverse Determination (Denial or Termination):**
  This operational policy establishes the time frames when re-application to the
  network can occur following a negative determination by the CC (Credentialing
  Policy 16)

• **Practitioner Physical and Mental Health Conditions and Impairments:**
  This policy provides a framework for assessing providers with potential
  impairments (Credentialing Policy 17)

• **Credentialing of Nurse Practitioners, Nurse Midwives and Physician’s
  Assistants:** This policy is invoked when there is a specific request by the
  business unit to use these provider types and to list them in the directories.
  Requirements for each type of provider are detailed. These provider types are to
  be credentialed only at the specific request of the business unit (Credentialing
  Policy 18)

  **Credentialing of Resident Physicians:** The requirements and processes for
  the credentialing of physicians in residency programs are outlined in this policy.
  This policy is invoked when there is a specific request by the business unit.
  Note: This applies only when a business unit wants to list a residency program
  or residents in directories. It is invoked only in those circumstances. It does not
  imply or suggest the routine credentialing of residents or fellows (Credentialing
  Policy 18.1)

• **Specialty Designations:** The framework for recognized training programs and
  requirements for various specialty and subspecialty designations (Credentialing
  Policy 19)

• **Delegation:** The principles and practices governing the delegation of any
  credentialing related activity are discussed in this series of policies
  (Credentialing Policy 20)
  - Revocation of Delegation (Credentialing Policy 20.1)
  - Individual Providers Leaving Delegated Arrangements (Credentialing
    Policy 20.2)
  - Interim Assessments for Plan not Requiring Full File Audit (Credentialing
    Policy 20.3)