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MANAGED CARE CREDENTIALING

Compliance Strategies for Health Plans, CVOs, and Delegated Entities

Amy M. Niehaus, MBA, CPMSM, CPCS

Managed Care Credentialing: Compliance Strategies for Health Plans, CVOs, and Delegated Entities

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Managed Care Credentialing: Compliance Strategies for Health Plans, CVOs, and Delegated Entities is published by HCPro, a Simplify Compliance brand.

ISBN: 978-1-68308-965-0
Product Code: CFMC2

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About the Author

Amy M. Niehaus, MBA, CPMSM, CPCS

Amy M. Niehaus, MBA, CPMSM, CPCS, is a credentialing and medical staff services consultant with over 25 years' experience in the industry. She advises clients in the areas of accreditation, regulatory compliance, credentialing, privileging, process simplification/redesign, credentialing technology, CVO development and certification, enrollment, and delegation.

Niehaus has been a member of the National Association Medical Staff Services (NAMSS) since 1991 and is dual-certified as a Certified Professional Medical Services Management (CPMSM) and a Certified Provider Credentialing Specialist (CPCS). She has served as a NAMSS Instructor since 2010, presenting CPCS and CPMSM certification programs and developing new content for NAMSS education programs. She has served in other NAMSS roles, including chair of its MCO Task Force, chair and member of the Education Committee, and independent study program editor. She was awarded the Joan Covell-Carpenter award in 2003 for her *Synergy* article entitled "Physician Credentialing Guide." She is also a former president of the Missouri Association Medical Staff Services and the Greater St. Louis Area Chapter.

Niehaus has been a speaker and educator since 2000. She has developed and presented various programs to state and national audiences on credentialing and privileging processes; The Joint Commission, NCQA, and URAC accreditation standards and survey preparation; CVO certification; provider enrollment; and delegation. She has authored and contributed to a variety of industry-related publications, including NAMSS *Synergy*, The Greeley Company, Credentialing Resource Center, AHLA MedStaff News, and *Becker's Hospital Review*. She is the author of the HCPro book *Credentialing for Managed Care: Compliant Processes for Health Plans and Delegated Entities*.

Niehaus has worked in multiple environments throughout her career, including acute care hospitals, CVOs, and managed care organizations, which have provided her with unique and diverse insight into all facets of the medical staff services and credentialing profession. She has held numerous management roles culminating as a director of credentialing for a national health benefits organization. Since 2014, she has utilized her knowledge and experience as a consultant to support numerous clients within the healthcare industry. She holds a Bachelor of Science degree from the University of Missouri and a Master of Business Administration from Maryville University in St. Louis.

Acknowledgments

The author would like to thank and recognize the following individuals for their various contributions to this book, including sharing their perspectives within their credentialing areas of expertise, providing tips and lessons learned through their years of experience in the field, providing sample tools and forms, and/or reviewing components of the book for accuracy and relevance in today's healthcare environment:

Keith R. Boyd, MHA
President/Owner, SourceOne CVO

Carrie L. Bradford, MHA, RHIA, CPMSM, CPCS
Senior Director, Professional Staff Services and Credentialing, NorthShore University Health System

Carol S. Cairns, CPMSM, CPCS
President, PRO-CON
Senior Consultant, The Greeley Company

Pamela L. Gilbert, CPMSM, CPCS
Manager, Provider Enrollment and Life Cycle, Priority Health

Vickie Hawkins, CPCS, CPMSM

Patricia T. Lowman, MHA, CPMSM, CPCS, CHQM-MC
Director, PremierHealth Medical Staff Services and CVO

Michael R. Myers
President, ICE Board of Directors
President and CEO, Dignity Health Management Services

Shannon Rochon, CPCS
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President, Washington Association Medical Staff Services
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Emilia Webster, CPMSM, CPCS
Director, Provider Affairs, Henry Ford Health System
Michigan Association Medical Staff Services, Health Plan Representative

Introduction

The world of credentialing has expanded dramatically over the past few decades. Initially, medical services professionals (MSP) primarily worked in standalone hospitals and didn't need to know about the credentialing activities in other organizations, such as managed care organizations (MCO) and health plans, because, for the most part, those activities did not impact their roles and responsibilities. The same held true for MCOs, which focused on developing products and networks to provide covered healthcare services to its members. Each organization worked within its own silo and performed its credentialing activities in accordance with its own accrediting and regulatory requirements.

But then the healthcare environment started to change. Many hospitals became part of larger healthcare systems, patient care services extended outside of the hospital to outpatient clinics and surgery centers, physician/hospital organizations (PHO) and independent practice associations (IPA) were created to form alliances and gain contracting leverage in the marketplace, and hospitals began employing practitioners and assuming responsibility for enrolling them with third-party payers.

Today, we have the perfect storm: Hospital credentialing, managed care credentialing, and delegated credentialing are all coming together onto the same stage. As healthcare systems and hospitals are looking for ways to integrate more fully and achieve greater efficiencies, many hospital medical staff services departments are taking on the additional responsibilities of enrolling employed practitioners and attaining delegated credentialing from commercial payers to improve their organization's revenue cycle.

Now more than ever before, MSPs, credentialing specialists, and enrollment specialists in all healthcare environments need to know more about MCOs and the regulations and standards that drive their credentialing processes. This book was developed to support those MSPs and specialists by providing the information, tools, and techniques they need to succeed in this ever-changing industry. Whether you are a seasoned hospital MSP who is now tasked with integrating provider enrollment or taking on delegated credentialing or someone who needs to learn how to perform credentialing in a health plan, this book was created with you in mind.

This manual will provide readers with the following information:

- An overview of the managed care environment
- An interpretation of the accreditation standards and regulatory requirements that drive the MCO credentialing process
- An understanding of a health plan's credentialing process
- Insight into what delegated credentialing entails for both parties
- The role of credentials verification organizations in delegated credentialing

- Understanding of the various NCQA accreditation programs and survey process
- Opportunities to test knowledge through quizzes and other learning activities
- Industry resources and tools

In addition, readers will benefit from the knowledge and experience of industry professionals, who have provided their own tips, tools, and leading practices to support health plans and MCOs in achieving compliance or to support health systems, hospitals, and provider groups in developing or improving provider enrollment practices or achieving delegated credentialing.

Disclaimer

Please note that this guide is not intended to be the sole source of information for an organization or individual desiring to learn more about the credentialing requirements for MCOs and health plans. It is intended to supplement the applicable accrediting body's standards manual with the experience, perspectives, and knowledge from those working within the industry.

Sources Used for Credentialing Regulations and Accreditation Standards

National Committee for Quality Assurance (NCQA) Health Plan Standards effective 7/1/2019
www.ncqa.org

URAC Health Plan Standards v7.2
www.urac.org

Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

Title 42: Public Health
PART 455—PROGRAM INTEGRITY: MEDICAID
Subpart E—Provider Screening and Enrollment
http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=a29d8c1484a8f28d5938eff29ffa2636&mc=t-rue&n=pt42.4.455&r=PART&ty=HTML

Chapter 1

Overview of the Managed Care Environment

Before we get into the details of how and why insurers credential, let's start with a little background on the managed care environment. First, let's talk about the name. There are many terms used to describe these types of organizations. *Managed care organization* (MCO) has been used throughout the healthcare industry to describe companies that provide healthcare insurance and benefits. Examples include national organizations such as Aetna, Blue Cross Blue Shield, and United Healthcare, as well as regional and local insurers. These organizations are also known as *health plans, health insurers, healthcare benefit companies, third-party payers,* and *commercial payers*. These terms tend to be used somewhat interchangeably within the industry, but throughout this book, the most commonly used terms will be *health plan, MCO,* and *payer*.

Another nuance of the terminology used within the industry is the distinction between *provider* and *practitioner*. The industry tends to use the term *provider* to describe both practitioners and facilities, as it includes all aspects of healthcare delivery, which is relevant to the discussion of health plans. Throughout this manual, *practitioner* will refer to an individual working in healthcare, such as a physician, chiropractor, nurse practitioner, or social worker. The term *provider* will mean healthcare facilities, such as hospitals, surgery centers, pharmacies, durable medical equipment companies, etc., in addition to practitioners.

So, what is *managed care*? According to the U.S. National Library of Medicine, managed care describes "programs intended to reduce unnecessary health care costs through a variety of mechanisms, including:

- Economic incentives to select less costly forms of care by both physicians and patients,
- Reviewing medical necessity of services,
- Increased beneficiary cost sharing,
- Controls on inpatient admissions and lengths of stay,
- Selective contracting with health care providers, and
- Intensive management of high-cost cases"

URAC requirements cover a similar scope of providers as NCQA and essentially require that all practitioners providing covered healthcare services be credentialed. This includes individuals practicing within group practices or outpatient clinics even if they are not individually contracted or listed in directories, such as speech/occupational/physical therapists. Alternative medicine providers such as massage therapists or acupuncturists are also considered to be within the scope for URAC. Like NCQA, URAC excludes hospital-based physicians (e.g., anesthesiologists) who are credentialed by the hospital.

CMS requirements for Medicare Managed Care state that all physicians and other practitioners allowed to practice independently under state law and provide services to the plan's members be credentialed. This excludes hospital-based practitioners (unless they are listed individually to enrollees, such as in a directory) as well as medical students, residents, and fellows. Figure 2.1 is a table that summarizes the credentialing requirements of NCQA, URAC, and CMS.

Figure 2.1 Credentialing Scope Summary

	NCQA	URAC	CMS
Included	• Licensed independent practitioners • Behavioral healthcare practitioners • Hospitals • Surgery centers • Home health agencies • Skilled nursing facilities • Behavioral health facilities	• Licensed independent practitioners • Behavioral healthcare practitioners • Hospitals • Surgery centers • Home health agencies • Skilled nursing facilities • Behavioral health facilities • Speech therapy • Occupational therapy • Physical therapy • Alternative medicine providers	• Physicians • Licensed independent practitioners
Excluded	• Hospital-based practitioners • Dental network dentists • Consultants • Locum tenens • Pharmacists in utilization management-delegated	• Hospital-based practitioners	• Hospital-based practitioners • Medical students • Residents • Fellows

Credentialing criteria

In its policies, a health plan must describe its criteria for credentialing and recredentialing of practitioners within its scope. Such criteria include licensure, Drug Enforcement Administration (and/or state Controlled Dangerous Substances) certification, malpractice insurance, education, training, and board certification. Accreditors do not require specific criteria or define how the health plan must apply its criteria; the organization makes those decisions. For example, what does the health plan want to require to ensure a quality network for its members? Is board certification mandated or optional? What makes sense, based on geographical differences, for malpractice insurance limits or claims history?

A health plan that has a large rural member base may have different requirements when it comes to board certification or malpractice insurance limits, as it may be more difficult to attract and retain practitioners in those areas. At a minimum, health plans must require current licensure in the state in which the practitioner will treat members. We will explore additional criteria later in this chapter.

The credentialing processes that a health plan follows should be described in sufficient detail to ensure compliance with accreditation and regulatory requirements. Although most health plans perform a review process, URAC specifically requires that the credentialing policies describe the process by which the health plan reviews credentialing information for completeness, accuracy, and conflicting information. A health plan can meet this standard by conducting interrater reliability or peer audits, using checklists, or utilizing its credentialing database to run reports. (Also see Chapter 4 for additional review processes.)

Enrollment Tip

Review each contracted health plan's criteria to ensure a complete application is submitted to avoid any unnecessary delays.

Verifications

Each accreditor/regulator has specific requirements regarding verifications. The credentialing policies and procedures should identify the verifications performed as part of the plan's process as well as the sources used. Due to the complexity and details involved with this process, Chapter 3 is devoted to explaining verification.

Confidentiality

Individuals who perform credentialing activities within an organization are expected to maintain the confidentiality of all information obtained during that process—especially information that is not considered publicly available, such as malpractice history, disciplinary actions, and information provided directly by the applicant (e.g., health status). An organization's policies and procedures should describe the processes it uses to ensure that confidentiality is maintained. These processes should address access to the physical credentials file, the credentialing department, and the credentialing database. Those involved with credentialing should receive appropriate training during orientation and again on an annual basis and should also sign a confidentiality agreement on an annual basis.

Chapter 3

Verification Requirements

The purpose of the verification process is to ensure that the information provided by the applicant is accurate and to determine whether the applicant's credentials meet the organization's criteria, as outlined in its policies. Verifications are performed during both initial credentialing and recredentialing, although only those elements subject to change (e.g., licensure) are required to be reverified at recredentialing. Figure 3.1 summarizes the various credentialing elements that must be verified through an appropriate source (either primary or secondary source accepted) and the associated time frames required by the regulatory and accreditation bodies impacting managed care credentialing. More details about each of these elements will be provided throughout this chapter.

Verification Time Frames

Establishing specific time frames for obtaining verifications ensures that decisions are based on current information. Compliance with National Committee for Quality Assurance (NCQA) health plan verification time frames is measured by counting backward from the date of the medical director's or credentialing committee's decision. For example, if the health plan made its decision on July 14, 2019, the license, board certification, claims history, license sanctions, and Medicare/Medicaid sanctions must have been verified no earlier than January 15, 2019. For the application, attestation, and work history, the information must have been received no earlier than July 14, 2018. URAC measures its six-month time frame from month/year to month/year. For example, a verification obtained any time in January 2019 is current through July 31, 2019.

These time frame requirements are often misinterpreted to mean that the entire credentialing process has to be completed within 180 days, but that is not the case. If a verification date goes beyond 180 (or 365) days and a decision has not yet been made, then the organization must simply reverify that credentialing element prior to making a final decision. With most verification data available through the Internet, the credentialing process typically takes much less time to complete than the accreditors' verification time frames allow.

Figure 3.1 Verification Summary of NCQA, URAC, and CMS (Medicare Advantage)

Verification element	Credentialing cycle	Time frame (Days are measured in calendar days)		
		NCQA	URAC	Medicare Advantage
License (current)	Initial credentialing Recredentialing	180 days	6 months	6 months
DEA or CDS (current)	Initial credentialing Recredentialing	Prior to decision	6 months	6 months
Education and training	Initial credentialing	Prior to decision	6 months	6 months
Board certification, if applicable	Initial credentialing Recredentialing	180 days	6 months	6 months
Primary facility admitting privileges	Initial credentialing Recredentialing	N/A	N/A	6 months
Work history	Initial credentialing	365 days	180 days	6 months
Malpractice insurance	Initial credentialing Recredentialing	365 days (via application/ attestation)	6 months	6 months
Malpractice liability claims	Initial credentialing Recredentialing	180 days	6 months	6 months
License sanctions	Initial credentialing Recredentialing Ongoing	180 days	6 months	6 months
Medicare/Medicaid sanctions	Initial credentialing Recredentialing Ongoing	180 days	6 months	6 months
Medicare opt-out	Initial credentialing Recredentialing Ongoing	N/A	N/A	6 months
Application/Attestation	Initial credentialing Recredentialing	365 days	180 days	6 months
Authorization	Initial credentialing Recredentialing	N/A	180 days	N/A
Preclusion list	Initialing credentialing Ongoing	N/A	N/A	30 days

Figure 4.1 Options for Addressing Practitioner Quality Issues

Documentation required	Level of review	Steps taken after discovery
• Copy of report • Name of verifier • Type of sanction or complaint • Date of sanction or complaint • Date of discovery	• Medical director • Credentialing committee chair • Credentialing committee	• Contact practitioner to confirm identity, if needed • Obtain additional information, if necessary • Notify medical director • Perform office site visit • Refer to credentialing committee • Implement corrective action plan • Immediate suspension/termination

Office site quality

In June 2016, NCQA retired its office site quality standard, meaning it will no longer assess health plans' compliance with this requirement for the purpose of accreditation. However, a health plan may still perform office site visits to assess whether practice locations meet quality, safety, and accessibility standards, as dictated by a health plan's policies or to adhere to more stringent requirements set forth by state Medicaid agencies if offering managed Medicaid networks. In addition, state regulations may require health plans to perform site visits at initial credentialing and at recredentialing.

An office site review may be warranted when the health plan receives member complaints or an adverse event occurs. Health plans may also identify issues or concerns based on information received through member satisfaction surveys or from routine office visits by network management or provider relations staff.

Typically, these site standards include physical accessibility and appearance, adequacy of waiting and exam room space, and adequacy of medical records kept by the office. The health plan may utilize a standardized site visit tool that incorporates its criteria and elements to be evaluated during a review, which would be completed at the time of or shortly after a site visit. This tool may address questions, such as the following:

- Office site criteria
  - Is it handicap accessible?
  - Is it clean?
  - Are there adequate seats in the waiting room?
  - Are the office hours posted?
- Medical records
  - Are they legible?
  - Are records maintained in a secure and confidential manner?
  - Can a specific member's record be easily located upon request?

It is important for the health plan to ensure that its reviewers are trained in the specific criteria so that practitioner offices are evaluated in a standard and consistent manner. Health plans may also consider contracting with a vendor to perform site visits on their behalf. A plan may have difficulty maintaining the level of experience and skill set within its own organization due to the variability in circumstances that warrant site visits. See the Appendix for a sample office site quality tool.

Tip

Be sure to check for state regulations that may require site visits to be performed at initial credentialing and recredentialing.

Recredentialing

At least every three years, the health plan must recredential its participating practitioners within the credentialing scope. The recredentialing process typically begins anywhere from three to six months prior to a practitioner's expiration date, depending on a plan's operational efficiency and use of technology. The process is very similar to the initial credentialing process in the use of an application form and performing verification of credentialing elements, with the focus on updating and reviewing information that is subject to change. (Refer to Chapter 3 for details.) In addition, CMS (Medicare) and URAC require health plans to incorporate practitioner performance information, although most health plans will include this information regardless of any regulatory or accreditation requirement. A profile may be created to report the practitioner's complaints, site visits, and any quality or utilization data collected over the past three years. The same review and decision-making process used in the initial credentialing process applies to the recredentialing process.

In order to complete the recredentialing process within the three-year cycle, the practitioner must return the required information in a timely manner. Health plans may expect the recredentialing application to be returned within 30 days of receipt of the request or no later than 60 days prior to the recredentialing expiration. Most often, a reminder request or two will be sent for delinquent responses. Depending on the health plan's requirements for sufficient notification of termination, it may also establish a process to notify the practitioner within the final request that participation will be terminated on the date that his or her credentialing expires. In the event that a practitioner is terminated for not submitting an application or completing the recredentialing process, the plan does not need to report this administrative action to the NPDB, as it is not related to quality of care.

Tip

If it is identified during recredentialing that a practitioner is on a leave of absence, ensure that there are timely communications to temporarily remove the practitioner from the member directory until such time that the recredentialing process can be completed upon his or her return to practice.

If the participating practitioner has maintained his or her data in the CAQH database, has a current attestation, and continues to authorize access to the health plan, the application can simply be pulled and processed. If all information is available to the plan, recredentialing can many times be completed without the practitioner even realizing it, thus reducing the impact and burden on the practitioner and office staff.

Appeals

The health plan must offer an appeal process to practitioners for any adverse decision it makes regarding a participating practitioner with quality of care issues. An adverse decision may include limitation, suspension, or termination, based on the plan's review of objective evidence and consideration of the impacts on patient care. At a minimum, the appeal process must comply with the Health Care Quality Improvement Act (HCQIA) of 1986, as well as with any relevant state regulations. As a reminder from Chapter 1, HCQIA provides immunity to organizations for conducting a peer review process in good faith. Details of the appeal process may vary widely among health plans, and health plans are highly encouraged to involve legal counsel in developing these processes to ensure that they comply with all federal and state regulations, in addition to accreditation requirements.

If the appeal process results in a final adverse determination, the health plan must take the appropriate steps to notify the appropriate authorities, such as the NPDB and state licensing board. The reports will become a permanent part of a practitioner's record, so legal counsel should review them before they are submitted to ensure that they appropriately reflect the issue and rationale for the action taken.

The health plan must have policies and procedures that describe when and how reporting occurs, to whom incidents are reported, and what specific incidents are reportable. The policy does not have to name the individual responsible for reporting, but it must address what is expected of the organization's staff and outline accountability so that staff understand their responsibilities in order to perform their functions correctly.

Tip

If a provider is terminated for a business or administrative reason, such as failing to provide recredentialing materials in a timely manner, the health plan is not required to offer a formal appeal process. However, the plan may offer some type of recourse to the provider through its policies and procedures. For example, it may allow a specific time frame in which the practitioner can rectify the administrative lapse and remain within the network.

Differences From Hospital Credentialing

The operational process of credentialing a practitioner to participate in a health plan's network has some similarities to a hospital's credentialing processes; however, there are also important distinctions. Figure 4.2 highlights some of the key differences between health plan credentialing and hospital credentialing, using NCQA and Joint Commission standards, respectively.

Figure 4.2 Differences Between Health Plan Credentialing and Hospital Credentialing

	NCQA (health plan)	The Joint Commission (hospital)
Element		
Education and training	Highest level of education or training is verified, unless board certified	All relevant education and training are verified
Peer references	Not required	Required at initial appointment/ granting of privileges
Malpractice history	Verify minimum of past 5 years	As defined in bylaws or policy
Time limits	Applicable for verifications and notification to applicant of final decision	As defined in bylaws or policy
Privileging	Not applicable	As applicable
Final decision-making authority	Credentialing committee (or designated medical director)	Governing body
Recredentialing/reappointment cycle	At least every 3 years	Not to exceed 2 years

Chapter 8

Test Your Knowledge

This chapter is dedicated to testing your knowledge of credentialing for managed care through quizzes, case studies, and other learning activities.

Chapter 1: Overview of the Managed Care Environment

- Quiz

Chapter 2: Accreditation and Regulatory Requirements

- Quiz
- Match game

Chapter 3: Verification Requirements

- Quiz
- Case study 1

Chapter 4: The Credentialing Process

- Quiz
- Case study 1

Chapter 5: Delegated Credentialing

- Quiz
- Case study 1
- Case study 2
- Case study 3
- Delegated credentialing agreement review activity
- File audit activity

Chapter 6: Credentials Verification Organizations

- Quiz

Chapter 7: NCQA Accreditation

- Quiz

Chapter 3: Verification Requirements

Quiz questions

1. Why are education/training and work history not verified at time of recredentialing?

2. ***True or false:*** CMS requires that health plans with Medicare Advantage products query the System for Award Management.

3. Which of the following data sources is acceptable for obtaining license sanction information for nonphysician behavioral health providers?

   a. Chiropractic Information Network/Board Action Database (CIN-BAD)

   b. Federation of State Medical Boards (FSMB)

   c. American Medical Association (AMA)

   d. National Practitioner Data Bank (NPDB)

4. An applicant attests on his application that his malpractice insurance coverage limits are $0. The health plan credentials the applicant with this information. Is this compliant with NCQA?

5. ***True or false:*** Licensure is required to be primary source–verified.

6. Which of the following verifications does NCQA require for a non-board-certified interventional cardiologist?

   a. Medical school

   b. Internship

   c. Residency

   d. Fellowship

7. Time limits are placed on the verifications for what purpose?

   _____

   _____

8. ***True or false:*** Using the ABMS "Certification Matters" link on its website is considered a primary source.

9. Verification of hospital admitting privileges may be required by:

   a. NCQA

   b. URAC

   c. CMS

   d. Not required

10. ***True or false:*** Querying the National Practitioner Data Bank meets the minimum requirement to verify the past five years of malpractice history.

Quiz answers

1. **At recredentialing, only information that is subject to change is required to be verified.**
2. **False**
3. **d**
4. **Yes, but only if the health plan's credentialing policy does not require malpractice coverage.**
5. **True**
6. **c**
7. **Time limits are used so that health plans make credentialing decisions based on reasonably current information.**
8. **False**
9. **c**
10. **True**

Appendix

Appendix 5 Washington State Practitioner Application

- **Keep an unsigned and undated copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate.
- Please sign and date pages 11 and 13 .
- Please document any YES responses on the Attestation Question page.
- Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- Attach copies of requested documents each time the application is submitted.
- If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- If a section does not apply to you, please check the provided box at the top of the section.
- Expect addendums from the requesting organizations for information not included on the WPA.

This application is submitted to:

1. INSTRUCTIONS

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered. *Please do not use abbreviations*. **Current copies of the following documents must be submitted with this application:** (all are required for MDs, DOs; as applicable for other health practitioners).

- DEA Certificate
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application. Dates need to be listed in mm/yyyy Format)

**** All sections must be completed in their entirety. ****

2. PRACTITIONER INFORMATION – Legal Name Required

Last Name: (include suffix; Jr., Sr., III)	First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions:			
Home Mailing Address:		City:	
		State:	Zip Code:
Home Telephone Number: ( )	Pager Number: ( )	Cell Phone Number: ( )	E-Mail Address:
Birth Date: (mm/dd/yyyy)	Birth Place (city, state, country):		Citizenship:
Social Security Number:	☐ Male ☐ Female	Languages Fluently Spoken by Practitioner:	
Have you ever voluntarily opted-out of Medicare? Yes☐ No ☐			
NPI:	Medicare Number: (WA)	Medicaid (DSHS) Number(s):	L & I Number(s):
Specialty primarily practicing:		Sub specialties primarily practicing:	
Other Professional Interests in Practice, Research, etc.:			

Appendix 5 Washington State Practitioner Application (cont.)

3. PRACTICE INFORMATION CHECK ALL THAT APPLY			
Effective Date at Primary Practice location (MM/YY) _____ **Practice Setting** ☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐ Primary Care Site ☐ Urgent Care ☐Other			
Practitioner Profile ☐ PCP ☐ Specialist ☐ Check if you are both PCP & OB OB in your practice ☐ Yes ☐ No Deliveries ☐ Yes ☐ No			
Name of Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:		
	State:	Zip Code:	Org. NPI#:
Patient Appointment Telephone Number: ( )	Fax Number: ( )		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Practice Website			
Office Manager / Administrator Name:	Administration Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Credentialing Contact (if different from above):	Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		
Is the office wheelchair accessible? ☐Yes ☐No Are you accepting new patients? ☐Yes ☐No Have you limited your practice in any way (e.g. 18 years or older?) ☐Yes ☐No If yes, please explain: _____ _____ Do you currently supervise ARNP's or PA's? ☐Yes ☐No If yes, please provide the name and specialty below: _____ _____ Please list languages fluently spoken by office staff: _____ _____	Office Hours Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday:_____ Do you provide 24 hour coverage? ☐Yes ☐No If no, please explain how your patients obtain advice and care after hours: _____ _____		

A. Inpatient Coverage Plan (for those without admitting privileges)	**Does Not Apply** ☐
Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

B. Covering Practitioners/Call Group			**Does Not Apply** ☐
Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional covering practitioners if needed

MANAGED CARE CREDENTIALING

Compliance Strategies for Health Plans, CVOs, and Delegated Entities

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The role of the MSP is expanding to include payer enrollment and delegated credentialing responsibilities for managed care organizations. Traditionally siloed, MSPs are now beginning to take on both responsibilities, which means they must learn the nuances of managed care credentialing as well as the regulatory and accreditation requirements of NCQA, CMS, and URAC.

Managed Care Credentialing: Compliance Strategies for Health Plans, CVOs, and Delegated Entities provides the answers to MSPs' inevitable questions as they begin to manage the tasks of payer enrollment and delegated credentialing. Author **Amy M. Niehaus** guides readers through each payer's requirements, the differences between hospital and managed care credentialing, and how to help their organization establish delegated credentialing agreements and prepare for audits.

Whether you are new to managed care credentialing or are taking on delegated credentialing responsibilities, this book will help you:

- Learn the regulatory and accreditation requirements related to managed care credentialing
- Streamline the provider enrollment process through delegation
- Meet your organizational goals of compliance, operational efficiency, cost savings, and practitioner satisfaction
- Identify the differences between hospital and managed care credentialing

About Simplify Compliance

Simplify Compliance, with its three pillars of thought leadership, expertise, and application, provides critical insight, analysis, tools, and training to healthcare organizations nationwide. It empowers healthcare professionals with solution-focused information and intelligence to help their facilities and systems achieve compliance, financial performance, leadership, and organizational excellence. In addition, Simplify Compliance nurtures and provides access to productive C-suite relationships and engaged professional networks, deploys subject matter expertise deep into key functional areas, and enhances the utility of proprietary decision-support knowledge.

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ISBN-13: 978-1-68308-965-0

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