MASS ADVANTAGE
Plan to love your plan.

PROVIDER CREDENTIALING

Purpose of Credentialing

Credentialing is the process of validating a provider's credentials and qualifications. The credentialing and recredentialing processes also encompass a complete review of malpractice histories, quality of care concerns and licensure status. Mass Advantage prides itself on the integrity and quality of the composition of the provider and provider networks.

Credentialing and Recredentialing Standards

Mass Advantage has established credentialing and recredentialing policies and procedures that meet CMS, and NCQA standards.

All information must be current to begin the credentialing process. Submit all applications and attachments in a timely manner with the most current information available.

- Applicant has successfully graduated from an accredited school of medicine, osteopathy, podiatry, dentistry, or other professional school (as applicable).
- Applicant has successfully completed an internship and residency program (as applicable).
- Applicant has an unrestricted current license to practice in State(s) where contracted to practice, and where applicable, has a current, unrestricted DEA registration and state-controlled substance license.
- Applicant has signed and dated a properly completed Medicaid Disclosure Statement.
- A completed provider credentialing application with a signed attestation that has not been flagged for an adverse action.
- Applicant must attest to the correctness and completeness of all information furnished and acknowledges that any significant misstatement or omission from the application constitutes grounds for a discovery that the provider did not meet criteria for participation in the network, agrees to abide by the policies and procedures.

- There are no substantive discrepancies in information received from the applicant or references.
- Applicant has valid, professional liability insurance coverage satisfactory to Mass Advantage with limits of dollar amounts, name of company and expiration date.
- Board certification, eligibility, or equivalent experience in the specialty/ies in which they practice medicine.
- Other items as deemed appropriate.

The credentialing/re-credentialing process involves primary sourced verification of provider credentials.

Upon completion of the credentialing application, source verification and credentialing process the application is forwarded to the CMO or designee for review. The CMO or Designee physician will review the file and determine if the file meets credentialing criteria and is considered a “clean file”. A “clean file” is a file with no deficiencies or issues identified. If clean the CMO or designee physician will recommend approving the file and provider for contract.

If the file is “unclean” by which contains issues such as lawsuit, criminal history, negative educational/affiliation verifications etc., that file will then be presented to the Credentialing Committee for discussion of next steps at the next scheduled committee meeting.

The Credentialing Committee reviews a summary of all applicants. The Credentialing Committee may accept, reject, or pend the recommendations of the CMO or designee. The final decision to approve or reject an applicant is with the Credentialing Committee and must be documented in the file.

The decision to accept or reject a provider is based on the information provided and available. This is including but is not limited to the information gathered through the completed application process and the verification of all collected information. Credentialing criteria has been set to establish consistent, clear objectives for the credentialing for prospective providers.

If the applicant is rejected for any reasons related to quality of care, competence or professional conduct, the Credentialing Department will inform applicant of his/her right to an appeal/additional review. The Credentialing Department will notify the applicant of the decision by formal letter within 30 calendar days of the Credentialing Committees decision.

The denial of a provider's initial application to become the provider/provider shall not be grounds for a fair hearing and review under this policy. Providers who are denied initial credentialing may, within thirty (30) calendar days of receiving notice of such denial, file a written request for reconsideration containing their views on the decision, and attaching any additional information they would like the to consider. Such requests for reconsideration will be reviewed by the CMO or Designee physician and Credentialing Committee and the provider will be notified of the final decision of the within 30 calendar days after the Credentialing Committee Meeting. Further, it shall not be grounds for a fair hearing review if a provider's participation as the Provider and/or Provider Agreement is terminated or not renewed for reasons other than the provider's quality of care, competence, or professional conduct. When any provider receives a notice of an adverse decision by the Credentialing Committee that would invoke the fair hearing process as described above, he/she may request a fair hearing before a Hearing Committee.

All providers must be re-credentialed at least every 36 months in order to continue participation within Mass Advantage. This helps to ensure Mass Advantage's continued compliance with Center for Medicare and Medicaid Services (CMS) and), as well as to uphold the integrity and quality of the networks. Extensions cannot be granted.

Ongoing and Performance Monitoring

Mass Advantage's Credentialing Department conducts ongoing monitoring of sanctions, licensure disciplinary actions and member complaints.

Sanction information is reviewed by utilizing the Office of Inspector General's (OIG) report, the Medicare Opt Out Listing (CMS), and applicable state disciplinary report. Information can also be obtained from the American Medical Association (AMA) and the National Provider Data Bank (NPDB) as needed.

Monitoring of limitations on licensure is conducted on a monthly basis. If a Mass Advantage participating provider is found on the OIG, Medicare Opt Out List, or applicable state disciplinary action report, the provider's file is immediately pulled for further investigation. Depending on severity level of the sanction, the provider may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or immediately terminated. In all instances, the information is reported to the QI/UM Committee.

Monitoring of Member Complaints is conducted on a quarterly basis. The Mass Advantage Credentialing Department reviews complaint reports, outlining member complaints filed against providers. The Credentialing Department will review and investigate all complaints regarding: attitude of provider, provider treatment, quality issues of physician, and any complaints regarding adverse events. If after investigation the complaint is considered viable, it is documented. Depending upon the severity level of the complaint(s), the provider may be sent to the Medical Director for review and recommendation, sent to Quality Improvement/Utilization Management Committee for review and decision and/or terminated and outcome presented to Quality Improvement/Utilization Management Committee.

Mass Advantage's re-credentialing process includes a comprehensive review of a provider's credentials, as well as a review of any issues that may have been identified through a member complaint report and/or quality of care database.

Provider Absences

Mass Advantage continues to follow NCQA guidelines for providers called to active military service, on maternity leave or an approved sabbatical. However, it is the provider's or his/her office's responsibility to notify Mass Advantage in writing that the provider is called to active duty or beginning the leave, as well as an expected return date. The letter should also include the provider who will be covering during his or her leave. The Mass Advantage Credentialing Department will not terminate the provider in these cases if appropriate coverage is in place. Provider/provider's office should notify Mass Advantage of providers return, as soon as possible, but not exceeding ten (10) business days from their return. The Mass Advantage Credentialing Department will determine, based upon the length of time, if the provider will have to complete a recredentialing application. If the provider requires recredentialing, it must be completed within sixty (60) calendar days of the provider resuming practice.

Denial and Termination

In accordance with Mass Advantage's business practices, the inclusion of a provider in the Mass Advantage Provider Network is within the sole discretion of Mass Advantage Plan.

Mass Advantage conducts credentialing in a non-discriminating manner and does not make credentialing decisions based on an applicant's type of procedures performed, type of patients, or a provider's specialty, marital status, race, color, religion, ethnic/national origin, gender, age, sexual orientation or disability. Mass Advantage understands and abides by the Federal Regulation of the Americans with Disabilities Act whereby no individual with a disability shall on the sole basis of the disability be excluded from participation. If a provider does not meet Mass Advantage's baseline credentialing criteria, the QI/UM Committee will make a final determination on participation or continued participation. If a provider fails to submit information and/or documentation within requested time frames, processing of the provider application may be discontinued or terminated. All requests for re-credentialing updates must be completed and returned in a timely manner. Failure to do so could result in denial or termination of participation. Denial and termination decisions that are made based on quality concerns can be appealed. If necessary, the information is reported to the National Provider Data Bank and Bureau of Quality Management and Provider Integrity in compliance with the current 45 CFR Part 60 and the Health Care Quality Improvement Act, as well as State licensing boards.

Mass Advantage will notify providers in writing of any decisions to deny, suspend or terminate their privileges to participate in the network.

Providers who want to request a review of a termination, other than for quality of care concerns, must submit a written request for the review along with any supporting documentation to Mass Advantage within thirty (30) calendar days of the date of the certified notification.