

Credentialing and Re-credentialing

Humana – CareSource credentials and re-credentials all licensed independent practitioners including physicians, facilities and non-physicians with whom it contracts and who fall within its scope of authority and action.

Through credentialing, Humana – CareSource checks the qualifications and performance of physicians and other health care practitioners. Our senior clinical staff person is responsible for the credentialing and re-credentialing program.

You may submit a completed Council for Affordable Quality Healthcare (CAQH) Application via:
Humana – CareSource
Attention: Credentialing
12501 Lakefront Place
Louisville, KY 40299
Fax: 1-502-508-0521

CAQH Application

Humana – CareSource is a participating organization with CAQH. Please make sure that we have access to your provider application by:

1. Logging onto the CAQH website at CAQH.org utilizing your account information
2. Selecting the Authorization Tab
3. Making sure Humana – CareSource is listed as an authorized health plan
4. If not, please check the Authorized box to add

It is essential that all documents are complete and current. Please include copies of the following documents:

- Malpractice Insurance Fact Sheet
- A current Drug Enforcement Administration (DEA) Certificate
- Clinical Laboratory Improvement Amendment (CLIA) Certificate (if applicable)
- Collaborative Practice Agreement if an advanced registered nurse practitioner

Humana – CareSource conducts credentialing and re-credentialing activities utilizing the guidelines from the Kentucky Department of Medicaid Services (KDMS), the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA).

Contracted providers listed in the provider directory and the following are credentialed:

- Practitioners who have an independent relationship with Humana – CareSource. This independent relationship is defined through contracting agreements between Humana – CareSource and a practitioner or group of practitioners and is defined when Humana – CareSource selects and directs its enrollees to a specific practitioner or group of practitioners.
- Practitioners who see members outside the inpatient hospital setting or outside ambulatory free-standing facilities.
- Practitioners who are hospital-based, but see Humana - CareSource members as a result of their independent relationship.
- Dentists who provide care under Humana – CareSource medical benefits.

- Non-physician practitioners who have an independent relationship with the organization, as defined above, and who provide care under the organization’s medical benefits.

The following providers do not need to be credentialed:

- Practitioners who practice exclusively within the inpatient setting and who provide care for an organization’s members only as a result of the members being directed to the hospital or other inpatient setting.
- Practitioners who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility and who are not listed separately in the Humana – CareSource provider directory.
- Pharmacists who work for a pharmacy benefit management (PBM) organization.
- Practitioners who do not provide care for members in a treatment setting (e.g. board-certified consultants).

Provider Selection Criteria

Humana – CareSource is committed to providing the highest level of quality of care and service to our members. Our providers are critical business partners with us in that endeavor. As a result, we have developed the following provider selection criteria to facilitate this optimal level of care and service, as well as promoting mutually rewarding business partnerships with our providers.

Quality of care delivery, as defined by the Institute of Medicine, states:

“The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

Humana – CareSource has developed comprehensive care management and quality improvement programs to facilitate this level of quality-of-care delivery, as well as a comprehensive credentialing program to ensure that our providers have the appropriate training and expertise to serve our members from a care delivery and service perspective. Humana – CareSource bases selection on quality of care and service aspects, in addition to business and geographic needs for specific provider types in a nondiscriminatory manner. The following selection criteria have been put in place and are assessed during the credentialing and re-credentialing process, in addition to day-to-day monitoring via internal mechanisms and interactions with our members.

Selection Criteria:

- a. Active and unrestricted license in the state issued by the appropriate licensing board
- b. Previous five-year work history
- c. Current Drug Enforcement Administration (DEA) certificate (if applicable)
- d. Successful completion of all required education
- e. Successful completion of all training programs pertinent to one’s practice
- f. For M.D.s and D.O.s, successful completion of residency training pertinent to the requested practice type
- g. For dentists and other providers where special training is required or expected for services being requested, successful completion of training
- h. Board certification, if applicable
- i. Education, training and experience are current and appropriate to the scope of practice requested

- j. Malpractice insurance at specified limits established for all practitioners by the credentialing policy
- k. Good standing with Medicaid and Medicare
- l. Medicaid number
- m. Quality of care and practice history as judged by:
 - i. Medical malpractice history
 - ii. Hospital medical staff performance
 - iii. Licensure or specialty board actions or other disciplinary actions, medical or civil
 - iv. Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction
 - v. Other quality of care measurements/activities
 - vi. Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing
 - vii. Lack of issues on Health & Human Services-Office of Inspector General (HHS-OIG); General Services Administration (GSA, formerly EPLS)
- n. Signed, accurate credentialing application and contractual documents
- o. Compliance with standards of care and evidence of active initiatives to engage members in preventive care
- p. Agreement to comply with plan formulary requirements or acceptance of plan preferred drug list as administered through pharmacy benefit manager
- q. Agreement to access and availability standards established by the health plan
- r. Compliance with service requirements outlined in the provider agreement and provider manual

Organizational Credentialing and Re-credentialing

The following organizational providers are credentialed and re-credentialed:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free standing ambulatory surgery centers

Additional organizational providers also are credentialed:

- Hospice Providers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting
- Dialysis centers
- Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Rehabilitation hospitals (including outpatient locations)
- Diabetes education
- Portable X-ray suppliers
- Rural health clinics and federally qualified health centers
- Freestanding Birth Centers

The following elements are assessed for organizational providers:

1. Provider is in good standing with state and federal regulatory bodies.
2. Provider has been reviewed and approved by an accrediting body.
3. Every three years is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body.
4. Liability insurance coverage is maintained.
5. Copy of facility's state license (if applicable).

6. CLIA certificates are current.
7. Completion of a signed and dated application.

Providers will be informed of the credentialing committee's decision within 60 business days of the committee meeting. Providers will be considered re-credentialed unless otherwise notified.

Practitioner Rights

- Practitioners have the right to review, upon request, information submitted to support his or her credentialing application to the Humana – CareSource Credentialing Department. Humana – CareSource keeps all submitted information locked and confidential.
- Practitioners have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing Department prior to presentation to the credentialing committee. If any information obtained during the credentialing or re-credentialing process varies substantially from the application, the practitioner will be notified and given the opportunity to correct information prior to presentation to the credentialing committee.
- Practitioners have the right to be informed of the status of their credentialing or re-credentialing application upon written request to the credentialing department.

Provider Responsibilities

Providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. Humana – CareSource will initiate immediate action in the event that the participation criteria no longer are met. Providers are required to inform Humana – CareSource of changes in status, such as being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification or any event reportable to the National Practitioner Data Bank (NPDB).

Re-credentialing

Providers are re-credentialed a minimum of every three years. As part of the re-credentialing process, Humana – CareSource considers information regarding performance to include complaints and safety and quality issues collected through the quality improvement program, in addition to information regarding sanctions collected from the NPDB, Medicare and Medicaid Sanctions and Reinstatement Report, Medicare Opt-Out and the HHS/OIG and GSA (formerly EPLS). Providers will be considered re-credentialed unless otherwise notified.

Board Certification Requirements

All physicians applying to become participating providers with Humana – CareSource must be either board certified in their primary specialty or pursuing the pathway to certification as defined by their specialty board.

Delegation of Credentialing/Re-credentialing

Humana – CareSource will only enter into agreements to delegate credentialing and re-credentialing if the entity that wants to be delegated is NCQA accredited for these functions, utilizes a NCQA-accredited Credentials Verification Organization (CVO) and successfully passes a pre-delegation audit demonstrating compliance with NCQA federal and state requirements.

A pre-delegation audit must be completed prior to entering into any delegated agreement. All pre-assessment evaluations will be performed utilizing the most current NCQA and regulatory requirements. The following will be included (at a minimum) in the review:

- Credentialing and re-credentialing policies and procedures
- Credentialing and re-credentialing committee meeting minutes from the previous year
- Credentialing and re-credentialing file review

Delegates must be in good standing with Medicaid and CMS. Monthly reporting will be required from the delegated entity, which will be defined in an agreement between both parties.

Appeals of Credentialing/Re-credentialing Decisions

Humana – CareSource may decide that an applying or participating provider may pose undue risk to our members and should be denied participation or be removed from Humana – CareSource’s network. If this happens, the applying or participating provider will be notified in writing. Appeal opportunities are available to a participating provider if he or she has been affected by an adverse determination. To submit an appeal request, the following steps apply:

Step 1 — Submit to the senior medical director an appeal request in writing, along with any other supporting documentation. Send it to:

Humana – CareSource
Attn: Dr. Sylvester Barczak, Senior Medical Director
640 Eden Park Drive
Cincinnati, OH 45202

Step 2 — If the committee maintains its original decision, an appeal may be made consistent with provisions of the Humana – CareSource Fair Hearing Plan. An appeal request must be submitted in writing and received by Humana – CareSource within 30 days of the date the provider is notified of the first appeal decision. Appeals may be sent to:

Humana – CareSource
Attn: Dr. Sylvester Barczak, Senior Medical Director
640 Eden Park Drive
Cincinnati, OH 45202

Applying providers do not have appeal rights. However, they may submit additional documents to the address above for reconsideration by the credentialing committee.

Provider Disputes

Provider disputes related to quality, professional competency or conduct should be sent to:

Humana – CareSource
Attn: Dr. George Andrews, Quality Improvement
500 W. Main St.
Louisville, KY 40202

Provider disputes that are contractual or nonclinical should be sent to:

Humana – CareSource
Attn: Dr. George Andrews, Provider Relations
101 S. Fifth St.
Louisville, KY 40201

Adverse Actions

Humana – CareSource complies with the federal Health Care Quality Improvement Act and has an active peer review committee. Humana – CareSource reserves the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a participating provider, who, in the opinion of the Humana – CareSource senior medical director or peer review committee, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of our members. Participating providers who are subject to an adverse action that affects their status for more than 30 days are offered an opportunity for a fair hearing that entails an additional physician panel review of the action.

Cultural Considerations and Competencies

Participating providers are expected to deliver services in a culturally competent manner which includes, but is not limited to, removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social circumstances of the patient.

Participating providers also must meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.

Humana – CareSource recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the health care experience and health outcomes. It is committed to developing strategies that eliminate health disparities among culturally diverse groups and address gaps in care.

A report by the Institute of Medicine in 2002 confirmed the existence of racial and ethnic disparities in health care. Unequal treatment found racial differences in the type of care delivered across a wide range of health care settings and disease conditions, even when controlling for socioeconomic status factors, such as income and insurance coverage. Annual National Healthcare Disparities Reports from the Agency for Healthcare Research and Quality (AHRQ) confirm that these gaps persist in the American health care system.

Communication is paramount in delivering effective care. Mutual understanding may be difficult during cross-cultural interaction between patients and providers. Some disparities may be attributed to miscommunication between providers and patients, language barriers, cultural norms and beliefs and attitudes that determine health-care-seeking behaviors. Providers can address racial and ethnic gaps in health care with awareness of cultural needs and by improving communication with their growing number of diverse patients.

Humana – CareSource offers a number of initiatives to deliver services to all members regardless of ethnicity, socioeconomic status, culture and primary language. These include language assistance services, race and ethnicity data collection and analysis, internal staff training and Spanish resources. Initiatives from other health-related organizations give providers other resources and materials that emphasize and support awareness of gaps in care and information on culturally competent care.

In addition, Humana – CareSource recognizes cultural differences in religious beliefs and ethical principles. As a result, providers are not required to perform a treatment or procedure that is contrary to their religious beliefs or ethical principles.