Credentialing is the process by which Blue Cross and Blue Shield of New Mexico (BCBSNM) ensures that the physicians and certain other providers meet the professional standards that are described in the Credentialing Policy. The credentialing standards cover areas such as education, advanced training, board certification, licensure, disciplinary action, and legal action.

BCBSNM’s credentialing program complies with applicable laws, including Section 13.10.28 NMAC.

Credentialing is not synonymous with participation on a BCBSNM network. A physician or other provider may be denied participation in a BCBSNM network because the specialty or area of service is already adequately represented or for other reasons as permitted by applicable laws. Only physicians or other providers who are determined by the Medical Director and/or Credentialing Committee as having met credentialing standards are eligible to participate with BCBSNM. In compliance with regulations of the Office of the Superintendent of Insurance and standards of National Committee for Quality Assurance (NCQA) standards, we perform primary source verification on a number of elements used for establishing credentials.

BCBSNM’s credentialing verification process includes a verification of qualifications of providers applying to become participating providers within 45 calendar days of receipt of a provider’s request for credentialing (including on-line availability of completed uniform credentialing form and request that BCBSNM obtain it) or receipt of a provider’s completed uniform credentialing form, whichever is earlier. The following activities will take place within this 45 calendar days:

(a) obtain the completed uniform credentialing form in electronic format;
(b) obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the applicant’s credentials;
(c) a final decision by BCBSNM’s credentialing committee; and
(d) notify the provider of BCBSNM’s decision.

Continued on next page
Overview, Continued

Contents

This section contains the following topics:

<table>
<thead>
<tr>
<th>Section</th>
<th>See Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.1 Initial Credentialing</td>
<td>16-3</td>
</tr>
<tr>
<td>16.2 Getting Started with CAQH</td>
<td>16-7</td>
</tr>
<tr>
<td>16.3 Recredentialing</td>
<td>16-9</td>
</tr>
<tr>
<td>16.4 Appeals to Network Terminations</td>
<td>16-11</td>
</tr>
<tr>
<td>16.5 Delegation</td>
<td>16-11</td>
</tr>
<tr>
<td>16.6 Medical Record Documentation Standards</td>
<td>16-12</td>
</tr>
<tr>
<td>16.7 16.8 Attachments Medical Record Documentation Standards NMAC 13.10.28</td>
<td>16-13</td>
</tr>
</tbody>
</table>
16.1 Initial Credentialing

Initial credentialing occurs when a provider has not previously been credentialed by BCBSNM. The Credentialing Committee evaluates whether the provider meets credentialing standards. Upon receiving a provider’s request for credentialing (including on-line availability of completed uniform credentialing form and request that BCBSNM obtain it) or a provider’s completed credentialing form, HCSC Credentialing Department shall review the application to verify that the application includes all necessary information and documentation that is reasonably related to the information in the application. The HCSC Credentialing Department may initially attempt to obtain additional or missing information by informal means including but not limited to fax, telephone, or e-mail.

HCSC will notify the applicant by US certified mail within 10 days of receipt that the request for credentialing has been received, but if the application is incomplete, that the 45-day time period set forth in Subsection C of 13.10.28.11 NMAC shall not commence until the applicant provides all requested information or documentation. Any request for additional information that has not been met through an informal exchange and remains outstanding at the end of the initial 10-day review period shall also be sent to the provider via the same or separate certified mail within 10 business days of receipt of the application, to include:

(a) a complete and detailed description of all of the information or supporting documentation that is reasonably related to information in the application that BCBSNM requires to approve or reject the credentialing application; and

(b) the name, address, e-mail, and telephone number of a person who serves as the applicant’s point of contact for completing the credentialing application process; and

(c) notice that if an application remains incomplete and the applicant has been unresponsive to requests for information beyond 45 days, it may be denied for failure to respond.

Within 45 calendar days of the date of receipt of a request for credentialing, HCSC shall assess and verify the qualifications of a provider applying to become a participating provider; and review the application and determine whether to approve or deny the credentialing application.
HCSC will approve the provider for a period of up to three years; or may provisionally accept the provider for a period of one-year, or deny the provider for the BCBSNM network.

HCSC will issue a decision in writing by US mail at the physical or mailing address listed in the application, and by e-mail (if provided).

If the credentialing application is approved, re-credentialing verification is required every three years.

If the application is approved provisionally, then re-credentialing shall be required annually or a shorter time if required by NCQA and approved by the Superintendent of Insurance.

Providers who do not meet credentialing standards may not participate in the BCBSNM networks.

BCBSNM will reimburse a provider, subject to co-payments, co-insurance, deductibles, or other cost-sharing provisions, for any clean claims for covered services, provided that:

(a) the date of service is more than 45 calendar days after the date the provider requested credentialing from BCBSNM and either the provider supplied a completed uniform credentialing application or made the completed uniform credentialing application including submission of any supporting documentation that requested in writing during the initial 10-day review period;

(b) BCBSNM has approved, or has failed to approve or deny the applicant’s completed uniform credentialing application within the established timeframes;

(c) the provider has no past or current license sanctions or limitations, as reported by the New Mexico medical board or another pertinent licensing and regulatory agency, or by a similar out-of-state licensing and regulatory entity for a provider licensed in another state; and

(d) the provider has professional liability insurance or is covered under the Medical Malpractice Act.

A provider who, at the time services were rendered, has been approved by HCSC for credentialing or who has been awaiting a credentialing decision and was not in a practice or group that has contracted with the health carrier to provide services at specified rates of reimbursement, shall be paid by BCBSNM in accordance with the BCBSNM’s standard reimbursement rate or at an agreed upon rate.
A provider who, at the time services were rendered, has been approved by HCSC for credentialing or who has been awaiting a credentialing decision and was in a provider group that has contracted with BCBSNM to provide services at specified rates of reimbursement, shall be paid in accordance with the terms of the provider group contract.

BCBSNM will reimburse a provider until the earlier of the following occurs:

(a) HCSC denies the provider’s credentialing application;
(b) HCSC approves the provider's credentialing application and the provider and health carrier enter a contract to replace a previously agreed upon rate, or
(c) the passage of three years from the date the insurer received the provider’s completed uniform credentialing application.

Note: Before a provider can join the BCBSNM Provider Networks, the provider will need to be assigned a Provider Record. Please refer to Section 3, Provider Services of this manual for more information.

Providers must use the Council for Affordable Quality Healthcare's (CAQH®) ProView™ for initial credentialing and recredentialing. CAQH ProView, a free online service, allows providers to fill out one application to meet the credentialing data needs of multiple organizations. The CAQH ProView online credentialing application process supports our administrative simplification and paper reduction efforts. This solution also supports quality initiatives and helps to ensure the accuracy and integrity of our provider database.

CAQH is a not-for-profit collaborative alliance of the nation’s leading health plans and networks. The mission of CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staffs. CAQH is solely responsible for its products and services, including CAQH ProView.

Continued on next page
16.1 Initial Credentialing, Continued

Credentialing Process (continued)

All New Mexico providers applying for initial or continuing participation with BCBSNM should complete and submit their credentialing and recredentialing applications through CAQH ProView by accessing the CAQH website. Providers that do not have internet access may submit their application via mail to CAQH by first contacting the CAQH Help Desk at 888-599-1771.

Note: BCBSNM’s requirement of use of the CAQH ProView does not apply to physicians and other professional providers participating through delegated credentialing agreements/contracts or who are solely practicing in a hospital based environment.

Additional Resources

<table>
<thead>
<tr>
<th>CAQH Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help Desk (888) 599-1771</td>
</tr>
<tr>
<td>CAQH ProView Log in: <a href="https://proview.caqh.org">https://proview.caqh.org</a></td>
</tr>
<tr>
<td>Help Desk E-mail Address: <a href="mailto:providerhelp@proview.caqh.org">providerhelp@proview.caqh.org</a></td>
</tr>
<tr>
<td>Help Desk Hours: 5 a.m. – 7 p.m., MT, Monday – Thursday 5 a.m. – 5 p.m., MT, Friday</td>
</tr>
<tr>
<td>Supporting Documentation: Scanned copies of supporting documents should be submitted directly through CAQH ProView. From the “Documents” page on your data profile, you can upload a new document, replace an existing document, or delete a document.</td>
</tr>
</tbody>
</table>

Provider Quick Reference Guide:
http://www.caqh.org/ProView/Provider-UserGuide.pdf

*The Council for Affordable Quality Healthcare, Inc. (CAQH) is a not-for-profit collaborative alliance of the nation’s leading health plans and networks. The mission of CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staffs. CAQH is solely responsible for its products and services, including CAQH ProView.

Obtaining Credentialing Status

Providers can obtain the current status of their credentialing application by contacting the Provider Relations Representative assigned to the provider’s region.

A full list of Provider Relations Representatives is available in the Network Contact List under the Contact Us section of the BCBSNM provider website, bcbsnm.com/provider.

Continued on next page
16.1 Initial Credentialing, Continued

Who Requires Credentialing

BCBSNM requires full credentialing of the physicians and other professional providers listed below for participation in the networks.

- MDs and DOs
- DDSs (oral and maxillofacial surgery)
- Licensed physical therapists, occupational therapists
- Optometrists, audiologists, speech and language pathologists
- Behavioral health providers*
- Physician assistants, surgical assistants, advanced practice nurses, certified midwives, registered nurse first assistants, when required
- Podiatrists
- Chiropractors
- DOMs

*The licensing board for psychologists (PhDs) does not provide a quick verification method of a provider's license. PhDs will be fully credentialed and made effective after credentialing approval.

Note: If you are a provider that requires the following additional form listed below, you must complete and forward by fax to 866-290-7718.

- Hospital Coverage Letter – required for those providers who do not have admitting privileges at a participating network hospital

Continued on next page
16.1 Initial Credentialing, Continued

Follow the table below to submit a request for contracting/participating in BCBSNM’s New Mexico networks.

- Eligible specialties include, but are not limited to, anesthesia, emergency medicine, radiology, pathology, neonatology and hospitalist.
- The facility based application only applies to providers who practice exclusively in a facility, either a hospital OR a freestanding outpatient facility.

Hospital- or facility-based providers must have the following:

- Hospital privileges
- Type 1 and/or Type 2 NPI
- New Mexico State Board of Medical Examiners license (temporary permit is acceptable) or appropriate New Mexico licensure
- Certificate/AANA# (applicable to CRNA providers only)

**Note:** A BCBSNM provider record does not automatically activate the New Mexico network. Claims will be processed out-of-network until the provider has applied for network participation, been approved and activated in the network.

<table>
<thead>
<tr>
<th>If provider is…</th>
<th>Then…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility, including behavioral health and ancillary providers</td>
<td>Complete the <a href="#">Participating Provider Interest Form for Facilities</a> and fax to 866-290-7718.</td>
</tr>
<tr>
<td>Solo practitioner or medical group</td>
<td>Complete the <a href="#">Participating Provider Interest Form for Professional Providers</a> and fax to 866-290-7718.</td>
</tr>
<tr>
<td>Urgent care center</td>
<td>Complete the <a href="#">Participating Provider Interest Form for Professional Providers</a> and <a href="#">Urgent Care Center Attestation</a> and fax to 866-290-7718.</td>
</tr>
</tbody>
</table>
16.2 Getting Started with CAQH

Providers seeking to participate with BCBSNM must have an CAQH Provider ID to register and begin the credentialing process.

First Time Users

- **If you are not registered with CAQH** – When you obtain a BCBSNM Provider Record for claim payment and submit a current signed BCBSNM contract/agreement, BCBSNM will add your name to its roster with CAQH. CAQH will then mail the access and registration instructions to you, along with your unique CAQH Provider ID, allowing you to obtain immediate access to CAQH ProView via the Internet.
- When you receive your CAQH Provider ID, go to the [CAQH website](#) to register.

**Note:** Registration and completion of the online application is free. Once registration is completed, you may use your CAQH ProView user name and password to log in at any time.

Existing Users

**If you are already registered with CAQH** and completed your CAQH ProView application through your participation with another health plan, log in to CAQH ProView and add BCBSNM as one of the health plans that can access your information.

Refer to Authorize Tab instructions in the [CAQH Reference Guide](#).
16.2 Getting Started with CAQH, Continued

Completing the Application Process

The CAQH ProView standardized application is a single, standard online form that meets the needs of all participating health care organizations. When completing the application, you will need to indicate which participating health plans and health care organizations you authorize to access your application data. All provider data you submit through CAQH ProView is maintained by CAQH in a secure, state-of-the-art data center.

When you are ready to begin entering your data, log in to CAQH ProView with your user name and password. The online guide will describe the materials and information needed to complete the application.

View the application process.
Also refer to the Provider Quick Reference Guide.

If you have any questions on accessing CAQH ProView, you may contact the CAQH Help Desk at (888) 599-1771 for assistance.

Note: BCBSNM may need to supplement, clarify or confirm certain responses on your application with you. Therefore, you may be required to provide us with supplemental documentation in some situations, in addition to the information you submit through CAQH ProView.

Visit the CAQH website for more information about CAQH ProView and the application process.

Updating your Information

Keeping your information current with CAQH and BCBSNM is your responsibility.

Updating your BCBSNM provider file:
BCBSNM members rely on the accuracy of the provider information in our online Provider Finder®. This is why it’s very important that you inform BCBSNM whenever any of your practice information changes. If you are a participating provider with BCBSNM, you may request most changes online by emailing us.

CAQH ProView:
You will be sent automatic reminders from CAQH to review and attest to the accuracy of your data. Use CAQH ProView to report any changes to your practice.
16.3 Recredentialing

Recredentialing occurs at regular intervals after initial credentialing. Currently the interval is 36 months, but this interval could change. Contact the Network Services Department for the most current information.

Note: BCBSNM may terminate its participation agreement with a provider with or without cause at any time, regardless of time remaining before re-credentialing is due.

BCBSNM does not require a participating provider to be re-credentialled based on:

(a) a change in the provider’s federal tax identification number;

(b) a change in the federal tax identification number of a provider’s employer; or

(c) a change in the provider’s employer, if the new employer is a participating provider; or also employs other participating providers.

As a part of recredentialing, the Credentialing Committee evaluates whether the provider continues to meet credentialing standards.
16.3 Recredentialing, Continued

The process of recredentialing is consistent with NCQA and State of New Mexico requirements.

If you are not currently registered with CAQH, BCBSNM will add your name to its roster with CAQH. CAQH will then mail to you the access and registration instructions, along with your personal CAQH Provider ID, allowing you to obtain immediate access to CAQH ProView via the Internet to complete and submit your application. This will help you to conform to the requirements of your provider contract/agreement to continue your participation with BCBSNM’s networks.

If you are an existing user of CAQH, you are required to review and attest to your data once every four months. At the time, you are scheduled for recredentialing, BCBSNM will send your name to CAQH to determine if you have already completed the CAQH ProView credentialing process and authorized BCBSNM or selected “global authorization”. If so, BCBSNM will be able to obtain current information from the CAQH ProView database and complete the recredentialing process without having to contact you.

If you are contracted for the Medicaid network, a provider disclosure must be completed and submitted with your current documents to CAQH as part of the complete application packet.

Note: If you are a provider that requires the following additional form listed below, you must complete and forward by fax or mail to BCBSNM as indicated below.

- **Hospital Coverage Letter** – required for those providers who do not have admitting privileges at a network hospital.

Continued on next page
16.3 Recredentialing, Continued

Re-credentialing Process (continued)

Forward applicable completed form(s) to BCBSNM:
Fax to: 866-290-7718
or
Mail to:
Blue Cross and Blue Shield of New Mexico
Network Services Department
P.O. Box 27630
Albuquerque, NM 87125-7630
A provider who does not continue to meet credentialing standards will no longer be eligible for participation in the network. In those cases, BCBSNM will terminate the provider’s participation. Terminations for cause are appealable as detailed in Section 15.5, Provider Terminations. When BCBSNM’s credentialing decision regarding a provider is delayed more than 45 days after receipt of a completed credentialing application and additional criteria are met, such provider has the right to dispute BCBSNM’s reimbursement of their claims as detailed in Section 15.4, Credentialing and Payment Disputes.
16.5 Delegation

Under certain infrequent circumstances, some functions ordinarily assumed by BCBSNM are delegated. For example, as discussed above, primary source verification of credentials may be delegated to a Credentials Verification Organization (CVO). Credentialing functions, utilization management, and quality management may be delegated to other entities such as Independent Practice Associations (IPAs). Such delegation is always established through written agreement.

Physicians and other providers who are contracted with entities to whom BCBSNM has delegated certain functions should be aware that BCBSNM retains ultimate authority for that function.

For example, a physician may be credentialed by an IPA that contracts its services to BCBSNM. If that IPA has been granted delegated status for credentialing, it would not be necessary for the physician to undergo separate credentialing by BCBSNM. However, the participation of that physician with BCBSNM remains subject to that physician meeting BCBSNM credentialing standards. Regardless of whether the physician has been credentialed by the IPA, if BCBSNM determines that the physician does not meet credentialing standards, that physician may be denied participation with BCBSNM.

If the IPA loses its delegated status for any reason (such as contractual changes), BCBSNM will re-assume responsibility for credentialing and recredentialing of providers who continue to serve on the BCBSNM network. However, the fact that a provider met credentialing standards with a delegated IPA does not assure or guarantee that BCBSNM credentialing standards are met, or that BCBSNM will pursue a contract with that provider.

Whenever BCBSNM delegates credential verification activities to a contracting entity, BCBSNM will review and approve the contracting entity’s credential verification program before contracting and will require that the entity comply with all applicable requirements of Section 13.10.28.1, et seq. NMAC.

BCBSNM monitors the contracting entity’s credential certification activities through oversight activities that include:

(a) Review of the contracting entity’s credential verification plans, policies, procedures, forms, and adherence to verification procedures; and
(b) evaluation of the contracting entity’s credential verification program at least every two years.

(c) the verification procedures and standards as defined by the national committee for quality assistance (NCQA).

Questions about credentialing delegation should be directed to the delegated entity or to the Network Services Department at BCBSNM.
16.6 Medical Record Documentation Standards

The medical record is often key to quality of care, particularly as the complexity of medical care grows. Medical Record Documentation Standards for BCBSNM network providers are included in the Attachments section below. Providers are expected to be in full compliance with medical record documentation standards.

16.7 Attachments

Medical Records Documentation Standards
NMAC 13.10.28
Medical Records
Documentation Standards

A. Confidentiality and Security Standards:
1. Records treated as confidential information
2. Stored in a centralized secure location accessible only to authorized personnel who are periodically provided training for confidentiality and security of patient information
3. retrievable in timely manner by office staff and practitioners
4. Confidential information is released only in accordance with applicable state and federal laws
5. Appropriate safeguards are in place to protect the confidentiality of the medical record, in compliance with applicable state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA)

B. Minimum Documentation Standards:
1. Record must be legible, timely, current, detailed and organized to permit effective and confidential patient care and quality review
2. Each chart entry must be dated
3. Each chart entry must have author identification and title with a legible signature and co-signature (if applicable)
4. Two forms of patient identification information must be noted on each printed page (e.g., name and DOB)
5. Personal biographical data (i.e., date of birth, sex, race/ethnicity, mailing/residential address, employer, telephone number(s), emergency contact information, marital status, consent forms, guardianship information)
6. Signed release of information allowing for communication between behavioral health provider and primary care provider. If member refuses to allow such communication, this should be documented (behavioral health only)
7. Past medical history for patients seen two or more times includes:
   a. Problem list for tracking significant illness and conditions
   b. Relevant family history
   c. Medication history to include medication strength, directions, and effectiveness of medication
   d. Social history, including but not limited to, tobacco and alcohol use and/or substance abuse for ages 12 and older
8. Allergies and the adverse reactions in a uniform location of the record; or notation of no known allergy (NKA) or no known drug allergy (NKDA), if applicable
9. History or other subjective data and physical exam or other objective data for the presenting complaint, including relevant psychological and social conditions affecting the patient’s physical and behavioral health status
10. For medications prescribed, documentation must include name, strength, amount, direction for use, and refills. Effectiveness should be documented upon follow up.

11. Diagnosis is documented for each patient visit

12. Treatment/follow up plan and patient discharge instructions for each encounter

13. Preventive health services reviewed and documented for patients of all ages, such as but not limited to, immunizations, well visits, weight counseling and BMI assessment, etc. (physical health only)

14. Diagnostic test results and other prescribed therapies, with evidence of provider review and patient notification of abnormal results

15. Coordination of care between providers to include referrals, with evidence of provider review and treatment plan integration of consultation, therapy, home health, emergency care and other reports

16. Advance directives or the documentation of discussion of advance directives for ages 18 and older (physical health only)