

**Community Mental Health Affiliation
of Mid-Michigan**

PROCEDURE: 5.2	Page 1 of 5	SUBJECT: Credentialing/Re-credentialing
Related Policy : 5.0		SUBJECT: Network Administration
Issuing Director: Director of Affiliation Operations		Original Effective Date: 02-08-07

REVISED DATE

03/11/08

Review Date(s)

02/19/09					

I. PURPOSE:

To establish guidelines for credentialing and re-credentialing individuals and organizational providers (hereinafter "PROVIDERS") directly or contractually employed by CMHAMM and its members.

II. STANDARDS:

- A. 438.214(b)(2) Credentialing and Re-credentialing
- B. 438.12 Provider Discrimination Prohibited
- C. 438.214(c) Nondiscrimination
- D. MDCH Guideline Credentialing and Re-Credentialing Processes (September 2006)

III. PROCEDURES:

A. Credentialing Individual Practitioners

1. The Credentialing procedures of the Community Mental Health Service Providers/Coordinating Agencies (CMHSPs/CAs) shall apply to individual practitioners, employed and/or under contract, in the provider network consisting of:
 - a. Physicians (M.D.s or D.O.s)
 - b. Physician Assistants
 - c. Psychologists
 - d. Licensed Bachelor Social Workers, Licensed Master's Social Workers, Limited Licensed Social Workers or Registered Social Service Technicians
 - e. Licensed Professional Counselors
 - f. Nurse Practitioners, Registered Nurses, or Licensed Practical Nurses
 - g. Occupational Therapists, Or Occupational Therapy Assistants
 - h. Physical Therapists or Physical Therapy Assistants
 - i. Speech Pathologists
2. CMHSP/CA Credentialing and re-credentialing processes shall not discriminate against a PROVIDER solely on the basis of license, registration or certification; or against a PROVIDER who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.
3. PROVIDERS excluded from participation under either Medicaid or Medicare shall not be considered for employment or contracting. The Sanctioned Provider Listings found at

websites <http://exclusions.oig.hhs.gov> and at www.michigan.gov/mdch shall be used to determine provider status under these programs.

4. If the responsibility for credentialing/re-credentialing is delegated by the CMHSP/CA to another entity, the right to approve, suspend or terminate a provider selected by that entity is retained by the PIHP. The PIHP shall retain responsibility for oversight regarding delegated credentialing or re-credentialing decisions.
5. CMHSP/CA policies and procedures shall designate an individual staff person and entity (e.g. a credentialing committee), as appropriate, responsible for oversight of the credentialing process and delineate their roles. The PIHP's Network Administrator shall assure that credentialing-re-credentialing processes in place across the affiliation comply with PIHP policy and procedure and are being carried out by the CMHSP/CA's designated staff member in accordance with those policies and procedures.
6. The credentialing steps taken by one CMHAMM member to credential contract PROVIDERS may be accepted by the other members within CMHAMM without duplication.
7. An individual file will be maintained for each credentialed PROVIDER which shall include:
 - a. The initial credentialing and all subsequent re-credentialing applications and supporting documentation;
 - b. Information gained through primary source verification; and
 - c. Any other pertinent information used in determining whether or not the PROVIDER met the credentialing standards.

B. Initial Credentialing

1. PROVIDERS shall complete a written application attesting to the following:
 - a. Lack of present illegal drug use.
 - b. Any history of loss of license and/or felony convictions.
 - c. Any history of loss or limitation of privileges or disciplinary action.
 - d. Attestation by the PROVIDER of the correctness and completeness of the application.
2. The CMHSP/CA shall perform background checks which may include, but not be limited to, criminal checks, verification of licensure, Medicaid/Medicare sanction listing, and sex offender tracking. Once the background checks have been performed and satisfactory results are obtained, the CMHSP/CA may then continue with the approval process
3. Designated CMHSP/CA staff shall review the PROVIDER'S work history for the prior five years.
4. There shall be verification from primary sources of:
 - a. Licensure or certification.
 - b. Board certification, if applicable, or highest level of credentials obtained, or completion of any required internships/residency programs or other postgraduate training.
 - c. Documentation of graduation from an accredited school.
 - d. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query. In lieu of NPDB/HIPDB query, all of the following shall be verified:
 - i. Minimum five year history of professional liability claims resulting in a judgment or settlement;
 - ii. Disciplinary status with regulatory board or agency;
 - iii. Medicare/Medicaid sanctions.

- e. If the PROVIDER is a physician, then physician profile information obtained from the American Medical Association (A.M.A.) may be used to satisfy the primary source requirements of a., b., and c. above.
5. The Network Administrator shall ensure that credentialing information is complete and that findings are documented in an approved format. CMHSP/CA policies and procedures shall describe the methodology used to document that each credentialing or re-credentialing file is complete and reviewed prior to presentation to a credentialing committee for evaluation, as appropriate.
6. Designated CMHSP/CA staff shall review the information obtained and determine whether to approve credentials or grant temporary or provisional credentials. Initial credentialing determinations will be made and communicated to the applicant PROVIDER within thirty one (31) days of receipt of a completed application including submission of all supporting documentation. Temporary or provisional credentials may be granted for a period not to exceed one hundred fifty (150) days.
7. The CMHSP/CA's credentialing/re-credentialing policy and procedures shall describe the role of participating providers in making credentialing decisions, if applicable.
8. PROVIDERS shall be approved to provide those services that are consistent with their professional licensure and within their scope of practice as defined by state licensure.

C. Temporary/Provisional Credentialing of Individual PROVIDERS

Temporary or provisional credentials may be granted when it is in the best interest of Medicaid Beneficiaries that PROVIDERS be available to provide care prior to formal completion of the entire credentialing process.

1. For consideration of temporary or provisional credentialing, PROVIDERS shall complete a written application attesting to the following:
 - a. Lack of present illegal drug use.
 - b. Any history of loss of license and/or felony convictions.
 - c. Any history of loss or limitation of privileges or disciplinary action.
 - d. Attestation by the PROVIDER of the correctness and completeness of the application.
2. Designated CMHSP/CA staff shall review the PROVIDER'S work history for the prior five years.
3. There shall be verification from primary sources of:
 - a. Licensure or certification.
 - b. Board certification, if applicable, or highest level of credentials obtained, or completion of any required internships/residency programs or other postgraduate training.
 - c. Documentation of graduation from an accredited school.
 - d. Medicare/Medicaid sanctions.
4. The CMHSP/CA must review the information obtained and determine whether to grant provisional credentials. Credentialing determinations will be made and communicated to the applicant PROVIDER within thirty one (31) days of receipt of a completed application including submission of all supporting documentation. Temporary or provisional credentialing shall not exceed 150 days.
5. PROVIDERS shall be approved to provide those services that are consistent with their professional licensure and within their scope of practice as defined by state licensure.

D. Re-credentialing

Licensed, registered or certified PROVIDERS shall be re-credentialed every two years, to include:

1. An update of information obtained during the initial credentialing process.
2. A review of Medicare/Medicaid sanctions.
3. Primary source verification of license, registration or certification.
4. Review of grievances, complaints and appeals information.
5. Review of quality concerns as evidenced by QAPIP studies, QI findings, or other sources for information on service quality.

E. Organizational PROVIDERS

1. At the time of initial application, organizational PROVIDERS shall submit an application for network participation, signed authorization to perform a background check, and a signed contract. The background checks may include, but not be limited to, criminal checks, verification of licensure, Medicaid/Medicare sanction listing, and sex offender tracking.
2. Once the background checks have been performed and satisfactory results are obtained, the CMHSP/CA may then continue with the contract approval process.
3. The CMHSP/CAs shall perform background checks initially and at least every two years to assure that the license to operate is current and that the provider has not been excluded from Medicaid or Medicare participation.
4. The CMHSP/CAs shall credential and re-credential directly-employed and contracted service providers in accordance with the PIHP's credentialing/re-credentialing policies and procedures.

F. Adverse Credentialing Decisions

An individual practitioner or organizational PROVIDER that is denied credentialing or re-credentialing by the CMHSP/CA shall be informed of the reasons for the adverse decision in writing by the CMHSP/CA.

G. Appeal Process

In the event a credentialing or re-credentialing application is denied, or a PROVIDER is suspended or terminated for any reason other than need, the PROVIDER may appeal the decision by submitting a letter of appeal to the CEO of the CMHSP/CA for which participation was denied within ten (10) business days of the date of the determination notice. The letter shall concisely state the basis for the appeal and shall include any supporting documentation. All appeals will be reviewed and a decision made within fourteen (14) business days of receipt of the appeal letter. The decision issued by the CEO of the CMHSP/CA shall be final and binding. This appeal process shall apply to PROVIDERS employed and/or directly contracted with the PIHP when the PIHP denies, suspends or terminates a PROVIDER for any reason other than for lack of need.

H. Reporting

The CMHSP/CA shall report any conduct by a member of its provider network that results in suspension or termination from the provider network to the PIHP who will, in turn, report the conduct to the appropriate authorities (i.e. MDCH, the PROVIDER'S regulatory Board or

agency, the Attorney General) and any other federal and State entities as specified in the Medicaid Managed Specialty Supports and Services Contract.

I. Delegated Credentialing/Re-credentialing Responsibilities

The PIHP shall:

1. Retain the right to approve, suspend, or terminate PROVIDERS selected by the CMHSP;
2. Be responsible for oversight of delegated credentialing or re-credentialing decisions;
3. Meet all requirements associated with the delegation of PIHP functions.
4. Require CMHSP/CAs not to accept the credentialing decisions of another PIHP.

IV APPLICATION:

PIHP and all CMHAMM CMHSPs/CAs

V. MONITOR AND REVIEW:

The Network Administrator shall monitor CMHSP/CA compliance with these procedures. The PIHP Director of Affiliation Operations will review the procedure annually. External review will include MDCH and CMS site visits and reporting.

VI. RELATED POLICIES AND PROCEDURES:

CMHAMM Policy	5.0	Network Management
CMHAMM Procedure	5.1	Provider Network Management