

## PATHWAYS CMH

<b>POLICY TITLE:</b> Credentialing – Credentialing & Oversight	<b>CATEGORY:</b> Personnel – Employee Guidelines	
<b>EFFECTIVE DATE:</b> June 4, 2014	<b>BOARD APPROVAL DATE:</b> June 4, 2014	
<b>REVIEWED DATE:</b> June 30, 2015	<b>REVISION(S) TO POLICY STATEMENT:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>OTHER REVISION(S):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>RESPONSIBLE PARTY:</b> COO/Human Resources Director	<b>CEO APPROVAL:</b> Mary Swift, CEO	

### **APPLIES TO:**

Pathways Employees  
Pathways Contract Providers

### **POLICY:**

Pathways assures consumer safety and provision of services by competent and qualified behavioral healthcare providers by implementing a comprehensive credentialing and recredentialing plan. To ensure compliance and identify quality or network issues, continuous credential monitoring occurs across the network. Pathways directs credentialing through its own activity, contracts, delegation agreements, and monitoring of organizational providers. The Pathways Credentialing Committee is chaired by the Senior Clinical Leader, and is charged with developing policy and procedures for the Credentialing Process. Pathways Credentialing Committee retains authority for the credentialing of Pathways Clinical Staff, and organizational providers. Each Organizational Provider implements written policies and procedures for the selection and retention of providers that are compliant with all federal, state and regional rules/regulations and accreditation requirements.

### **PURPOSE:**

To set standards for the credentialing and recredentialing of Pathways clinical staff and provide ongoing monitoring to ensure all providers are in full compliance with federal, state, and regional rules/regulations, and NorthCare Network standards. This policy does not establish the acceptable scope of practice for any of the identified providers, nor does it imply that any service delivered by the providers identified in the body of the policy is Medicaid-billable or reimbursable.

### **DEFINITIONS:**

- Credentialing*** (As defined by the American Society of Addiction Medicine and the American Managed Behavioral Healthcare Association): The process of reviewing, verifying, and evaluating a provider's credentials (i.e., professional education, clinical training, licensure, board and other certification, clinical experience, letters of reference, other professional qualifications, and disciplinary actions) to establish the presence of the specialized professional background required for membership, affiliation, or a position within a healthcare organization or system. The result of credentialing is that a provider is granted membership in a medical staff or provider panel.
- National Practitioner Databank (NPDB) and the Healthcare Integrity and Protection Databank (HIPDB)***: The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Office of Workforce Evaluation and Quality Assurance, Practitioner Data Banks Branch is responsible for the management of

the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. HRSA. They can be located on the Internet at [www.npdb-hipdb.hrsa.gov/](http://www.npdb-hipdb.hrsa.gov/).

3. **Organizational Providers:** are providers with whom Pathways contracts and that directly employ and/or contract with individual practitioners to provide health care services.
4. **PIHP:** is the Prepaid Inpatient Health Plan under contract with the Department of Community Health to provide managed behavioral health services to Medicaid eligible individuals.
5. **Practitioner/Provider:** is any individual that is engaged in the delivery of healthcare services and is legally authorized to do so by the State in which he or she delivers the services.
6. **Senior Clinical Staff Person:** The appointed leadership role of the credentialing program of at least one senior clinical staff person who has: current, unrestricted clinical license(s); qualifications to perform clinical oversight for the services provided; post-graduate experience in direct patient care; and Board certification (if the senior clinical staff person is an M.D. or D.O.).

#### **REFERENCES:**

- 42 CFR §438.214
- Balanced Budget Act of 1997
- URAC Health Plan Credentialing Standards 7.2 version P-CR-1,P-CR 6, P-CR 8,PCR-12,P-CR 13,P-CR 14,P-CR-16
- Medicaid Provider Manual
- MDCH/PIHP Master Contract (Medicaid Managed Specialty Supports and Services Concurrent 1915(B)(c) Waiver Program)
- Medicaid Sub-Contracting Agreement (PIHP/CMHSP Contract)
- NorthCare Network/Member CMHSP Delegation Agreement
- NorthCare Network Policies:
  - Background Check
  - Compliance Plan
  - Credentialing Program
  - Delegation Agreement with Member CMHSPs
  - Network Provider Grievance and Appeals
  - Privileging
  - Standard Application Policy
  - Training

#### **HISTORY:**

Dates Reviewed: June 30, 2015

Dates Revised:

Dates Approved: June 4, 2014

## PROCEDURES:

General Guidelines: Pathways and each Organizational Provider is responsible for ensuring that each provider, employed or under contract, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements.

### **I. Credentialing Individual Practitioners employed/contracted by Pathways or Organizational Providers**

#### A. General Guidelines - Credentialing Individual Practitioners

1. The Provider Organization must have a written system in place for credentialing and recredentialing individual practitioners included in their provider network that are not operating as part of an organizational provider. Credentialing and recredentialing must be conducted and documented for at least the following health care professionals:
  - a. Physicians (M.D.s and D.O.s)
  - b. Physician's Assistants (P.A.s)
  - c. Psychologists (Licensed, Limited Licensed, and Temporary Licensed) (LPs, LLPs, TLLPs)
  - d. Master's Social Workers - Licensed and Limited Licensed (LMSW, LLMSW)
  - e. Bachelor's Social Workers - Licensed and Limited Licensed (LBSW, LLBSW)
  - f. Registered Social Service Technicians (SSTs)
  - g. Professional Counselors - Licensed and Limited Licensed (LPCs and LLPCs)
  - h. Nurse Practitioners (NPs)
  - i. Registered Nurses (RNs)
  - j. Licensed Practical Nurses (LPNs)
  - k. Occupational Therapists (OTRs)
  - l. Occupational Therapist Assistants (OTAs)
  - m. Physical Therapists (PTs)
  - n. Physical Therapist Assistants (PTAs)
  - o. Speech Pathologists
  - p. Dietician
  - q. Certified Addictions Counselor: Certified Alcohol & Drug Counselor (CADC)– Michigan, CADC– International Credentialing and Reciprocity Council (IC & RC)
  - r. Certified Clinical Supervisor (CCS), CCS – IC & RC, CCS –Michigan)
  - s. Certified Criminal Justice Professional (CCJP)
2. Pathways and Organizational Provider's must ensure:
  - a. That the credentialing and recredentialing processes do not discriminate against:
    - i. A health care professional, solely on the basis of license, registration or certification; or
    - ii. A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.
    - iii. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either

Medicare or Medicaid. A complete list of Centers for Medicare and Medicaid Services (CMS) sanctioned providers is available on their website at <http://exclusions.oig.hhs.gov>. A complete list of sanctioned providers is available on the Michigan Department of Community Health website at [www.michigan.gov/mdch](http://www.michigan.gov/mdch) (click on Providers, click on Information for Medicaid Providers, click on List of Sanctioned Providers).

3. If Pathways or an Organizational Provider delegates to another entity any of the responsibilities of credentialing/recredentialing or selection of providers that are required by this policy, the entity to whom authority has been delegated must meet all requirements associated with the delegation of Pathways or the Network Organizational Provider functions. Pathways or the Organizational Provider is responsible for oversight regarding the respective entity's delegated credentialing or recredentialing decisions. Pathways retains final authority to approve, suspend, or terminate a provider selected by that entity.
4. Compliance with the standards outlined in this policy must be demonstrated through Organizational Provider's policies and procedures. Compliance will be assessed based on the Organizational Provider's policies and standards in effect at the time of the credentialing/recredentialing decision.
5. Pathways and the Organizational Provider's written credentialing policies must reflect the scope, criteria, timeliness and process for credentialing and recredentialing providers. The policies must be approved by the Organizational Provider's governing body, and:
  - a. Identify the Organizational Provider administrative staff member and Credentialing Committee responsible for oversight and implementation of the process and delineate their role;
  - b. Describe the use of participating providers in making credentialing decisions;
  - c. Describe the methodology to be used by Organizational Provider's staff members or designees to provide documentation that each credentialing or recredentialing file was complete and reviewed, as per (1) above, prior to presentation to the credentialing committee for evaluation;
  - d. Describe how the findings of the Organizational Provider's Quality Assessment Performance Improvement Program are incorporated into the recredentialing process
  - e. Describe how the confidentiality of credentialing records is maintained. This will include the procedures that outline how authorized access to credentialing files is limited and maintained. And the procedures that outline the training for all credentialing staff and Credentialing Committee members regarding the confidentiality of credentialing files and Committee meeting activities.
6. Organizational Provider's must ensure that an individual credentialing/recredentialing file is maintained for each credentialed provider. Each file must include:
  - a. The initial credentialing and all subsequent recredentialing applications;
  - b. Information gained through primary source verification;

- c. Documentation that each file was complete and reviewed prior to evaluation by the credentialing committee; and
- d. Any other pertinent information used in determining whether or not the provider met the CMHSP/SA Provider credentialing and recredentialing standards.

## B. Initial Credentialing of Individual Providers

At a minimum, policies and procedures for the initial credentialing of the individual providers require the review of the application by the Credentialing Committee within 180 days of a completed application with applicant signed attestation page. Pathways will utilize the NorthCare standard application for individual providers whether they are employees or contract providers. Primary and secondary source verification must be within six months prior to review. The review and approval of an application must be completed prior to designation as a participating provider.

1. The written application is completed, signed and dated by the provider and attests to the following elements:
  - 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. An acknowledgement of the ongoing responsibility to notify the employer in a timely manner of any adverse change in licensure or certification status. As soon as the employee is aware or should have been aware of the change, the employer must be notified.
  - e. Attestation by the applicant of the correctness and completeness of the application.
2. An evaluation of the provider's work history for the prior five years.
3. Verification from primary sources of:
  - a. Licensure or certification including the expiration of the license or certificate and the date of verification
  - b. Board Certification, or highest level of credentials attained if applicable, 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 or, in lieu of the NPDB/HIPDB query, all of the following must be verified:
    - i. Minimum of five-year history of professional liability claims resulting in a judgment or settlement;
    - ii. Disciplinary status with regulatory board or agency; and
    - iii. Medicare/Medicaid sanctions.
  - e. If the individual practitioner undergoing credentialing is a physician, then the Physician Masterfile System obtained from the American Medical Association may be used to satisfy the primary source of requirements of (a), (b), and (c) above.

4. A cover letter is required with all credentialing applications stating the following mechanisms and the specific staff to contact regarding any concerns in these matters:
  - a. Communicate about the status of their credentialing request
  - b. Have the opportunity to correct incomplete, inaccurate or conflicting credentialing information.
  - c. Understand that updated information does not prevent the organization from considering the additions or corrections in the credentialing process and submitting to the credentialing committee even if after correction the application appears to be a “clean application”.
5. A clean application does not require review by the Credentialing Committee and the Senior Clinical Staff Person may approve the application. A clean application is where the provider has completed all applicable sections of the credentialing application; where indicated the provider has signed, initialed and dated the credentialing application; and all necessary support documentation has been submitted and is included with the credentialing application in the provider’s file.
  - a. The provider application must be submitted on the standard NorthCare Network Credentialing Application.
6. If during the review of an application issues of quality of care emerge, such as missing or inconsistent information, training requirements or consumer safety or malpractice issues:
  - a. The organization is required to document their investigation of those issues and send findings to the Credentialing Committee.
  - b. The Credentialing Committee will make a decision as to whether to approve with 1) no conditions (other than usual probationary period) 2) require a plan of correction along with probation 3) deny the request for credentialing.
7. Written Notification of Credentialing Determination within 10 Days:
  - a. Written notice to all applicants must be provided within ten days of the Credentialing Committee’s decision as to their application.
  - b. For any adverse determinations made by the Committee: an individual practitioner or organizational provider that is denied credentialing or re-credentialing shall be informed of the reasons for the adverse credentialing decision in writing.
  - c. If an individual or organizational provider, disagrees with a credentialing determination to deny suspend or terminate for any reason other than lack of need, the matter may reviewed at a higher level by submitting a written request to the Chief Executive Officer or designee within thirty (30) calendar days of disposition. The request must include the following (see Appeals Request Form):
    - i. Reason for dispute;
    - ii. Documentation to support the appeal

- C. Temporary / Provisional Credentialing of Individual Practitioners (applies only to Pathways Temporary or provisional credentialing of individual practitioners is intended to increase the available network of providers in underserved areas, whether rural or urban (per MDCH Credentialing Policy FY13). Pathways, if wishing to implement, must have policies and procedures to address granting of temporary or provisional credentials 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. Temporary or provisional credentialing shall not exceed 150 days.

NorthCare Network and Member CMHSPs shall have up to 31 days from receipt of a complete application (or request for credentialing), accompanied by the minimum documents identified below, within which to render a decision regarding temporary or provisional credentialing.

For consideration of temporary or provisional credentialing, at a minimum, a provider must complete a signed application that must include the following items:

- Lack of present illegal drug use.
- History of loss of license, registration, or certification and/or felony convictions.
- History of loss or limitation of privileges or disciplinary action.
- A summary of the provider's work history for the prior five years.
- Attestation by the applicant of the correctness and completeness of the application.

Pathways must conduct primary source verification of the following:

- Licensure or certification;
- Board certification, if applicable, or the highest level of credential attained; and
- Medicare/Medicaid sanctions.

Pathways Senior Clinical Staff Person must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification for credentialing must be completed in the timeframes outlined above.

D. Recredentialing Individual Practitioners Employed/Contracted by Pathways or Organizational Providers

The recredentialing policies for physicians and other licensed, registered, or certified health care providers must identify procedures that address the recredentialing process and include requirements for each of the following:

1. Formal Recredentialing at least every two years.
2. Update of standard application submitted for initial credentialing and cover letter with contact information of how to communicate with credentialing staff regarding application.

3. A standard process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a minimum, review of:
  - a. Medicare/Medicaid sanctions
  - b. State sanctions or limitations on licensure, registration or certification
  - c. Member/client concerns which include grievances (complaints) and appeals information including dignity and respect
  - d. Organizational Provider Quality issues such as the delivery of quality healthcare through evidence based treatments; practice guidelines and fidelity to standards of treatment; and abiding by agency standards of clinical documentation and other requirements
  - e. Changes in scope of practice
4. The same procedures outlined in Section B. 1-7 for initial credentialing of individual practitioners are applied to recredentialing applications.

## II. CREDENTIALING/RE-CREDENTIALING ORGANIZATIONAL PROVIDERS

### A. The Organizational Provider will:

1. Complete the standard NorthCare Network Organizational Application for credentialing and update the application for recredentialing. Recredentialing applications must include a process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a minimum, review of:
  - a. Medicare/Medicaid sanctions
  - b. State sanctions or limitations on licensure, registration or certification.
  - c. Member/client concerns which include grievances (complaints) and appeals information including dignity and respect.
  - d. Organizational Provider Quality issues such as the delivery of quality healthcare through evidence based treatments; practice guidelines and fidelity to standards of treatment; and abiding by agency standards of clinical documentation and other *requirements*.

### B. The Credentialing Organization must:

1. Validate and re-validate at least every two years, that the organizational provider is licensed or certified as necessary to operate in the State, and has not been excluded from Medicaid or Medicare participation relating to procurement issues from [www.epls.gov](http://www.epls.gov) and related to health care issues from <http://exclusions.oig.hhs.gov>.
2. At a minimum, the review of the application by the Credentialing Committee within 180 days of a completed application with applicant signed attestation page. Primary and secondary source verification must be within six month prior to review. The review and approval of an application must be completed prior to designation as a participating provider in the Provider Directory.



3. A cover letter is provided to credentialing/recredentialing applicant stating the following mechanisms and the specific staff to contact regarding any concerns in these matters:
  - a. Communicate about the status of their credentialing request
  - b. Have the opportunity to correct incomplete, inaccurate or conflicting credentialing information.
  - c. Understand that updated information does not prevent the organization from considering the additions or corrections in the credentialing process and submitting to the credentialing committee even if after correction the application appears to be a “clean application”.
4. At a minimum, every two years, the Credentialing organization conducts a credentialing audit of contracted facilities or other organizational providers that includes a review of credentialing policies and procedures to assure minimal compliance with Pathways policies and procedures; the security and confidentiality of credentialing records and an audit of credentialing files. The sample size of credentialing files should be 10 percent of such files, but in no case less than 10 files nor more than 30 files.
5. If during the review of an application issues of quality of care emerge, such as missing or inconsistent information, training requirements or consumer safety or malpractice issues:
  - a. The organization is required to document their investigation of those issues and send findings to the Credentialing Committee.
  - b. The Credentialing Committee will make a decision as to whether to approve with
    - 1) no conditions (other than usual probationary period)
    - 2) require a plan of correction along with probation
    - 3) deny the request for credentialing.
6. Written Notification of Credentialing/Recredentialing Determination within 10 Days:
  - a. The Organization is responsible to issue written notice to all applicants within ten days of the Credentialing Committee’s decision as to their application.
  - b. For any adverse determinations made by the Committee the Provider shall be informed of the reasons for the adverse credentialing decision in writing.
  - c. If an organizational provider disagrees with a determination in the application process or during review of a provider’s status, and wishes to have the matter reviewed at a higher level, the provider may do so by submitting a written request to the Chief Executive Officer or designee within thirty (30) calendar days of disposition. The request must include the following (see Appeals Request Form):
    - i. Reason for dispute;
    - ii. Documentation to support the appeal

### **III. DEEMED STATUS**

Individual practitioners or organizational providers may deliver healthcare services to more than one Network Provider. Organizations may recognize and accept credentialing activities conducted by any other Network Provider in lieu of completing their own credentialing activities. In those instances where an organization chooses to accept the credentialing

decision of another Network Provider, the organization must maintain copies of the credentialing Provider's decision in their administrative records.

#### **IV. REPORTING REQUIREMENTS**

The organization must have procedures for reporting improper known organizational provider or individual practitioner conduct that results in suspension or termination from the Pathways Network to appropriate authorities (i.e., DCH, the provider's regulatory board or agency, the Attorney General, etc.). Such procedures shall be consistent with current federal and state requirements, including those specified in the DCH Medicaid Managed Specialty Supports and Services Contract. After hire, it is the responsibility of the provider to notify the employer/payor in a timely manner of any adverse change in licensure or certification status. As soon as the provider is aware or should have been aware of the change, the employer/payor must be notified. Acknowledgement of this responsibility is to be documented in the annual performance review of the provider.