NORTHERN MICHIGAN REGIONAL ENTITY
ADMINISTRATIVE MANUAL

PROCEDURE NAME: **CREDENTIALING PROCEDURE**
CHAPTER: **FIVE – PROVIDER NETWORK & CONTRACT MANAGEMENT**
PROCEDURE #: **05-02-001**
EFFECTIVE DATE: **April 14, 2014**

PURPOSE
To establish guidelines for credentialing/re-credentialing individuals and organizational providers ("Providers") directly or contractually employed by the Northern Michigan Regional Entity (NMRE), the five Member Community Mental Health Services Programs (CMHSPs), and the Coordinating Agency (CA).

APPLICATION
All NMRE organizational provider clinical staff either employed or contracted by the five Member CMHSPs, and the Substance Use Disorder (SUD) provider panel.

PROCEDURE
A) Credentialing Individual Practitioners

1) The credentialing procedures of the CMHSPs/CA will apply to individual practitioners, employed and/or under contract, in the provider network consisting of:
   a) Physicians (M.D. or D.O.)
   b) Physician Assistants
   c) Nurse Practitioners
   d) Psychologists
   e) Limited Licensed Psychologists
   f) Licensed Master's Social Workers
   g) Licensed Bachelor's Social Workers
   h) Limited Licensed Social Workers
   i) Registered Social Service Technicians
   j) Licensed Professional Counselors
   k) Limited Licensed Professional Counselors
   l) Registered Nurses
   m) Licensed Practical Nurses
   n) Occupational Therapists
   o) Occupational Therapy Assistants
   p) Physical Therapists
   q) Physical Therapy Assistants
   r) Speech Pathologists
   s) Dieticians
   t) Pharmacists
   u) Board Certified Behavioral Analysts

2) CMHSP/CA credentialing/re-credentialing process will not discriminate against a Provider solely on the basis of license, registration or certification, or against a Provider who service 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 will not be considered for employment or contracting. The current Federal and State Sanctioned Provider Lists will be used to determine status under these programs.

4) Providers will ensure all contractedpractitioners, as well as any person that has an ownership or controlling interest in the Provider entity or is related to another owner of the Provider entity, submit a signed Providers Disclosure of Ownership statement at the time of credentialing, enrollment, or contracting, and updated at least every two (2) years thereafter.

5) 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 NMRE. The NMRE shall retain responsibility for oversight regarding delegated credentialing/re-credentialing decisions.

6) CMHSP/CA policies and procedures will designate an individual staff person and entity (e.g., a credentialing committee), as appropriate, responsible for oversight of the credentialing process and delineate its role. The NMRE's Provider Network Manager will assure that credentialing/re-credentialing processes in place across the twenty-one (21) counties served by the NMRE comply with NMRE policies and procedures and are being carried out by the CMHSP/CA's designated staff member in accordance with those policies and procedures.

7) The credentialing steps taken by one NMRE Member to credential contract Providers may be accepted by the other Members within the NMRE without duplication.

8) 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, whether individual or organizations, will complete a written application attesting to the following as indicated:
   a) Lack of present illegal drug use (individuals);
   b) Any history of loss of license and/or felony convictions (both individuals and organizations);
   c) Any history of loss or limitation of privileges or disciplinary action (both individuals and organizations); and
   d) Attestation by the Provider of the correctness and completeness of the application (both individuals and organizations).

2) The CMHSP/CA will 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 will review the Provider's work history for the previous five years.

4) There will 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 will 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; and
iii) Medicare/Medicaid sanctions.

e) If the Provider is a physician, then physician profile information obtained from the American Medical Association (AMA) may be used to satisfy the primary source requirements of (a), (b), and (c) above.

5) The designated CMHSP/CA staff will ensure that credentialing/re-credentialing information is complete and that findings are documented in the approved format. CMHSP/CA policies and procedures will describe the methodology used to document that each credentialing/re-credentialing file is complete and reviewed prior to presentation to credentialing committee for evaluation, as appropriate.

6) Designated CMHSP/CA staff will review the information obtained and determine whether to approve credential 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 policies and procedures will 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 of 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, whether individuals or organizations, will complete a written application attesting to the following as applicable:
   a) Lack of present illegal drug use (individuals);
   b) Any history of loss of license and/or felony convictions (both individuals and organizations);
   c) Any history of loss or limitation of privileges or disciplinary action (both individuals and organizations);
   d) Attestation by the Provider of the correctness and completeness of the application (both individuals and organizations).

2) Designated CMHSP/CA staff will review the Provider's work history for the prior five years.

3) There will 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 will not exceed one hundred fifty (150) days.

5) Providers will 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 will be re-credentialed every two years to include:
1) An update of information obtained during the initial credentialing process;
2) A review of Medicaid/Medicare 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 Quality Assessment Performance Improvement Program (QAPIP) studies, Quality Improvement findings or other sources for information on service quality.

E) Organizational Providers

1) At the time of initial application, organizational Providers will 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/CA will 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/CA will credential/re-credential directly employed and contracted service providers in accordance with the NMRE's credentialing/re-credentialing policies and procedures.

F) Adverse Credentialing Decisions

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

G) Appeal Process

In the event a credentialing/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 Chief Executive Officer (CEO) of the CMHSP/CA for which participation was denied within ten (10) business days of the date of the determination notice. The letter will concisely state the basis for the appeal and will 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 will be final and binding. This appeal process will apply to Providers employed and/or directly contracted with the NMRE when the NMRE denies, suspends, or terminates a Provider for any reason other than for lack of need.

Reporting

The CMHSP/CA will report any conduct by a member of its provider network that results in suspension or termination from the provider network to the NMRE who will, in turn, report the conduct to the appropriate authorities [i.e., Michigan Department of Community Health (MDCH), the Provider's regulatory Board or agency, the Attorney General] and any other Federal and State entities as specified in the MDCH/PIHP Medicaid Managed Specialty Supports and Services Contract. Additionally, NMRE will notify MDHHS BHDDA regarding any disclosures of criminal offense as found in sections 1128(a) and 1128(b)(1)(2), or (3) of the Social Security Act, or that have had civil monetary penalties or assessments imposed under section 1128A of the Act.

REFERENCE
MDCH/PIHP Medicaid Specialty Supports and Services Contract Attachment P.6.4.3.1

REVISED: **July 21, 2016**

REVIEWED: **April 14, 2014**

Signed copy is on file with NMRE
Dave Schneider
Northern Michigan Regional Entity Chief Executive Officer

Date