POLICY AND PROCEDURE MANUAL

SUBJECT Credentialing	ACCOUNTABILITY NMRE, NMRE Network Providers	Effective Date: May 28, 2014	Pages:
REQUIRED BY	BBA Section: PIHP Contract Section: Other: (listed under "References")	Last Review Date: July 19, 2019	Past Review Date: April 21, 2016
Policy: ☒ Procedure: ☐	Review Cycle: Annual Author: NMRE Provider Network Manager	Responsible Department: Provider Network	Reviewers: NMRE Operations

Definitions

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system or his/her representative.

National Practitioner Databank (NPDB) and the Healthcare Integrity and Protection Databank (HIPDB): The US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Health Professionals, Office of Workforce Evaluation and Quality Assurance, Practitioner Data Banks Branch is responsible for the management pf the NPDB and HIPDB HRSA.

Network Provider: Any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the state's contract with the NMRE, its member CMHSPs, and the Substance Use Disorder provider panel.

Prepaid Inpatient Health Plan (PIHP): A organization that is responsible for managing Medicaid services related to behavioral health and development disabilities.

Purpose

The purpose is to ensure that anyone rendering services to beneficiaries is appropriately credentialed within the state and is qualified to perform the services by having met all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements.

Policy

The NMRE will monitor its Network Providers so that appropriately qualified and competent staff provide covered and authorized services. Credentialing will be based upon specific license, education, training, experience, and competence. The provider's level of competence and professional ethics must

be of the highest order, and must continuously meet or exceed the qualifications, standards, and requirements.

A. The PIHP will:

   1. Be responsible for oversight of credentialing or re-credentialing decisions; and

   2. Terminate the credentialing of a provider when appropriate.

B. The NMRE will ensure that the credentialing and re-credentialing processes do not discriminate against:

   1. A behavioral health care provider, solely on the basis of license, registration, or certification and;

   2. A behavioral health care provider who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

C. The NMRE will ensure the following:

   1. The provision of high quality and cost-effective mental health and substance use disorder services to NMRE consumers.

   2. Consumer access to a timely, geographically convenient, and specialized array of mental health and substance use disorder treatment and support services.

   3. LIPs meet and/or exceed the accreditation and regulatory standards for practicing and delivering services independently.

   4. The decision to enter a contractual relationship with any LIP credentialed by the NMRE under this policy is left to each CMHSP based on the needs of their board and community.

References

1. MDHHS contract Attachment PII.B.A
2. Act 368 of 1978, Public Health Code 333.1617
3. MCL 400.734b
4. Public Acts, 28 and 29 of 2006
5. Public Acts, 61 pf 2004
6. NMRE Excluded Provider Checks
7. NMRE Disclosure of Ownership
8. NMRE Sanctions
9. NMRE Monitoring

Approval Signature

7/19/19

NMRE Chief Executive Officer

Date

SUBJECT Credentialing	ACCOUNTABILITY NMRE, NMRE Network Providers	Effective Date: April 14, 2014	Pages:
REQUIRED BY	BBA Section: PIHP Contract Section: Other: (listed under "References")	Last Review Date: July 19, 2019	Past Review Date: July 21, 2016
Policy ☐ Procedure ☒	Review Cycle: Annual Author: NMRE Provider Network Manager	Responsible Department: Provider Network	Reviewers: NMRE

Procedure

Initialing and ongoing credentialing/privileging is the responsibility of Network Providers. The NMRE will monitor for compliance during its annual site visits, or as needed. The NME retains the right to approve, suspend, or terminate from participation in the provision of Medicaid funded services any Network Provider that fails to meet all requirements associated with the delegation of the PIHP function. The NMRE is responsible for oversight regarding delegated credentialing or re-credentialing decisions.

A. Credentialing Individual Practitioners

1. Credentialing procedures will apply to individual practitioners, employed and/or under contract by the NMRE or its Network Providers including:

    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. Network Providers' credentialing/re-credentialing processes will not discriminate against anyone solely on the basis of license, registration or certification, or against anyone who provides services to high-risk populations or who specializes in the treatment of conditions that require costly treatment.

3. Network 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. Network Providers will ensure all contracted practitioners, 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 every three (3) years or at the renewal of the contract and at any time there is a revision to the information, change in ownership, or upon request for updated information.

5. The Network Providers' policies and procedures will designate an individual staff person and entity (e.g., a credentialing), 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 the twenty-one (21) county NMRE region comply with regulatory requirements, the MDHHS-PIHP Contract, and NMRE policies and are being carried out accordingly by the Network Provider.

6. The credentialing steps taken by one Network Provider may be accepted by the other Network Providers within the NMRE without duplication.

7. A separate file will be maintained for each credentialed provider which will 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 the Provider met the credentialing standards.

B. Initial Credentialing

1. 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); and

    d. Attestation by the applicant of the correctness and completeness of the application (both individuals and organizations).

2. Network Providers 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 background checks have been performed and satisfactory results are obtained, Network Providers may continue with the approval process.

3. Network Providers will review the applicant's work history for the previous five years.

4. Network Providers will conduct primary source verification 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 NPSB/HIPDB query, all 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. For physicians, 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. Network Providers will ensure that credentialing/re-credentialing information is complete and that findings are documented in the approved format. Network Providers' 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. Network Providers will 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 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. Network Providers' credentialing/re-credentialing policies and procedures will describe the role of participating providers in making credentialing decisions, if applicable.

8. Network 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.

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 applicants 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 applicant of the correctness and completeness of the application (both individuals and organizations).

2. Network Providers will review the applicant's work history for the prior five years.

3. Network Providers will conduct primary source verification 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. Network Providers will review the information obtained and determine whether to grant provisional credentials. Credentialing determinations will be made and communicated to the applicant 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. Network 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 Network Providers will be re-credentialed every two years to include:

1. Any updated 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, Network Providers may continue with the contract approval process.

3. Network Providers will perform background checks initially and at least every two years to assure that the license to operate is current and that the provider (both individuals and organizations) has not been excluded from Medicaid or Medicare participation.

4. Network Providers will credential/re-credential directly employed and contracted service providers (both individuals and organizations) 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 a Network Provider will be informed of the reasons for the adverse decision in writing by the Network Provider.

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 Network Provider's Chief Executive Officer CEO) 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 Network Provider's CEO 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.

H. Reporting

The Network Provider 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.

Approval Signature

7/19/19

NMRE Chief Executive Officer Date