POLICY AND PROCEDURE MANUAL	BCCMHA	PAGE 1 OF 13
CATEGORY – ORGANIZATIONAL PROCEDURES	CHAPTER 6	SUBJECT Y
PROVIDER NETWORK CREDENTIALING	REVISED 10/12/11 12/12/13 10/31/16 03/08/17	EFFECTIVE 06/09/2010

I. PURPOSE

The purpose of the provider network is to enroll and credential competent and qualified providers to meet the needs of the population served by Barry County Community Mental Health Authority (BCCMHA). The policy establishes guidelines for credentialing and re-credentialing behavioral health organizational providers, facility providers, and independent contractors.

II. APPLICATION

The provision of this policy applies to administrative staff of BCCMHA and contractual service providers.

III. POLICY

BCCMHA may credential and re-credential behavioral health organizations, facilities, and independent behavioral health contractual providers with whom it contracts and fall within its scope of authority and action. BCCMHA, as part of its provider network practices, will not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. BCCMHA will not discriminate against a provider solely on the basis of license or certification. This does not preclude BCCMHA from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to clients and the community served.

It is the responsibility of the BCCMHA Credentialing Committee to review and recommend approval of the credentialing application of applicants prior to them being designated as a participating provider on the BCCMHA provider network.

PROVIDER CREDENTIALING

BCCMHA will communicate with providers about their credentialing status upon request throughout the credentialing process.

IV. DEFINITIONS

Organizational Provider: Entities that directly employ and/or contract with individuals to provide behavioral health care services. Examples of organizational providers include, but are not limited to: Community Mental Health Services Programs; homes for the aged; and home health agencies.

Facility Provider: A qualified treatment system, facility, or organization, providing or seeking to provide Behavioral Health support or direct care services authorized for contracting through the credentialing and privileging process as evidenced by appropriate degree, licensure, certification, registration or accreditation and standards of quality.

Group/Individually Licensed Provider: An individual contracted with by BCCMHA to provide behavioral health care, support, or services who has met the qualifications evidenced by education, training, certification, registration, or experience. The provider is required to hold a professional licensure, certification, or registration (i.e., OTR, LLP, etc.)

Independent Contract Provider: An individual contracted with by BCCMHA to provide behavioral health care, support, or services, who has met the qualifications evidenced by education, training, or experience. The provider is not required to hold a professional licensure, certification, or registration (i.e., SLP, BSW, etc.).

Provider: An individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which he or she delivers the services.

Specialized Residential Providers: Licensed foster care homes operating with a specialized certification from the Department of Health and Human Services.

V. STANDARDS & PROCEDURES

Initial Credentialing

PROVIDER CREDENTIALING

The Contract Manager will provide applications for network participation and credentialing to contractual providers on request, upon entering into a contractual relationship, or when being considered for ongoing contractual relationships older than one year. The application packet includes:

- ✓ Cover Letter
- ✓ Individual Practitioner Application Form which gathers:
    i. Personal or organizational data (name, address, TIN/SSN, etc.)
    ii. Education/Training
    iii. License/Certification
    iv. Accreditation, if applicable
    v. National Practitioner Data Bank query, if applicable
    vi. Residency/Fellowship, if applicable
    vii. Current Resume with Employment History (at least five prior years), if applicable
    viii. Federal & State Exclusion Lists
    ix. Malpractice Claim History
    x. Clinical Staff Membership, if applicable
    xi. Recipient Rights Claims
    xii. Disciplinary Action

- ✓ Organizational Applications Form which gathers:
    i. Organizational Data (name, address, TIN/SSN, etc.)
    ii. Current W-9
    iii. License/Certification, if applicable
    iv. Accreditation, if applicable
    v. Staffing
    vi. Federal & State Exclusion Lists
    vii. Liability, Workman's Comp, and Auto Insurance, as applicable
    viii. Recipient Rights Claims

- ✓ BCCMHA Code of Ethics.
- ✓ Attestation with assurance regarding accuracy and completeness of information, ability to perform duties, and acknowledgement of obligation to provide continuous quality care to BCCMHA clients.
- ✓ Consent for inspecting records related to license, training, experience, competence and any other information required by the application.
- ✓ Insurance verification, including but not limited to, liability, malpractice, and workman's compensation.

PROVIDER CREDENTIALING

- ✓ Release of liability indicating that BCCMHA is released from liability in the process of obtaining and evaluating credentialing application and related information.
- ✓ The application with attestation to the application's completeness, lack of present illegal drug use, loss of license history, any felony convictions, and history of loss or limitations of privileges or disciplinary action must be signed and dated by the applicant.
- ✓ Provider responsibilities, definitions, and applicable provider network policies are submitted to the provider.

Upon completion of the credentialing packet, the application and supporting documentation is submitted to the Contract Manager within the time period stated on the cover letter. Failure to provide a completed packet within the designated time frame may prevent BCCMHA from entering into or may negatively impact the contractual relationship with the applicant. Failure to provide requested information within the application or providing information containing significant misrepresentations or omissions may be grounds for denial of the application.

Once the application is complete, and the information is verified against primary sources and other sources regarding state licensure, board certification (if applicable), Medicare/ Medicaid sanctions, OIG sanctions, and other federal and/or state exclusion lists and is incorporated into a credentialing provider file. The file will be maintained for each credentialed provider and the file will include the initial and all subsequent credentialing applications. In lieu of the National Practitioner Data Base query, all of the following must be verified:

A. Minimum five year history of professional liability claims resulting in a judgment or settlement;
B. Disciplinary status with regulatory board or agency; and
C. Medicare/Medicaid Sanctions

Prior to review of the committee, the Contract Manager will verify completeness, accuracy and look for any conflicting information in the credentialing application. A checklist will be utilized to review information and to ensure that primary source verifications have been documented to ensure a complete file is ready for committee review. Upon conclusion of preparing the file for review, the Contract Manager will sign and date on the space indicated on the checklist indicating the initial review is complete. Throughout the credentialing process, BCCMHA will communicate with providers upon their request regarding the status of their credentialing applications. Additional information will be accepted from providers to correct incomplete, inaccurate or

conflicting credentialing information. When missing information is observed during the review of credentialing applications, the Contract Manager will request this information from the provider to ensure a complete file is prepared for the Credentialing Committee. Documentation submitted with the application must be collected less than six months prior to review. Primary and secondary source verifications must be completed and collected no more than six months prior to review. If documentation is older, an attestation shall be obtained from the applicant that indicates the documentation remains valid. See Attachment C, Credential Committee Charter.

Documentation Requirement	**Clean File Criteria**
Complete application with a signed and dated statement from an authorized representative of the facility attesting that the information submitted with the application is complete and accurate to the facilities' knowledge, and authorization BCCMHA to collect any information necessary to verify the information in the credentialing application.	Complete application with no positively answered attestation questions.
State licensure information. License status and any license violations or special investigations incurred during the past five years or during the credentialing cycle will be included in the credentialing packet for committee consideration.	No license violations and no substantiated special state investigations in time frame (in past five years for initial and past two years for re-credentialing)
Accreditation by a national accrediting body (if such accreditation has been obtained). If an organization is not accredited, an on-site review may occur by designated staff prior to contracting.	Full accreditation status during the last accreditation review or no plan of correction or action based upon the on-site review.
Verification that the provider has not been excluded from federal/state healthcare program participation.	Is not on the OIG Sanction List/SAM List

PROVIDER CREDENTIALING

A copy of the facility's liability insurance policy declaration sheet (Certificate of Insurance).	Current insurance coverage meeting contractual needs.
Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query.	No malpractice lawsuits and/or judgements from within the last 10 years.
Any other information necessary to determine if the facility meets the network-based participation criteria.	Information provided as requested.
Quality information will be considered at re-credentialing.	Grievance and appeals and recipient rights complaints are within the expected thresholds given the provider size and other performance indicators, if applicable, meet standard.

The Contract Manager will make the complete application and supporting documentation available for review by the Credentialing Committee. The Credentialing Committee will review all applications and approve or deny credentialing status for staff members. Recommendations to approve or deny credentialing status for contractors and/or organizational providers will be submitted to the Southwest Michigan Behavioral Health (SWMBH) Credentialing Committee for final decision. The SWMBH Credentialing Committee's denial of credentialing status approved by BCCMHA's Credentialing Committee may be appealed to the SWMBH CEO group. The process from application to review shall take no more than 120 days, and the entire credentialing process must be completed within 180 days.

Information discovered through the credentialing process that may impact the quality of care or service provided to clients will prompt an additional review of the provider. Such circumstances are likely to be, but not limited to, information about malpractice litigation, missing information or inconsistent information. In such instances the committee will review the information and request the Contract Manager or other designee to further research the issue with the provider. The provider file will be pended at that time until the investigation can be completed. The investigation will include review of the information submitted, interview with the provider and obtaining any

further information as requested by the Credentialing Committee. The investigation will be documented by the Contract Manager or other designee. The Contract Manager will review the investigation findings and develop a summary of the issues for presentation at the Credentialing Committee. This summary will be presented at the next scheduled Credentialing Committee meeting once the investigation and summarization is complete. The committee will make a credentialing determination.

Applicants will be notified, in writing, of the credentialing decision within 10 business days following the final decision, and specify the reason for any limited or adverse credentialing decision. In the case of a limited or adverse decision, the applicant will be notified of their right to appeal and/or dispute the decision, and of the process for such appeal and/or dispute.

Applicants have the right to review information submitted in support of their credentialing application and will be permitted to do so upon request, in writing, to the Contract Manager.

Re-Credentialing

The application for credentialing or re-credentialing will be kept on file and completed once every two years. This does not preclude the ongoing monitoring of state/federal sanctions, state sanctions or limitations of licensure or certification, and client grievances and appeals. The above mentioned ongoing sanction and licensure/certification monitoring is conducted annually at a minimum. See Attachment D, Credentialing and Re-Credentialing Process.

BCCMHA will send a re-credentialing application and packet to the network provider no later then 60 days prior to the next required re-credentialing date. Notification of re-credentialing will be submitted to applicants in a letter. A summary or photocopy of the provider's previous credentialing application will be made available upon request.

The re-credentialing packet is identical to the initial application packet. Contents of the pack include:

- ✓ Cover Letter
- ✓ Application form which gathers data on:
    i. Personal Data (name, address, TIN/SSN, etc.)
    ii. Education/Training
    iii. License/Certification
    iv. Accreditation, if applicable

PROVIDER CREDENTIALING

v. National Practitioner Data Bank query, if applicable
vi. Residency/Fellowship, if applicable
vii. Current Resume with Employment History (at least five prior years), if applicable
viii. Federal & State Exclusion Lists
ix. Malpractice Claim History
x. Clinical Staff Membership, if applicable
xi. Recipient Rights Claims
xii. Disciplinary Action
xiii. Malpractice/Liability Insurance Information

- ✓ Organizational Applications Form which gathers:
  - ix. Organizational Data (name, address, TIN/SSN, etc.)
  - x. License/Certification, if applicable
  - xi. Accreditation, if applicable
  - xii. Staffing
  - xiii. Federal & State Exclusion Lists
  - xiv. Liability Insurance
  - xv. Recipient Rights Claims

- ✓ BCCMHA Code of Ethics
- ✓ Attestation with assurance regarding accuracy of information, ability to meet contractual obligations and/or contractual services for BCCMHA.
- ✓ Consent for obtaining and inspecting all records related to license, education, training, experience, competence and any other information required by the application.
- ✓ Insurance verification.
- ✓ Release of liability, indicating that BCCMHA is released from liability in the process of obtaining and evaluating credentialing application and related information.
- ✓ A copy of the previously submitted credentialing application for review and revision. This will assist the provider and make the re-credentialing process easier.

Upon completion of the re-credentialing packet, the application and supporting documentation is submitted to the Contract Manager within the time period stated on the cover letter. Failure to provide a completed packet within the designated time frame may result in the withholding of service claim reimbursement until the completed packet and appropriate supporting documentation is received. Failure to provide requested

information within the application or providing information containing significant misrepresentations or omissions may be grounds for denial of the application and ultimately termination of the contractual relationship.

Once the application is complete, the information is verified against primary sources and other sources regarding Medicare/Medicaid sanctions, OIG sanctions, and other federal and/or state exclusion lists and is incorporated into a credentialing provider file. The file will be maintained for each credentialed provider and the file will include the initial and all subsequent credentialing applications.

Prior to review of the committee, the Contract Manager will verify completeness, accuracy and look for any conflicting information in the credentialing application. A checklist will be utilized to review information and to ensure that primary source verifications have been documented to ensure a complete file is ready for committee review. Upon conclusion of preparing the file for review, the Contract Manager will sign and date on the space indicated on the checklist indicating the initial review is complete. Throughout the re-credentialing process, BCCMHA will communicate with providers upon their request regarding the status of their credentialing applications. Additional information will be accepted from providers to correct incomplete, inaccurate or conflicting credentialing information. When missing information is observed during the review of credentialing applications, the Contract Manager will request this information from the provider to ensure a complete file is prepared for the Credentialing Committee.

Documentation Requirement	**Clean File Criteria**
Complete application with a signed and dated statement from an authorized representative of the facility attesting that the information submitted with the application is complete and accurate to the facilities' knowledge, and authorization for BCCMHA to collect any information necessary to verify the information in the credentialing application.	Complete application with no positively answered attestation questions.

PROVIDER CREDENTIALING

State licensure information. License status and any license violations or special investigations incurred during the past five years or during the credentialing cycle will be included in the credentialing packet for committee consideration.	No license violations and no substantiated special state investigations in time frame (in past five years for initial and past two years for re-credentialing)
Accreditation by a national accrediting body (if such accreditation has been obtained). If an organization is not accredited, an on-site review may occur by designated staff prior to contracting.	Full accreditation status during the last accreditation review or no plan of correction or action based upon the on-site review.
Verification that the provider has not been excluded from federal/state healthcare program participation.	Is not on the OIG Sanction List/SAM List
A copy of the facility's liability insurance policy declaration sheet (Certificate of Insurance).	Current insurance coverage meeting contractual needs.
Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query.	No malpractice lawsuits and/or judgements from within the last 10 years.
Any other information necessary to determine if the facility meets the network-based participation criteria.	Information provided as requested.
Quality information will be considered at re-credentialing.	Grievance and appeals and recipient rights complaints are within the expected thresholds given the provider size and other performance indicators, if applicable, meet standard.

The Contract Manager will make the complete application and supporting documentation available for review by the Credentialing Committee. The Credentialing Committee will review all applications and approve or deny credentialing status for staff members.

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Recommendations to approve or deny credentialing status for contractors and/or organizational providers will be submitted to the SWMBH Credentialing Committee for final decision. The SWMBH Credentialing Committee's denial of credentialing status approved by BCCMHA's Credentialing Committee may be appealed to the SWMBH CEO group. The process from application to review shall take no more than 120 days, and the entire credentialing process must be completed within 180 days.

Applicants will be notified, in writing, of the re-credentialing decision within 10 business days following the final decision, and the reason for any limited or adverse credentialing decision will be specified. In the case of a limited or adverse decision, the applicant will be notified of their right to appeal and/or dispute the decision, and of the process for such appeal and/or dispute.

Information discovered through the re-credentialing process that may impact the quality of care or service provided to clients will prompt an additional review of the provider. Such circumstances are likely to be, but not limited to, information about malpractice litigation, missing information or inconsistent information. In such instances the committee will review the information and request the Contract Manager or other designee to further research the issue with the provider. The provider file will be pended at this time until the investigation can be completed. The investigation will include review of the information submitted, interview with the provider and obtaining any further information as requested by the Credentialing Committee. The investigation will be documented by the Contract Manager or other designee. The Contract Manager will review the investigation findings and develop a summary of the issues for presentation at the Credentialing Committee. This summary will be presented at the next scheduled Credentialing Committee meeting once the investigation and summarization is complete. The committee will make a credentialing determination.

Temporary Provisional Credentialing

A provider must complete a signed application that must include:

- ✓ Attestation to lack of present illegal drug use
- ✓ History of loss of license, registration or certification, as applicable to the contracted service
- ✓ Felony convictions
- ✓ History of loss or limitation of privileges or disciplinary action
- ✓ Evaluation of the work history for the prior five years, if an individual provider
- ✓ Attestation to the correctness and completeness of the application

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BCCMHA will render a decision regarding temporary/provisional re-credentialing within 31 days from receipt of a completed application after a review of information obtained and after it conducts appropriate primary source verification. The temporary/provisional credentialing shall not exceed 150 days. The same review and approval of provisional credentials will be employed as with an initial or re-credentialed applicant/provider. Following approval of provisional credentials, the process of credentialing will move forward as quickly as possible and according to the initial credentialing process outlined in this policy.

Also See Attachment E, Organizational and Practitioner File Checklist and Attachment F, Provider Network Application Review Tool.

REFERENCES

MDHHS Credentialing & Re-Credentialing Technical Requirements
SWMBH

PROVIDER CREDENTIALING

ATTACHMENTS

Attachment A – SWMBH Organizational Credentialing Application
Attachment B – SWMBH Independent Practitioner Credentialing Application
Attachment C – Contract Provider Release of Information
Attachment D – Credential Committee Charter
Attachment E – Credentialing and Re-Credentialing Processes
Attachment F - Organizational and Practitioner File Checklist
Attachment G – Credentialing Application

QUALITY IMPROVEMENT

The Quality Improvement Committee on an annual basis to enhance and improve the quality will evaluate this policy/procedure.

At any time employees can request in writing, on the form provided, that the Quality Improvement Committee review this policy or items in this policy. Employee's written requests can be given to any Quality Improvement Committee member.

When an area for improvement is indicated, the process for improvement as identified in the Quality Improvement Plan will be followed.

APPROVED BY:

Richard Thiemkey

Date

Executive Director

Kelly Jenkins

Date

PROVIDER CREDENTIALING

Chief Operating Officer

Emily Whisner, MA, LLP, CMHP, QMHP, QIDP

Date

Chief Clinical Officer

PROVIDER CREDENTIALING

Jill Bishop, MA, LLP, CMHP, QMHP, QIDP

Date

Clinical Director

Fay Featherly, MA, LLP, CAADC, CMHP, QIDP, QMHP

Date

Clinical Services Coordinator

Christine Hiar, MA, LLPC, CAADC, CCS, CMHP, QMHP

Date

Substance Use Disorders Coordinator

Amanda Hiltz, MA, LLP, CAADC, CMHP, QMHP, QIDP

Date

Case Management Supervisor

Tamie Case, MPA, CHC

Date

Corporate Compliance Officer/Contract Manager

Jayne Eaton Date
Positive Directions Manager/Safety Officer

PROVIDER CREDENTIALING

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REVIEW DATE

12/08/10
09/14/11
12/19/12
12/04/13
12/03/14
12/02/15
10/19/16
02/15/17
12/06/17