

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: January 31, 2024

Credentialing Program.P7

RESCINDS: June 27, 2018

CATEGORY: Personnel

SUBJECT: Credentialing Program

POLICY: Copper Country Mental Health Services Board (CCMHS) implements a comprehensive credentialing/re-credentialing plan that includes continuous credential monitoring, thereby assuring safety of persons served and provision of services by competent and qualified providers. Providers in bordering states are held to the same standards and procedures for credentialing and re-credentialing and must meet all applicable licensing and certification requirements of their state.

PURPOSE: CCMHS adopts this policy to assure that providers of clinical oversight, management, and direct services are fully qualified and in good standing. Accordingly, those providers are properly credentialed and privileged to perform the assignments detailed in their job descriptions. CCMHS utilizes continuous credentialing as described in this policy to monitor providers and to sanction providers who are out of compliance with CCMHS's credentialing standards. This process allows CCMHS to maintain a high quality of care and to respond more quickly when a provider ceases to be in compliance with credentialing criteria. 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:

Clean Application: The provider has completed all applicable sections of the NorthCare Network 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.

Credentialing Committee: A committee of professional peers led by a Senior Clinical Staff Person. The committee membership includes ad hoc members as well as required members to assure appropriate peer review for each provider. Delegation of this function to an organizational provider must be monitored for the same standards required for CCMHS's Credentialing Committee.

Credentialing Individual Providers: The process of reviewing, verifying, and evaluating a practitioner'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 practitioner is granted membership in a medical staff or provider panel. (As defined by the American Society of Addiction Medicine and the American Managed Behavioral Healthcare Association)

Credentialing Organizational Providers and Facilities: The process of validating 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 and that the organization properly credentials their directly employed and subcontracted direct service providers. Credentialing includes verifying and evaluating the applicant for information including but not limited to: State licensure information; a copy of the facility's liability insurance declaration; additional requirements per Michigan Medicaid Provider rules; a current copy of accreditation status; and a signed and dated attestation of authorized representative for the facility attesting the information is accurate and complete. Organizational providers are providers with whom CCMHS contracts and that directly employ and/or contract with individual providers to provide healthcare services. Examples of organizational providers include, but are not limited to hospitals, residential providers, and vocational providers. (As defined by MDHHS Contract P.6.4.3.1)

Databank: The National Practitioner Databank (NPDB) is an information clearinghouse created by Congress to improve health care quality and reduce health care fraud and abuse in the United States. The NPDB is also referred to as the Data Bank. The Data Bank is primarily an alert or flagging system intended to facilitate a comprehensive review of the professional credentials of health care practitioners, providers and suppliers.

Grievance: A formal complaint made based on something that somebody feels is unfair.

PIHP: The Prepaid Inpatient Health Plan under contract with the Department of Health and Human Services to provide managed behavioral health services to Medicaid eligible people.

Practitioner/Provider: Any individual 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.

Primary Source Verification: Verification based on information obtained directly from the issuing source of the credential.

Senior Clinical Staff Person: A senior clinical staff person who has: current, unrestricted clinical licenses(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.).

PROCEDURES:

I. Credentialing Individual Practitioners

A. Healthcare Professionals that Require Credentialing

Credentialing and re-credentialing must be conducted and documented for at least the following healthcare providers:

1. Physicians (MDs and DOs)
2. Physician Assistants (PAs)
3. Social Workers - Licensed and Limited Licensed Master's (LMSWs and LLMSWs)
4. Psychologists - Licensed, Limited Licensed and Temporary Limited Licensed (LPs, LLPs, and TLLPs)
5. Bachelor Social Workers - Licensed and Limited Licensed (LBSWs and LLBSWs)
6. Registered Social Service Technicians (SSTs)
7. Registered Nurses (RNs)
8. Licensed Practical Nurses (LPNs)
9. Nurse Practitioners (NPs)

10. Occupational Therapists (OTs)
11. Occupational Therapist Assistants (OTAs)
12. Physical Therapists (PTs)
13. Physical Therapist Assistants (PTAs)
14. Speech Pathologists
15. Dieticians
16. Limited Licensed or Licensed Professional Counselors
17. Certified Addictions Counselors CADC -Certified Alcohol & Drug Counselor – Michigan or CAADC-Certified Advanced Alcohol & Drug Counselor or CADC & CAADC through International Credentialing and Reciprocity Council (IC & RC)
18. Certified Clinical Supervisors (CCS), CCS-IC & RC, CCS-Michigan
19. Certified Criminal Justice Professionals (CCJP)
20. Certified Co-Occurring Disorders: CCDP-Certified Co-Occurring Disorders Professional or CCDP-D-Certified Co-Occurring Disorders Professional-Diplomat through IC &RC& MI
21. Board Certified Behavior Analyst
22. Student Interns in approved Master’s level educational program for social work, counseling, psychology, marriage and family therapy
23. Other behavioral healthcare specialists license, certified or registered by the State

B. Non-discrimination

CCMHS’s credentialing and re-credentialing process does not discriminate against:

1. A healthcare professional, solely on the basis of license, registration or certification; or
2. A healthcare professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

C. Excluded/Sanctioned Providers

CCMHS prohibits employment or contracts with providers who are excluded from participation under either Medicare or Medicaid. CCMHS completes Center for Medicare and Medicaid Services (CMS) queries on providers at <http://exclusion.oig.hhs.gov> as part of the application process. A complete list of sanctioned providers is available on the Michigan Department of Health and Human Services website at www.michigan.gov/mdhhs. CCMHS utilizes the Data Bank continuous query for monitoring excluded/sanctioned providers. If CCMHS receives notice or becomes aware that an employed staff or contracted provider has become an Excluded Party or Sanctioned Provider, CCMHS will terminate employment or the contract with the staff or provider upon verification of the information.

CCMHS will notify NorthCare’s CEO and/or Compliance Officer immediately if search results indicate that any of their network’s provider entities, or individuals or entities with ownership or control interests in CCMHS are on any of the exclusions databases.

D. Provider Credentialing Application

1. At the time of initial credentialing, all prospective providers shall complete NorthCare's Network Credentialing Application.
2. CCMHS will provide a cover letter to inform all credentialing applicants about the specific staff to contact in order to:
 - a. Communicate about the status of their credentialing request.
 - b. Have the opportunity to correct incomplete, inaccurate or conflicting credentialing information.

E. Background Check/Primary Source Verification

Primary and secondary source verification is completed within six months of the dated application. Telephone verification is acceptable if the call is documented and includes the name of the person at the issuing entity. The documentation is signed and dated by the CCMHS staff that obtains the information.

Following completion of the provider credentialing application, including submission of required support documentation, CCMHS's HR Department completes primary source verification on the following:

1. Licensure or certification.
2. Board certification, or highest level of credentials attained, if applicable, or completion of any required internships, residency programs, or other post-graduate training.
3. Documentation of graduation from an accredited school. CCMHS requires a copy of the provider's terminal degree diploma, if available, and official transcripts and/or LARA License.
4. Data Bank query.
5. If the individual practitioner undergoing credentialing is a physician, the physician profile information obtained from the American Medical Association may be used to satisfy the primary source requirements of (1), (2), and (3) above.

CCMHS may require prospective providers that will be directly employed by CCMHS to complete fingerprinting with the Michigan Long Term Care Background Check data base. This process includes the following background checks: Nurse Aid Registry (NAR), Offender Tracking Information System (OTIS), Public Sex Offender Registry (PSOR), System for Award Management (SAM) and the U.S. Health and Human Services Medicare/Medicaid Exclusion List (OIG). Additionally, CCMHS checks Internet Criminal History Access Tool (ICHAT) and the sanctioned provider list for the State of Michigan. The fingerprinting process determines if the provider is excluded from employment due to criminal history. Fingerprints remain in the database as a means of continuous monitoring of criminal record.

F. Credentialing File

CCMHS maintains a credentialing file for each credentialed provider. This file shall contain:

1. A completed provider credentialing application.

2. Copy of professional license(s) and verification of the license(s).
3. Board Certification, if applicable.
4. Copy of diploma, if available.
5. Official transcripts.
6. Background check.
7. Fingerprinting results (CCMHS employees only).
8. Data Bank query result.
9. 3 Written letters of reference.
10. Authorization of Clinical Privileges.
11. Proof of liability insurance, if applicable.
12. Any other pertinent information used in determining whether or not the provider met the credentialing standards.

CCMHS's HR Department completes a credentialing checklist, which is contained in the credentialing file. This checklist is used as a review method to assure completeness and accuracy of information in the file, as well as to identify and clarify any conflicting information. This checklist is completed before the file is given to the Credentialing Committee.

G. Confidentiality

Credentialing files and information, along with the minutes and records of the Credentialing Committee proceedings, will be maintained in a secure environment with access limited to CCMHS credentialing staff and site reviewers as necessary. To maintain the confidentiality and security of credential files, CCMHS's credential files are stored in a secure file room in CCMHS's HR Department. Access to credentialing files is limited to authorized credentialing personnel. CCMHS's Credentialing Committee will have a list of all staff with access to credentialing files. All electronic information related to credentialing is password protected and computers are locked when an employee leaves their workstation.

All CCMHS Credentialing Committee members, as well as anyone handling credentialing information (e.g., HR staff) are trained on the confidentiality of credential files. This training is documented in employee's training records. Signed confidentiality statements are obtained with this training and kept in employees' personnel files.

During the course of completing the responsibilities of the credentialing process, Credentialing Committee members may encounter Individually Identifiable Health Information. If this occurs, employees and committee members are required to preserve confidentiality. This is included in the confidentiality statement that is signed regarding performing as a committee member.

H. Credentialing Committee

1. Membership

CCMHS's Credentialing Committee consists of at least four (4) members appointed by the Executive Director for two-year terms. The Committee is chaired by the Senior Clinical Staff Person. Other

members include Human Resources staff, at least one provider who has no other role in management and one peer reviewer. Other providers, including specialty expertise, may be ad hoc members as needed and requested by the Senior Clinical Staff Person. When accessing an appropriate peer in order to discuss whether a particular type of provider is practicing reasonable standards of care, the clinical peer may attend the Credentialing Committee meeting in person or via telephone. The clinical peer's input will be reflected in the committee meeting minutes. All members of the Credentialing Committee will sign a confidentiality agreement and receive training regarding the confidentiality of the Committee's work before participating in a meeting of the Committee. The names of all attending will be documented in the meeting minutes.

2. Responsibilities of the Credentialing Committee

- a. To delegate the authority to approve or disapprove clean applications to the Senior Clinical Staff Person of the Committee.
- b. To review the credential file and application of all providers (individual and organizational) presented by the Senior Clinical Staff Person and give final approval or disapproval of the applicant for participation as a CCMHS provider.
- c. To discuss whether providers are meeting reasonable standards of care.
- d. To identify and lead the review and/or investigation of any quality of care issues discovered during the credentialing process (e.g., missing information, inconsistent information, malpractice issues, etc.). The presence of any past or current disciplinary action by the State Licensing Board, or documented by the Database, or any other regulatory authority and/or the existence of any pending malpractice suits or previous adverse malpractice judgments will be examined.
- e. To access appropriate clinical peer input when discussing standards of care for a particular type of provider.
- f. To maintain minutes of all committee meetings and to document all actions. The minutes of the meetings will protect the confidentiality of the applicants and provide sufficient detail to demonstrate a discussion was held for each applicant with issues regarding their application.
- g. To provide guidance to CCMHS staff on the overall direction of the credentialing program.
- h. To evaluate and report to CCMHS management on the effectiveness of the credentialing program.
- i. To review and approve CCMHS's credentialing and privileging policies and procedures.
- j. To meet as often as necessary to fulfill its responsibilities, but no less than quarterly.
- k. To make credentialing decisions based on multiple criteria related to professional competency, quality of care and the appropriateness by which health services are provided.
- l. To ensure discrimination does not occur, based on an individual's gender, sexual orientation, gender identity, age, race, religion, disability, ethnic origin, national origin and any other such prejudicial biases.
- m. To maintain a comprehensive list of all individual healthcare providers and review/update the list at each meeting.

3. Review of Credentials

All initial credentialing applications will be reviewed by CCMHS's Credentialing Committee within 180 days of the date of the provider signature on the attestation page. CCMHS will provide written notification of the credentialing determination within 10 days of the Senior Clinical Leader's review. An individual provider or organizational provider that is denied credentialing or re-credentialing will be provided with the reasons for the decision in writing. The provider has access to CCMHS's Appeals Process. Upon approval of the provider's credentialing application, the provider will be added to the list of providers for CCMHS.

4. Provisional Credentialing of Individual Practitioners

Provisional credentialing of providers is intended to increase the number of available providers in underserved areas. Provisional credentialing can be granted when it is in the best interest of Medicaid Beneficiaries to have providers available prior to the formal completion of the entire credentialing process. Provisional credentialing shall not exceed 150 calendar days. CCMHS will make a decision regarding provisional credentialing within 31 calendar days of receipt of the completed provider credentialing application.

For consideration of provisional credentialing, at a minimum, a provider must complete NorthCare Network's Credentialing Application and primary source verification must be completed on:

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

CCMHS's Senior Clinical Staff Person will review the information obtained and determine whether or not to grant provisional credentialing for all providers. CCMHS will move the credentialing process forward as quickly as possible for providers with provisional status.

II. Re-credentialing/Continuous Credentialing Individual Practitioners

- A. Formal re-credentialing for individual practitioners occurs every two years. The same procedures as for initial credentialing are applied and include:
 1. Updating the standard application submitted previously (either initially or at last re-credentialing).
 2. Providing a cover letter with contact information of how to communicate with credentialing staff regarding application.
- B. Continuous credentialing of providers at CCMHS is an ongoing process.
 1. CCMHS reviews Federal and State of Michigan information regarding individual practitioners and organizational providers who have received sanctions or limitations on licensure/ certification from various agencies as they are published or available. For continuous credentialing, CCMHS utilizes the following systems:
 - a. Long Term Care Workforce Background Check, which will alert CCMHS when a provider has been convicted of a crime that excludes him/her from employment at CCMHS.

- b. Driver's License check.
 - c. Data Bank continuous query which will alert CCMHS of any adverse licensure actions, adverse finding by a State licensing or certification authority, peer review organization negative actions or findings, private accreditation organization negative actions or findings, licensing and certification actions, civil judgments (health care related), criminal convictions (health care related), exclusions from Federal or State health care programs, and other adjudicated actions or decisions (formal or official actions or omissions that affect or could affect the payment, provision, or delivery of a health care item or service).
2. The annual performance review includes a review of at least, but not necessarily limited to:
- a. any corrective action taken;
 - b. trainings that have been completed;
 - c. any validated concerns (including dignity and respect) from people served;
 - d. provider quality issues (such as the delivery of quality healthcare through evidenced-based practices, practice guidelines and fidelity to standards of treatment);
 - e. adherence to standards of clinical documentation;
 - f. the provider's privileges;
 - g. driver's license.
 - h. ICHAT (Michigan State Police for criminal background check).

III. Credentialing/Re-credentialing Facilities and Other Organizational Providers

- A. Facilities and other organizational providers must credential staff according to their accreditation and contract with CCMHS. A NorthCare Organizational Credentialing Application will be completed for initial credentialing and for re-credentialing at least every two years. This is monitored as part of site reviews.
- B. Initially and at the time of contract renewal, CCMHS verifies that the organizational provider is licensed or certified as necessary to operate in Michigan and has not been excluded from Medicaid or Medicare participation relating to procurement and health care issues.
- C. CCMHS conducts annual reviews of all contract providers. Included is a review of the organization's credentialing/re-credentialing policies to assure compliance with CCMHS's credentialing policy.
- D. For re-credentialing, CCMHS staff will verify updated applications, review the annual site review report and submit their recommendation to CCMHS's Credentialing Committee for final approval to maintain participation in the network. Re-credentialing applications includes a process for ongoing monitoring and intervention, if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider. Ongoing monitoring includes a review of:
 1. Medicare/Medicaid sanctions;
 2. State sanctions or limitations on licensure, registration or certification;

3. Member/client concerns which include grievance (complaints) and appeals information including dignity and respect;
 4. 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. If issues of quality of care emerge during the review of an application, such as missing or inconsistent information, training requirements or consumer safety or malpractice issues:
1. CCMHS staff who reviewed the application will send findings of their review to CCMHS's Credentialing Committee with a recommendation to approve or disapprove the provider's application.
 2. The Senior Clinical Staff Person may request the staff who conducted the review to present the recommendation to the Credentialing Committee.
 3. CCMHS's Credentialing Committee will make a decision as to whether to approve with no conditions; require a plan of correction; or, deny the request for credentialing.
- F. At least every two years, CCMHS conducts a credentialing audit of contracted facilities or other organizational providers that includes a review of 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. If the sample size is less than ten, all ten files will be reviewed. In no case will more than thirty (30) files be reviewed.
- G. CCMHS will maintain a list of all credentialed organizational providers.

IV. Deemed Status

CCMHS may recognize and accept credentialing activities conducted by another CMHSP for any provider that delivers healthcare services to both CCMHS and the other CMHSP. In such situations, CCMHS shall maintain copies of the credentialing CMHSP's decisions in the provider's contract file.

V. Provider Directory

- A. The Provider Directory includes individual practitioners at CCMHS and all contract providers and facilities. The directory is maintained by CCMHS and published on CCMHS's website. A provider is removed from the directory within five (5) days of the determination that the provider is not being re-credentialed for any reason.
- B. CCMHS staff may print hard copies of the Provider Directory for people receiving services.
- C. CCMHS will use the spreadsheet provided by NorthCare to submit the credentialed/re-credentialed providers to the NorthCare Credentialing Committee. NorthCare holds the final approval authority for credentialing granted by CCMHS.
 1. CCMHS updates the spreadsheet when a provider or organization is credentialed or re-credentialed or any changes are made regarding any listed provider (no more than 45 days from the date of review by the Credentialing Committee).

2. The spreadsheet will be updated by NorthCare and returned to CCMHS's credentialing staff with approvals, denials and any additional information.

D. If a provider is removed from CCMHS's provider list for a sanction or incident that leads to exclusionary status, CCMHS will notify NorthCare within ten (10) business days.

VI. Reporting Requirements

A. CCMHS shall report any known improper conduct of any credentialed provider that results in suspension or termination as a provider for CCMHS to appropriate authorities (i.e., MDHHS, licensing, the Attorney General, etc.), as consistent with current Federal and State requirements, including those specified in the MDHHS Medicaid Managed Specialty Supports and Services Contract.

B. It is the responsibility of any provider to notify CCMHS of any adverse change in licensure or certification status as soon as the provider is aware of or should have been aware of the change. Acknowledgement of this responsibility is documented in the annual performance review of the provider.

C. CCMHS will notify NorthCare immediately when any providers are terminated.

VII. Removal as a Provider

In addition to termination as a result of being included on an Exclusions Database, providers may be removed under the following circumstances.

A. Expiration of Licenses

Any provider with an expired license will be removed from practice at CCMHS until the license can be verified. Any provider who has not renewed his/her license or certification within the applicable grace periods (per licensing) of its expiration will be terminated as a provider for CCMHS. Providers who are terminated for lapsed licensure or certification may reapply for participation as a provider for CCMHS at the discretion of CCMHS's Executive Director once licensure or certification is renewed.

B. Other Identified Credentialing Issues

If other credentialing issues arise (for instance, if a provider ceases to comply with credentialing criteria as determined through the processes of continuous compliance monitoring or re-credentialing or if the provider is not re-credentialed within the time frame required by CCMHS) the Senior Clinical Staff Person for the Credentialing Committee must be notified. The issues will be resolved through Committee action and/or CCMHS's disciplinary practices.

If CCMHS becomes aware of a lack of compliance to established practice standards on the part of any provider, CCMHS will reassess the provider's ability to perform the required services.

In such situations, CCMHS's Credentialing Committee will assess the information and will take action as deemed necessary. The Credentialing Committee may determine that no action is justified; recommend a letter of guidance, warning or reprimand; impose conditions for continued practice in the network; impose a requirement for monitoring or consultation; recommend additional training or education; or, determine that the provider should be terminated for cause (as in the case of a loss of license).

VIII. Appeal Process

Note: This appeals process is not available to providers when conditions result in immediate termination because of loss of required certification or licensure; listing of the provider by a State department or agency as being suspended from service participation in the Michigan Medicaid and/or Medicare programs; and/or the provider being listed by a State department or agency in its registry for Unfair Labor Practices.

If an organizational provider, group or individually licensed provider disagrees with a determination by CCMHS in the application process or during review of a provider's status, and wishes to have the matter reviewed at a higher level:

- A. The provider may submit a written request and supporting documentation to CCMHS's CEO or designee within thirty (30) calendar days of disposition. The request must include the reason for the appeal and the documentation to support the appeal.
- B. An appeal review will be conducted within twenty (20) calendar days of receipt of the provider request by a panel of at least three qualified individuals not involved in previous decisions relating to this appeal. At least one member will be a participating provider not involved in the day-to-day operations of network management and who is a clinical peer of the participating provider that filed the dispute.
- C. After formal review of the dispute, a written summary of the outcome will be given to the provider, within fourteen (14) calendar days of completion.
- D. The decision of the appeal review panel will be the final decision regarding the dispute.
- E. In the event of an emergent non-compliance dispute, the appeal process will be initiated and completed within five (5) working days.

CROSS REFERENCE:

42 CFR 438.610

URAC Standards

NorthCare Delegation Agreement

Medicaid Provider Manual

Medicaid Sub-Contracting Agreement

CCMHS Policy - Background Checks

CCMHS Policy - Clinical Privileging of Individual Practitioners

CCMHS Policy - Staff Competencies

CCMHS Policy - Contracting for Clinical Services

CCMHS Policy - Excluded Parties List