Section 3.20 Credentialing and Recredentialing

3.20.1 Introduction

The credentialing and recredentialing processes are integral components of the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) quality management program. The credentialing and recredentialing processes help to ensure that qualified behavioral health providers, who are capable of meeting the needs of the persons who are seeking and/or receiving behavioral health services, participate in the ADHS/DBHS provider network.

Credentialing and recredentialing is an ongoing review process to assure the current competence of practitioners by validating the training and competence of individual practitioners in particular specialty areas. This level of review is intended to provide verification that the appropriate training, experience, qualifications, and ongoing competence has been demonstrated by individual practitioners for the services they provide.

The credentialing and recredentialing requirements differ depending on the type of provider. Physicians, nurse practitioners, physician assistants, psychologists and all other behavioral health professionals who are registered to bill independently or provide behavioral health services for which they are licensed to perform must be credentialed prior to providing services in the ADHS/DBHS behavioral health system.

The specific requirements associated with the credentialing and recredentialing processes for each type of provider are discussed below.

3.20.2 References

The following citations can serve as additional resources for this content area:
42 CFR 438.214
A.R.S. Title 32, Chapter 33
A.R.S. § 36-551

4 A.A.C. 6
A.A.C. R9-20-101
A.A.C. R9-20-204
AHCCCS/ADHS Contract
ADHS/RBHA Contract
ADHS/TRBHA IGAs
AHCCCS Medical Policy Manual, Chapter 950
Section 3.9, Assessment and Service Planning
Section 3.10, SMI Eligibility Determination
ADHS/DBHS Covered Behavioral Health Services Guide

3.20.3 Scope

To whom does this apply?
This section applies to provider agencies and staff providing behavioral health services to persons enrolled in the ADHS/DBHS behavioral health system.

3.20.4 Did you know…?

If the Tribal/Regional Behavioral Health Authority (T/RBHA) delegates any of the credentialing/recredentialing or selection of provider responsibilities, the T/RBHA must retain the right to approve, suspend, or terminate any providers selected and may revoke the delegated function if the delegated performance is inadequate.

3.20.5 Definitions

Behavioral Health Professional

Behavioral Health Technician

Credentialing

Independent Licensed Practitioners

Primary Source Verification

Temporary/provisional credentialing

3.20.6 Objectives

The objectives of the credentialing and recredentialing processes are to:

- Maintain fair credentialing and recredentialing processes in which standards are applied consistently throughout the state;
- Obtain application information about a potential provider's background and work history;
- Verify credentials and other information (e.g., malpractice or sanction activity) with primary sources; and

- Provide flexibility in the process (i.e., expedited credentialing) so that any gaps in service within provider networks can be expeditiously addressed.

3.20.7 Procedures

3.20.7-A. General process for credentialing

Responsible Entity. Each T/RBHA or its designee must establish credentialing and recredentialing processes that are in compliance with the standards set forth in this section.
Magellan Credentialing Overview. Magellan uses credentialing criteria that define the licensure, education and training criteria practitioners must meet, and decision-making processes in the review and selection of behavioral health care professionals for inclusion into Magellan's practitioner/provider network. The following describes the general process for practitioner credentialing:

- Practitioners complete, sign and submit a Magellan Provider Application and any supporting documentation necessary to complete the credentialing process.
- Administrative verifications are completed and the credentialing file forwarded to the Regional Network Credentialing Committee (RNCC) for clinical credentialing determination.
- The practitioner is sent written notification of the credentialing decision within sixty (60) days of the determination.
- For those practitioners contracting, as well as credentialing, with Magellan, the practitioner's contract with mutually agreed upon terms is executed and an original is returned to the practitioner.
- Magellan does not delegate any credentialing functions.

Clinician Appeal Process

- Magellan will notify a clinician in writing of their right to appeal for instances in which Magellan chooses to terminate the clinician's contract based on issues of quality of care and/or service as outlined in this section. The termination notification includes the following directions on how to request and submit an appeal.
    - The clinician is given 33 days to submit a request for appeal.
    - The appeal must include all relevant information necessary to process the appeal request.
    - Administrative Credentialing Decisions.
        - Requests for appeal of administrative decisions are sent to: Magellan Health Services of Arizona, Inc. Attn: Credentialing Department 4801 East Washington Street, Phoenix AZ 85034.
        - Upon receipt of the request for appeal documentation, the request is forwarded to the RNCC for review and determination. The RNCC has at

least thirty (30) days from receipt of all necessary information to make a determination.

- The Credentialing department notifies the practitioner in writing of the RNCC's decision within thirty (30) calendar days of the decision.

- Other Credentialing Decisions (i.e. concerns regarding quality of care, non-compliance with Magellan policies and procedures, legal or ethical issues, etc.)
    - Requests for appeal of all other credentialing decisions are sent to the Magellan National Network Credentialing Committee (NNCC) Appeals Committee at the following address: Network Quality Services Coordinator, 14100 Magellan Plaza, Maryland Heights MO 63043.
    - Upon receipt of all necessary information, an appeal hearing is scheduled where NNCC makes a determination on the appeal request.
    - The NNCC notifies the practitioner in writing of their decision within thirty (30) calendar days of the decision.
    - Decisions by the RNCC and NNCC are binding and not appealable.

Accreditation by a nationally recognized accreditation organization. Accreditation by a nationally recognized accreditation organization will meet ADHS/DBHS credentialing and recredentialing standards. T/RBHAs must ensure, to the extent possible, that providers are not subjected to duplicative credentialing processes.

Fairness of Process. The T/RBHAs or their designee shall maintain fair credentialing and recredentialing processes which:

- Does not discriminate against a provider solely on the basis of the professional's license or certification; or due to the fact that the provider serves high-risk populations and/or specializes in the treatment of costly conditions;
- Affords the provider the right to review information gathered related to his/her credentialing application and to correct erroneous information submitted by another party. The organization is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law;
- Notifies the provider when the information obtained through the primary source verification process varies substantially from what the provider provided;
- Ensures credentialing/recredentialing information is kept confidential; and
- States that practitioners have a right to be informed of the status of their application upon request, and must describe the process for responding to such request, including information that the organization may share with practitioners with the exception that this does not require

the organization to allow a practitioner to review references, recommendations or other peer-review protected information.

Provider File. The T/RBHAs must maintain an individual credentialing/recredentialing file for each credentialed provider. Each file must include:

- The initial credentialing and all subsequent recredentialing applications, including attestation by the applicant of the correctness and completeness of the application as demonstrated by signature on the application;
- Information gained through credentialing and recredentialing queries;
- Utilization data, quality of care concerns, performance measure rates, and level of member satisfaction; and
- Any other pertinent information used in determining whether or not the provider meets the T/RBHA's credentialing and recredentialing standards.

Notification Requirement. The T/RBHAs must have procedures for reporting to appropriate authorities, including the Arizona Health Care Cost Containment System (AHCCCS), the provider's regulatory board or agency, Adult Protective Services (APS), Child Protective Services (CPS), Office of the Attorney General (OAG), any serious quality deficiencies that could result in a provider's suspension or termination from the T/RBHA's network. If the issue is determined to have criminal implications, a law enforcement agency must also be notified. The T/RBHA must:

- Maintain documentation of implementation of the procedure, as appropriate;
- Have an appeal process for instances in which the T/RBHA chooses to alter the provider's contract based on issues of quality of care and/or service; and
- Inform the provider of the appeal process.

Additional Standards. Other standards related to the credentialing process include the following:

- The credentialing process must be in compliance with federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid:
  - Documentation must show that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated without the right to appeal:
    - Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE); and
    - General Services Administration (GSA) Excluded Parties List System (EPLS);

- Mechanisms must be put in place to ensure that licensed providers renew licenses or certifications required by the appropriate licensing/certifying entity and continuously practice under a current and valid license/certification; and

- Behavioral health care providers who are part of the T/RBHA network are subject to an initial site visit as part of the initial credentialing process.

3.20.7-B. Temporary/Provisional Credentialing Process

The T/RBHA shall have 14 calendar days from receipt of a complete application to render a decision regarding temporary or provisional credentialing. Once provisional/temporary credentialing is approved, provider information must be entered into the T/RBHA's information system to allow payment to the provider effective the date the provisional credentialing is approved.

Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-alike Center, as well as hospital employed physicians (when appropriate), must be credentialed using the temporary or provisional credentialing process even if the provider does not specifically request their application be processed as temporary or provisional.

- If an expedited or temporary credentialing process is utilized, the following minimum requirements must be met:

A provider must complete a signed application that must include the following items:

- Reasons for any inability to perform essential functions of the position, with or without accommodation;

- Lack of present illegal drug use;

- History of loss of license and/or felony convictions;

- History of loss or limitation of privileges or disciplinary action;

- Current malpractice insurance coverage; and

- Attestation by the applicant of the correctness and completeness of the application.

In addition, the applicant must furnish the following information:

- Minimum five-year work history or total work history if less than five years; and

- Current Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate, as applicable.

The T/RBHA must conduct primary source verification of the following:

- Licensure or certification (A signed statement from the medical or nursing board of examiners stating they do primary verification of education and internship/residency as part of the licensing process is acceptable);

- Board certification, if applicable, or the highest level of credential attained; and
- National Practitioner Data Bank (NPDB) query; or
- In lieu of NPDB query, all of the following:
  - Minimum five-year history of professional liability claims resulting in a judgment or settlement;
  - Disciplinary status with regulatory board or agency; and
  - Medicare/Medicaid sanctions.

The T/RBHA's Medical Director must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and committee review, as outlined in this Section, should be completed.

The T/RBHA must ensure compliance with all applicable credentialing requirements within six months following the granting of temporary credentials. If the provider has not been credentialed during this six month time period, then the T/RBHA may issue a second temporary credential. All credentialing must be completed by the end of the second six-month period.

The provisional credentialing process (including primary source verification) takes approximately fourteen calendar days after receipt of a completed application and required documentation. Once administrative verifications are completed, the provisional file is submitted to the medical director for provisional credentialing criteria and will be forwarded to the RNCC for review and determination during their next scheduled meeting.

3.20.7-C. Credentialing requirements
The following behavioral health professionals are subject to credentialing and recredentialing requirements outlined below:

- Physicians (MD and DO)
- Licensed Psychologists
- Nurse Practitioners
- Physician Assistants
- Licensed Clinical Social Workers (only required if they will be billing independently)
- Licensed Professional Counselors (only required if they will be billing independently)
- Licensed Marriage and Family Therapists (only required if they will be billing independently)

- Licensed Independent Substance Abuse Counselors (only required if they will be billing independently)

The initial credentialing process for these providers must include the following components:

A written application to be completed signed and dated by the potential provider that attests to the following elements:

- Reasons for any inability to perform essential functions of the position, with or without accommodation;
- Lack of present illegal drug use;
- If applicable, history of loss of license and/or felony convictions;
- If applicable, history of loss or limitation of privileges or disciplinary action;
- Current malpractice insurance coverage; and
- Attestation by the applicant of the correctness and completeness of the application.

In addition, the applicant must furnish the following:

- Minimum five-year work history or total work history if less than five years; and
- DEA or CDS certification as applicable.

Primary source verification of:

- Licensure by the appropriate state licensing board;
- Board certification, if applicable, or highest level of credentials attained;
- Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training(a signed statement from the medical or nursing board of examiners stating they do primary verification of education and internship/residency as part of the licensing process is acceptable);
- NPDB query; or
- In lieu of NPDB query, all of the following must be verified:
  - Minimum five-year history (or total history if less than five years) of professional liability claims resulting in judgment or settlement;
  - Disciplinary actions and licensure status with regulatory board or agency if applicable;
  - Medicare/Medicaid sanctions if applicable; and

- State sanctions or limitations of licensure.

For credentialing of independent masters level behavioral health therapists who are registered by AHCCCS to bill independently, primary source verification of:

- Licensure by the Arizona Board of Behavioral Health Examiners (AzBBHE);
- A review of complaints received and disciplinary status through the AzBBHE;
- Minimum five-year history, or total history if less than five years, of professional liability claims resulting in a judgment or settlement; and
- Medicare/Medicaid sanctions, if applicable.

3.20.7-D. Credentialing requirements for individuals who are not licensed or certified
Individuals who are not licensed or certified must be included in the credentialing process and profiled as outlined in A.A.C. R9-20-204.

3.20.7-E. Recredentialing
The T/RBHAs or designee must ensure that all credentialed providers described in subsection 3.20.7-C are recredentialed. The recredentialing process must:

- Occur at least every three years; and
- Update information obtained during the initial credentialing process with the exception of:
  - History of loss of license and/or felony convictions;
  - Minimum five-year work history; and
  - Board certification, if the provider is Board certified.

The recredentialing of individual providers must include a process for ongoing monitoring and intervention and if appropriate, provider sanctions, complaints and quality issues, which include, at a minimum, reviews of:

- Medicare/Medicaid sanctions;
- State sanctions or limitations on licensure;
- Member concerns including grievances (complaints) and appeals information;
- Utilization management information (such as: hospital length of stay, pharmacy utilization);
- Performance improvement and monitoring (such as performance measure rates);

- Results of any medical record review audits; and

- Quality of care issues (including trend data). If an adverse action is taken with a provider due to a quality of care concern, the T/RBHA must report the adverse action to the ADHS/DBHS Clinical Quality Management Unit.

Magellan Recredentialing Process. Prior to the anniversary of the practitioner's credentialing date, the practitioner is notified of the requirements to submit a re-credentialing application and additional required documents. Practitioners are required to review, update, and sign a pre-populated re-credentialing form and submit any supporting documentation necessary to complete the re-credentialing process. Additional materials are submitted by fax and/or standard mail.

Magellan notifies the practitioner of any required information missing in the submission.

- Practitioner/provider credentials are re-verified with the exception of degree, institutional accreditations, work history and attestations for practitioners with prescriptive authority and clinical supervision. However, degree, or institutional accreditations are re-verified if there is new information or a change to the information since the most recent credentialing event.

- Once administrative credentialing is completed, the recredentialing file is forwarded to the RNCC for clinical recredentialing. All practitioners' re-credentialing information is reviewed by the RNCC and a clinical recredentialing decision rendered.

Quality information obtained since the most recent credentialing event is included in the recredentialing review, including provider monitoring results, site visits, complaints, record reviews, etc.

Once administrative credentialing is completed, the recredentials file is forwarded to RNCC for a clinical credentialing decision. The application review and recredentialing decision process takes approximately 4 to 8 weeks after receipt of a complete application. The timelines could be greater if adverse information is found during the verification process. The practitioner is notified of the re-credentialing determination within sixty (60) calendar days of the clinical recredentialing decision.

Practitioners who do not meet Magellan criteria for ongoing network participation are notified in writing of their ineligible status and the reason for the ineligibility (e.g., area(s) of criteria not met, general liability concerns etc.): and informed of their right to appeal. Appeals must be submitted within thirty-three (33) calendar days of the date of the written notification date. Instructions for requesting such an appeal are included in the notification.

3.20.7-F. Additional credentialing standards for hospitals and behavioral health facilities
Hospitals and behavioral health facilities (Office of Behavioral Health Licensure (OBHL) licensed Level I, II, III, outpatient clinics and ADHS/DBHS Title XIX certified Community Service Agencies) must ensure the following:

- The provider is licensed/certified to operate in Arizona as applicable and is in compliance with any other applicable state or federal requirements; and

- The provider is reviewed and approved by an appropriate accrediting body, or if not accredited, Centers for Medicare and Medicaid Services (CMS) certification, ADHS/DBHS Title XIX certification or state licensure review may substitute for accreditation. In this case, the provider must provide a copy of the report to the contracted T/RBHA that verifies that a review was conducted and compliance was achieved.

Initial Assessment of Organizational Providers
As a prerequisite to contracting with the provider, the T/RBHA must ensure that the organizational provider has established policies and procedures that meet AHCCCS requirements. The requirements described in this section must be met for all providers included in the T/RBHA network (including, but not limited to, hospitals, home health agencies, attendant care agencies, group homes, nursing facilities, behavioral health facilities, dialysis center, transportation companies, dental and medical schools, and free standing surgi-centers; see AHCCCS Medical Policy Manual, Chapter 950).

Prior to contracting with the provider, the T/RBHA must:

- Confirm that the provider has met all the state and federal licensing and regulatory requirements (a copy of the license or letter from the regulatory agency will meet this requirement);

- Confirm that the provider is reviewed and approved by an appropriate accrediting body as specified by the Centers for Medicare and Medicaid Services (CMS) (a copy of the accreditation report or letter from the accrediting body will meet this requirement). The T/RBHA must state in policy which accrediting bodies it accepts;

- Conduct an onsite quality assessment if the provider is not accredited. The T/RBHA must develop a process and utilize assessment criteria for each type of unaccredited organizational provider for which it contracts which must include, but is not limited to, confirmation that the organizational provider has the following:
  - A process for ensuring that they credential their practitioners;

  - Liability insurance;

  - Business license; or

- CMS certification or state licensure review/audit may be substituted for the required site visit. In this circumstance, the T/RBHA must obtain the review/audit documentation from

CMS or the state licensing agency and verify that the review/audit was conducted and that the provider meets the T/RBHA's standards. A letter from CMS that states the organizational provider was reviewed/audited and passed inspection is sufficient documentation when the T/RBHA has documented that they have reviewed and approved the CMS criteria and they meet the T/RBHA's standards.

- Review and approve the provider through the T/RBHA's credentialing committee.

Reassessment of Organizational Providers

T/RBHAs must reassess organizational providers at least every three years. The reassessment must include the following components and all information utilized by T/RBHAs must be current:

- Confirmation that the organizational providers remain in good standing with State and Federal bodies, and, if applicable, are reviewed and approved by an accrediting body. To meet this component, the T/RBHA must validate that the organizational provider meets the conditions listed below:
  - Federal requirements as applicable; and
  - Is licensed to operate in the State, and is in compliance with any other State requirements. If an organization provider is not accredited or surveyed or licensed by the State, an on-site review must be conducted, including minimally the components described above in subsection 3.20.7-F, 2nd bullet;
- Assess data available to the T/RBHA including:
  - The most current review conducted by the ADHS Division of Licensing and/or summary of findings (please include date of review);
  - Record of on-site inspection of non-licensed organizational providers to ensure compliance with service specifications.
- Evaluate organizational provider specific information including, but not limited to, the following:
  - Member concerns which include grievances (complaints);
  - Utilization management information (if applicable);
  - Performance improvement and monitoring (if applicable);
  - Results of medical records review audits (if applicable);
  - Quality of care issues and, if an adverse action is taken with a provider due to a quality of care concern, the T/RBHA must report the adverse action to the ADHS/DBHS Clinical Quality Management Unit; and

- Onsite assessment.

- Review and approval by the T/RBHA's credentialing committee with formal documentation that includes any discussion, review of thresholds, and complaints or grievances.

Notice of Requirements (Limited to Providers)

The T/RBHA must have procedures for reporting (in writing) to appropriate authorities (ADHS/DBHS, AHCCCS, the provider's regulatory board or agency, OAG, etc.) any known serious issues and/or quality deficiencies. If the issue/quality deficiency results in a provider's suspension or termination from the T/RBHA's network, it must be reported. If the issue is determined to have criminal implications, a law enforcement agency must also be notified.

- The T/RBHAs must maintain documentation of implementation of the procedure, as appropriate;

- The T/RBHA must have an appeal process for instances in which the T/RBHA chooses to alter the provider's contract based on issues of quality of care and/or service; and

- The T/RBHA must inform the provider of the appeal process.