NORTHCARE NETWORK

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<tr><td colspan="1">POLICY TITLE:
Credentialing Program</td><td colspan="2">CATEGORY:
Provider Network Management</td></tr>
<tr><td>EFFECTIVE DATE:
3/21/13</td><td colspan="2">BOARD APPROVAL DATE:
7/13/16</td></tr>
<tr><td>REVIEW DATE:
2/2/25</td><td>REVISION(S) TO POLICY STATEMENT:
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<tr><td>RESPONSIBLE PARTY:
Provider Network Specialist</td><td colspan="2">CEO APPROVAL DATE: 2/4/25
Megan Rooney, CEO</td></tr>
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APPLIES TO

NorthCare Network Personnel
Network Providers

POLICY

NorthCare Network assures due diligence in credentialing and re-credentialing to provide competent providers for the individuals we serve by implementing a comprehensive credentialing and re-credentialing program across the Network. NorthCare Network is responsible to apply legal, professional and ethical scrutiny to individual and organizational applicants seeking to be credentialed/recredentialed. The oversight and monitoring of the credentialing of sub-contract provider staff is delegated to direct contractors. 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 billable or reimbursable.

PURPOSE

The purpose of this policy is to set standards and guidelines for NorthCare Network and Network Providers to assure that clinical oversight, management, and services are provided by providers who are fully qualified, competent, and in good standing. In addition, this policy sets the expectation and guidelines for contract providers, within the NorthCare Network, to comply with applicable rules and regulations including, but not limited to, the Balanced Budget Act (BBA), Michigan Department of Health and Human Services (MDHHS), applicable Accreditation standards and NorthCare Network's Credentialing Program.

DEFINITIONS

1. ***Clean Application***: The provider has completed all applicable sections of the credentialing application; and 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 in the provider's file. The provider meets the credentialing criteria as stated in this policy, which is approved by the credentialing committee. Credentials verification supports the provider meets credentialing criteria and there are no issues to report to the credentialing committee.

2. ***Contractor***: Any provider, supplier, distributor, vendor or firm (person or entity) that furnishes services under primary contract with NorthCare Network.

3. ***Credentialing*** (As defined by the American Society of Addiction Medicine and the American Managed Behavioral Healthcare Association)**:** 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.

4. ***Credentialing Committee:*** The committee membership should reflect required members and ad hoc members to assure appropriate peer review for each provider and has at least one participating provider who has no other role in the organization's management. This committee has the final authority to approve or disapprove applications by providers for participation on the organization's provider panel and delegates authority for approval of clean credentialing applications to the identified staff member.

5. ***National Practitioner Databank (NPDB) and the Healthcare Integrity and Protection Databank (HIPDB):*** The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Processions, Office of Workforce Evaluation and Quality Assurance, Practitioner Data Banks Branch is responsible for the management of the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. HRSA. They can be located on the Internet at www.npdb.hrsa.gov/.

6. ***Organizational Providers (Facilities):*** are providers with whom NorthCare Network contracts and that directly employ and/or contract with individual practitioners to provide behavioral health care services. Examples of organizational providers include but are not limited to: Member Community Mental Health Services Programs; psychiatric hospitals; substance use treatment programs; and residential providers.

7. ***PIHP (Prepaid Inpatient Health Plan):*** In Michigan and for the purposes of ~~this~~ the MDHHS/PIHP contract, a PIHP is defined as an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 438. (In Medicaid regulations Part 438., Prepaid Health Plans (PHPs) that are responsible for inpatient services as part of a benefit package are now referred to as "PIHP" The PIHP also known as a Regional Entity under MHC 330.1204b or a Community Mental Health Services Program also manages the Autism iSPA, Healthy Michigan, Substance Abuse Treatment and Prevention Community Grant and PA2 funds.

8. **Primary Source Verification**: Verification from the original source of a specific credential (education, training, licensure) to determine the accuracy of the qualifications of an individual health care practitioner. Examples of primary source verification include, but are not limited to, direct correspondence, telephone verification [must be documented and signed/dated by person receiving the verification] and internet verifications.

9. ***Individual Practitioner/Provider:*** is any individual that is engaged in the delivery of healthcare services and is legally authorized to do so by the State in which he or she delivers the services.

10. ***Senior Clinical Staff Person:*** The appointed leadership role of the credentialing program of at least one senior clinical staff person who has: current, unrestricted clinical license(s); qualifications to perform clinical oversight for the services provided; five years' post -graduate experience in direct patient care; and Board certification (if the senior clinical staff person is an M.D. or D.O.).

11. ***Sub-Contractor:*** any provider, supplier, distributor, vendor or firm (person or entity) that furnishes services to or for a prime contractor or another subcontractor.

REFERENCES

- 42 CFR, (Balanced Budget Act of 1997), 438.214, 438.610
- Medicaid Provider Manual
- MDHHS/PIHP Contract,
- MDHHS Policies & Practice Guidelines - Provider Credentialing https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html
- PIHP/CMHSP Provider Network Agreement
- NorthCare Network Onboarding checklist
- NorthCare Network Policies, as applicable

HISTORY

REVISION DATE: 9/2/13, 9/17/13, 11/27/13, 5/14/14,5/5/15, 5/17/16, 12/13/16, 2/27/17, 12/2/19, 7/29/20, 1/11/22, 11/12/23, 8/9/24, 2/2/25
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BOARD APPROVAL DATE: 3/21/13, 12/4/13, 7/13/16

PROCEDURES

Organizations are required to have written policies and procedures for the selection, credentialing/recredentialing and retention of providers that are compliant with applicable federal, state and regional rules/regulations, 42 CFR 455.104-106,. Onboarding checklist is used to ensure all documents are obtained during credentialing/recredentialing. Continuous monitoring of the credentialing program occurs across the network to ensure compliance and identify quality or network issues. Organizations are responsible for ensuring that individual practitioners/providers, employed or under contract, and organizational providers meet all applicable licensing, scope of practice, contractual, and payor requirements. Credentialing decisions are made based on multiple criteria related to professional competency, quality of care and the appropriateness by which behavioral health services are provided.

I. Credentialing Individual Practitioners employed/contracted by NorthCare Network or Organizational Providers

A. Credentialing Individual Practitioners

1. The Organization must have a written system in place for credentialing and recredentialing individual practitioners included in their provider

network that are not operating as part of an organizational provider. NorthCare Network must ensure that each direct-hire or contractually employed individual practitioner meets all background checks, applicable licensing, scope of practice, contractual, and Medicaid Provider Manual (MPM) requirements.

2. Credentialing and recredentialing must be conducted and documented for at least the following health care professionals:
    a. Physicians (M.D.s and D.O.s)
    b. Physician's Assistants (P.A.s)
    c. Psychologists (Licensed, Limited Licensed, and Temporary Licensed) (LPs, LLPs, TLLPs)
    d. Master's Social Workers - Licensed and Limited Licensed (LMSW, LLMSW)
    e. Bachelor's Social Workers - Licensed and Limited Licensed (LBSW, LLBSW)
    f. Registered Social Service Technicians (SSTs)
    g. Professional Counselors - Licensed and Limited Licensed (LPCs and LLPCs)
    h. Nurse Practitioners (NPs)
    i. Registered Nurses (RNs)
    j. Licensed Practical Nurses (LPNs)
    k. Occupational Therapists (OTRs)
    l. Occupational Therapist Assistants (OTAs)
    m. Physical Therapists (PTs)
    n. Physical Therapist Assistants (PTAs)
    o. Speech Pathologists
    p. Board Certified Behavior Analysts
    q. Licensed Family and Marriage Therapists
    r. Dietician
    s. Certified Addictions Counselor: CADC -Certified Alcohol &Drug Counselor – Michigan or CAADC-Certified Advanced Alcohol & Drug Counselor or CADC & CAADC through International Credentialing and Reciprocity Council (IC & RC)
    t. Certified Clinical Supervisor (CCS), CCS – IC & RC, CCS – Michigan)
    u. Certified Criminal Justice Professional (CCJP) through IC &RC& MI
    v. Certified Co-Occurring Disorders: CCDP-Certified Co-Occurring Disorders Professional or CCDP-D-Certified Co-Occurring Disorders Professional-Diplomat through IC &RC& MI
    w. Student Interns in approved Master's level educational program for social work, counseling, psychology, marriage and family therapy
    x. Other behavioral healthcare specialists licensed, certified, or registered by the State.

3. NorthCare Network and Organizational Provider's must ensure:
    a. That the credentialing and recredentialing processes do not discriminate against:
        i. A health care professional, solely on the basis of license, registration or certification; or

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

b. Monthly checks are completed for compliance with Federal requirements that prohibit employment or contracts with organizational providers and /or individual practitioners excluded from participation under either Medicare or Medicaid.
   i. The OIG exclusions database and the State of Michigan Sanctioned Provider list must be searched monthly to capture exclusions and reinstatements that have occurred since the last search or at any time providers submit new disclosure information.
      - A complete list of sanctioned providers and practitioners is available on the OIG website at http://exclusions.oig.hhs.gov .
      - A complete list of sanctioned providers and practitioners is available on the MDHHS website at www.michigan.gov/MDHHS. (Click on Providers, then click on Information for Medicaid Providers, then click on List of Sanctioned Providers).
   ii. Evidence of monthly checks must be maintained in the organizational provider and individual practitioner credentialing file.

c. NorthCare Network must notify the MDHHS OIG immediately using the approved OIG reporting form and process if search results indicate that any of their network's provider entities, or individuals or entities with ownership or control interests in a provider entity are on the OIG exclusions database. NorthCare Network must also provide notification to MDHHS OIG if it has taken any administrative action that limits a provider's participation in the Medicaid program.

4. If NorthCare Network or an Organizational Provider delegates to another entity any of the responsibilities of credentialing/recredentialing or selection of providers that are required by this policy:
   a. the delegating entity must retain the right and final authority to approve, suspend, or terminate from participation in the provision of Medicaid funded services, an organizational provider or individual practitioner selected by that entity,
   b. the entity accepting the delegated responsibilities of credentialing/re-credentialing must meet all requirements associated with the delegation of NorthCare and the Organizational Provider functions;
   c. the delegating entity is responsible for oversight regarding delegated credentialing or re-credentialing decisions;
   d. NorthCare Network PIHP retains final authority to approve, suspend, or terminate a provider selected by that entity.

5. Compliance with standards outlined in this policy will be assessed based on the Organizational Provider's polices and standards in effect at the time of the credentialing/recredentialing decision.

6. Written credentialing policies must reflect the scope, criteria, timeliness and process for credentialing and recredentialing organizational providers and individual practitioners. The policies must be approved by the organization's credentialing committee and governing body, and:

    a. Identify the administrative staff member(s) and Credentialing Committee members responsible for oversight and implementation of the process and delineate their role;
    b. Describe the use of participating providers in making credentialing decisions;
    c. Describe the methodology to be used by staff members or designees to provide documentation that each credentialing or recredentialing file was complete and reviewed, prior to presentation to the credentialing committee for evaluation;
    d. Describe how the findings of the Quality Assessment Performance Improvement Program (QAPIP) are incorporated into the recredentialing process;
    e. Describe how the confidentiality of credentialing records is maintained. This will include the procedures that outline how authorized access to credentialing files is limited and maintained.
    f. Describe the training process for all credentialing staff and Credentialing Committee members regarding the confidentiality of credentialing files and Committee meeting activities.

7. An individual credentialing/re-credentialing file is maintained for each credentialed provider. Each file must include:
    a. The initial credentialing and all subsequent recredentialing applications;
    b. Information gained through primary source verification;
    c. Documentation that each file was complete and reviewed prior to evaluation by the credentialing committee; and
    d. Any other pertinent information used in determining whether the organizational provider and/or individual practitioner met or did not meet the PIHPs credentialing and re-credentialing standards.

8. Organizations must maintain a written process for ongoing monitoring, and intervention, if appropriate, of organizational providers and/or individual practitioners as it relates to sanctions, complaints, and quality issues. This process must include, at a minimum, review of:
    a. Monthly Medicare/Medicaid sanction checks
    b. Monthly State sanction checks
    c. Any limitations on licensure, registration, or certification.
    d. Beneficiary concerns which include appeals and grievances (complaints) information and recipient rights.

e. Noted quality issues at the PIHP level.

B. Initial Credentialing of Individual Providers

At a minimum, the initial credentialing of the individual providers requires the review of the application and credentialing packet by the Credentialing Committee within 90 calendar days of submission. The start time begins when the PIHP has received a completed signed and dated credentialing application from the individual practitioner. Completion time is indicated when written communication is sent to the individual practitioner notifying them of the PIHP's decision.

1. The written application is completed, signed and dated by the provider and attests to the following elements:
   a. Lack of present illegal drug use.
   b. Any history of loss of license and/or felony convictions.
   c. Any history of loss or limitation of privileges or disciplinary action.
   d. An acknowledgement of the ongoing responsibility to notify the employer in a timely manner of any adverse change in licensure or certification status. As soon as the employee is aware or should have been aware of the change, the employer must be notified.
   e. Attestation by the applicant of the correctness and completeness of the application.

2. An evaluation of the provider's work history for the prior five years. Gaps in employment of six months or more in the prior five years must be addressed in writing during the application process.

3. Verification from primary sources of:
   a. Licensure or certification and in good standing
   b. Board Certification, or highest level of credentials attained if applicable, or completion of any required internships/residency programs, or other postgraduate training.
   c. Official transcript of graduation from an accredited school and/or LARA license.
   d. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following must be verified:
      i. Historical checks of criminal convictions related to the delivery of a health care item or service.
      ii. Historical checks of civil judgments related to the delivery of a health care item or service
      iii. Disciplinary status with regulatory board or agency; and
      iv. Medicare/Medicaid sanctions or exclusions.
   e. If the individual practitioner undergoing credentialing is a physician, then the physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source of requirements of (a), (b), and (c) above.

4. A clean application does not require review by the Credentialing Committee and the Senior Clinical Staff Person may approve the application. A clean application is where the provider has completed all applicable sections of the 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 in the provider's file.
    a. The provider application must be submitted on the standard NorthCare Network Credentialing Application.

C. Temporary / Provisional Credentialing of Individual Practitioners ***(applies only to NorthCare Network and Member CMHSPs)***

Temporary or provisional credentialing of individual practitioners is intended to increase the available network of providers in underserved areas, whether rural or urban (per MDHHS/PIHP Contract). Policies and procedures must address granting of temporary or provisional credentials when it is in the best interest of individuals served that providers be available to provide care prior to formal completion of the entire credentialing process. Temporary or provisional credentialing shall not exceed **150 days**.

NorthCare Network and Member CMHSPs shall have up to 31 days from receipt of a complete application (or request for credentialing), accompanied by the minimum documents identified below, within which to render a decision regarding temporary or provisional credentialing.

For consideration of temporary or provisional credentialing, at a minimum, a provider must complete a signed application that must include the following items:

- Lack of present illegal drug use.
- History of loss of license, registration, or certification and/or felony convictions.
- History of loss or limitation of privileges or disciplinary action.
- A summary of the provider's work history for the prior five years.
- Attestation by the applicant of the correctness and completeness of the application.

Primary source verification of the following must be conducted prior to review by credentialing committee/senior clinical staff:

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

The Senior Clinical Staff Person must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification for credentialing must be completed in the timeframes outlined in this policy.

D. Recredentialing Individual Practitioners Employed/Contracted

The recredentialing polices for physicians and other licensed, registered, or certified health care providers must identify procedures that address the recredentialing process and include requirements for each of the following:

1. Recredentialing every three (3) years

2. Update of standard application submitted for initial credentialing with a cover letter that includes contact information of how to communicate with credentialing staff regarding application.

3. A standard process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a minimum, review of:
   a. Monthly Medicare/Medicaid sanctions checks
   b. Monthly State sanction checks
   c. Any limitations on licensure, registration or certification
   d. Beneficiary concerns which include appeals and grievances (complaints) information and/or recipient rights.
   e. Noted quality issues at the PIHP level

4. The same procedures for initial credentialing of individual practitioners are applied to recredentialing applications.

II. Credentialing/Recredentialing Organizational Providers

A. For organizational providers included in the PIHP network:
   1. The PIHP must validate every three (3) years that:
      a. Complete the standard NorthCare Network Organizational Application for credentialing and update the application for recredentialing.
      b. The organizational Provider is licensed or certified and in good standing as necessary to operate in the State.
      c. The organizational provider is approved by an accredited body (if a provider is not accredited, the PIHP must perform an on-site quality assessment).
      d. There is no malpractice lawsuits that resulted in conviction of criminal neglect of misconduct, settlements, and/or judgements within the last five (5) years.
      e. The organizational provider is not excluded from participation in Medicare, Medicaid, or other Federal contracts.
      f. The organizational provider is not excluded from participation through the OIG Exclusion Database and MDHHS Sanctioned Provider list.
         a. Monthly checks are completed for compliance with Federal requirements that prohibit employment or contracts with organizational providers and /or individual practitioners excluded from participation under either Medicare or Medicaid.

i. The OIG exclusions database and the State of Michigan Sanctioned Provider list must be searched monthly to capture exclusions and reinstatements that have occurred since the last search or at any time providers submit new disclosure information.

b. Evidence of monthly checks must be maintained in the organizational provider and individual practitioner credentialing file.

g. NorthCare Network must notify the MDHHS OIG immediately using the approved OIG reporting form and process if search results indicate that any of their network's provider entities, or individuals or entities with ownership or control interests in a provider entity are on the OIG exclusions database. NorthCare Network must also provide notification to MDHHS OIG if it has taken any administrative action that limits a provider's participation in the Medicaid program.

h. Current insurance coverage meeting contractual expectations is on file with PIHP.

B. The Credentialing Organization must:

1. The contract between the PIHP and any organizational provider specifies the requirement that the organizational provider must credential and re-credential their direct employees, as well as subcontracted service providers and individual practitioners in accordance with the PIHPs credentialing/re-credentialing policies and procedures (which must conform to MDHHS credentialing process.)
2. The PIHP must ensure that the initial credentialing of the organization providers applying for inclusion in the PIHP network must be completed within 90 calendar days of application submission. The start time begins when the PIHP has received a completed signed and dated credentialing application from the organizational provider. Completion time is indicated when written communication is sent to the organizational provider notifying them of the PIHP's decision.

III. Deemed Status/Reciprocity

Individual practitioners or organizational providers may deliver healthcare services to more than one Network Provider. Organizations may recognize and accept credentialing activities conducted by any other Network Provider in lieu of completing their own credentialing activities but must verify completeness of the requirements outlined herein. In those instances, where an organization chooses to accept the credentialing decision of another Network Provider, the organization must maintain copies of the credentialing Provider's decision in the organizational provider and/or the individual practitioner's credentialing file.

IV. Notification of Adverse Credentialing Decision:

An individual practitioner or organizational provider that is denied credentialing or re-credentialing by the PIHP must be informed of the reasons for the adverse credentialing decision in writing by the PIHP within 30 days of the decision.

V. Appeal of Adverse Credentialing Decision:

Each PIHP must have a written appeal process that is available when credentialing or re-credentialing is denied, suspended, or terminated for any reason other than lack of need. The written appeal process must be consistent with applicable federal and state requirements. The appeal process must be included as part of an adverse credentialing decision notification letter.

VI. Reporting Requirements

The organization must have procedures for reporting improper known organizational provider or individual practitioner conduct that results in suspension or termination from the NorthCare Network to appropriate authorities (i.e., MDHHS, the provider's regulatory board or agency, the Attorney General, etc.). Such written procedures must be consistent with current federal and state requirements, including those specified in the MDHHS Medicaid Managed Specialty Supports and Services Contract.