

CHAPTER 48 - CREDENTIALING OF CONTRACTED PROVIDERS

EFFECTIVE DATE: May 26, 2017

REFERENCES: AHCCCS AMPM Policy 950

The Quality Management Unit of the Division of Developmental Disabilities (Division) completes credentialing functions to ensure compliance with the Arizona Health Care Cost Containment System (AHCCCS) standards set forth in the AHCCCS Medical Policy Manual, Policy 950. The credentialing of health care providers is delegated to the Division's subcontracted health plans and is monitored by the Division at annual operational reviews. The credentialing of Qualified Vendors is completed by the Division, and this policy pertains specifically to them.

A. Initial Credentialing

Initial Credentialing occurs after a vendor is approved by the Division's Contracts Unit and is issued a Qualified Vendor Agreement, as follows:

1. The Contracts Unit notifies the Quality Management Unit of a new vendor that has met the "good to go" criteria.
2. Quality Management staff collect the required information as outlined in the Division's Medical Policy Manual Policy 950 (Credentialing and Recredentialing Processes) and create a file.
3. Quality Management staff conduct an on-site assessment.
4. The credentialing file is presented to the Division's Credentialing Committee for approval.
5. Once the vendor has been approved, the Division notifies the vendor, via letter, that the vendor has been approved and that recredentialing will occur at least every three years thereafter.

B. Provisional Credentialing

If a provider is immediately needed and a contract has been issued before the next Credentialing Committee meeting:

1. The Chief Medical Officer, or Medical Director, reviews the initial credentialing file and makes a determination within 14 calendar days from the request.
2. If the vendor has been approved by the Chief Medical Officer or Medical Director, the Division notifies the vendor that it has been provisionally approved and can start to provide authorized services.
3. The vendor's credentialing information will be presented at the next Credentialing Committee meeting for final approval.

C. Recredentialing

Recredentialing occurs at least every three years as follows:

1. Quality Management staff collect the required information as outlined in the Division's Medical Policy Manual Policy 950 (Credentialing and Recredentialing Processes) and create a file.
2. The credentialing file is presented to the Division's Credentialing Committee for approval.
3. If the vendor has been approved, the Division notifies the vendor, via letter, that the vendor has been approved and that recredentialing will occur in three years.

D. Credentialing Denial, Suspension or Termination

1. The Division may deny, suspend, or terminate credentialing for the following reasons:
 - a. Not having verification of current insurance
 - b. Not being in good standing with state, federal and/or accrediting bodies (if applicable)
 - c. Not having current licensure, patterns of licensure compliance issues and/or on-site assessment identifies significant issues
 - d. Patterns/Trends regarding complaints/grievances, utilization management, quality of care concerns and/or incidents
 - e. Program monitoring and/or certification compliance issues and/or trends
 - f. Contract actions, corrective action plans
 - g. Other contractual obligations not meet
 - h. A determination of fraud, abuse or waste
 - i. Other concerns relevant to vendor performance and compliance.
2. The reason for the denial, suspension, or termination is documented.
3. The vendor's status is communicated to the Assistant Director, Contracts Management Unit staff, and the Assistant Attorney General for appropriate action.
4. AHCCCS and relevant licensing or certifying boards, law enforcement agencies, and/or protective agencies, are notified of credentialing actions.