950 CREDENTIALING AND RECREDENTIALING PROCESSES

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Credentialing and Recredentialing System

The Division of Developmental Disabilities (Division) maintains a system for credentialing and recredentialing providers.

The Division delegates a portion of the required responsibilities of credentialing/ recredentialing to subcontractors.

A. The Division or its subcontractors conducts and documents credentialing and recredentialing for all providers, including those employed by an organizational provider contracted with the Division for care and services to members. Credentialing and recredentialing is completed for the following provider types:

1. Physicians (Medical Doctor [MD])
2. Doctor of Osteopathic Medicine (DO)
3. Doctor of Podiatric Medicine (DPM)
4. Nurse practitioners
5. Physician Assistants
6. Certified Nurse Midwives acting as primary care providers, including prenatal care/delivering providers
7. Dentists (Doctor of Dental Surgery [DDS] and Doctor of Medical Dentistry [DMD])
8. Affiliated Practice Dental Hygienists
9. Psychologists
10. Optometrist
11. Certified Registered Nurse Anesthetist
12. Occupational Therapist
13. Speech and Language Pathologist
14. Physical Therapists
15. Independent behavioral health professionals who contract directly with the Division, including:
    a. Licensed Clinical Social Worker (LCSW)

b. Licensed Professional Counselor (LPC)

c. Licensed Marriage/Family Therapist (LMFT)

d. Licensed Independent Substance Abuse Counselor (LISAC)

16. Board Certified Behavioral Analysts (BCBAs)

17. Any non-contracted provider that is rendering services and sees 50 or more members per contract year

18. Covering or substitute oral health providers that provide care and services to members while providing coverage or acting as a substitute during an absence of the contracted provider. Covering or substitute oral health providers must indicate on the claim form that they are the rendering provider of the care of service.

B. The Division or it subcontractors ensure:

1. The credentialing and recredentialing processes do not discriminate against a provider who serves high-risk populations or who specializes in the treatment of costly conditions.

2. There is compliance with federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid or that employ individuals or entities that are excluded from participation.

C. The Division delegates a portion of the required responsibilities of credentialing/ recredentialing to subcontractors.

1. The Division retains the right to approve, suspend, or terminate any provider credentialed by a subcontractor.

2. The Division is responsible for making an independent decision regarding any provider approved through a delegated credentialing process into its network.

D. The Division or its subcontractor's Chief Medical Officer (CMO), or in the absence of the CMO, another designated physician:

1. Acts as the Chair of the Credentialing Committee

2. Implements the decisions made by the Credentialing Committee

3. Oversees the credentialing process.

E. The Division ensures the use of participating Arizona Medicaid network providers in making credentialing decisions through participation in the Credentialing Committee.

F. The Division or its subcontractor maintains an individual electronic or hard copy credentialing/recredentialing file for each credentialed provider in accordance

with AHCCCS policy.

G. Credentialed providers are included in the claims payment system within 30 calendar days of Credentialing Committee approval.

H. Credentialed providers must be entered/loaded into the claims payment system with an effective date of no later than the date the provider was approved by the Credentialing Committee or the contract effective date, whichever is later.

I. For Locum Tenens, the Division or its subcontractor verifies the status of the physician with the Arizona Medical Board and national databases.

Initial Credentialing

The Division or its subcontractors uses the Arizona Health Plan Association's Credential Verification Organization (CVO) as part of the credentialing process. The initial credentialing of physicians, other licensed health care providers, behavioral health providers, and BCBAs follow AHCCCS policy.

The Division or its subcontractor ensures network providers can ensure physical access, accommodations, and accessible equipment for members with physical and mental disabilities. Accommodations are reasonable and providers ensure culturally competent communications with members. The Division or its subcontractor ensures that providers can communicate, in a culturally competent manner, in the preferred language of those with limited-English-proficient members, diverse cultural and ethnic backgrounds, and disabilities, and regardless of gender, sexual orientation, or gender identity.

The Division or its subcontractor ensures that initial credentialing will include:

A. A written application to be completed, signed and dated by the provider that attests to the follow elements:

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

2. Lack of present illegal drug use,

3. History of loss of license and/or felony convictions,

4. History of loss or limitation of privileges or disciplinary action,

5. Current malpractice insurance coverage,

6. Attestation by the applicant of the correctness and completeness of the application (a copy of the signed attestation must be included in the provider's credentialing file), and

7. Minimum five year work history or total work history if less than five years.

B. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification, if a prescriber.

C. Verification from primary sources of:

1. Licensure or certification,

2. Board certification, if applicable, or highest level of credentials attained.

Temporary/Provisional Credentialing

The Division or its subcontractor maintains procedures to address temporary or provisional credentials, when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.

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

The Division or its subcontractors follow AHCCCS policy when granting temporary or provisional credentialing to:

A. Providers needed in medically underserved areas

B. Providers joining an existing, contracted oral health provider group

C. Covering or substitute providers providing services to members during a provider's absence from the practice.

The Division or its subcontractor renders a decision regarding temporary or provisional credentialing in 14 calendar days from receipt of a completed application.

If a covering or substitute provider is used and is approved through the temporary/ provisional credentialing process, the Division or its subcontractor ensures that its system allows payments to the covering/substitute provider. Covering or substitute providers also meet the requirements set forth in AHCCCS policy.

A. For consideration of temporary or provisional credentialing, at a minimum, a provider completes a signed application that includes:

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

2. Lack of present illegal drug use

3. History of loss of license and/or felony convictions

4. History of loss or limitation of privileges or disciplinary action

5. Current malpractice insurance coverage

6. Attestation by the applicant of the correctness and completeness of the application. A copy of the most current signed attestation will be included in the provider's credentialing file.

B. The applicant furnishes:

1. Work history for the past five years, or total work history if less than five years

2. Current Drug Enforcement Agency (DEA) or Controlled Drug System (CDS) certificate.

C. The Division or its subcontractor conducts primary verification of the following licensure or certification (a print out of license from the applicable Board's official website denoting that the license is active with no restrictions is acceptable).

1. Board certification, if applicable, or the highest level of credential attained, and

2. National Provider Data Bank (NPDB) query, including:

a. Minimum five year history of professional liability claims resulting in a judgment or settlement

b. Disciplinary status with regulatory board or agency

c. State sanctions or limitations of licenses

d. Medicare/Medicaid sanctions, exclusions, and terminations for cause.

D. The Division's or its subcontractor's CMO reviews the information obtained and determines whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and Credentialing Committee review, as outlined in this policy, is completed.

Recredentialing Individual Providers

A. The Division or its subcontractors use the Arizona Health Plan Association's CVO as part of its credentialing process. Recredentialing of physicians and other licensed or certified health care providers:

1. Occurs at least every three (3) years

2. Includes an update of information obtained during the initial credentialing process

3. Verifies continuing education requirements are met, if applicable

4. Includes a process for monitoring health care providers specific information, including:

a. Member concerns, which include grievances (complaints)

b. Utilization management information (e.g., emergency room utilization, hospital length of stay, disease prevention, pharmacy utilization)

c. Performance improvement and monitoring (e.g.,

performance measure rates)

d. Results of medical record review audits, if applicable

e. Quality of care issues (including trend data). If an adverse action is taken with a provider, including non-renewal of a contract, the Division reports the adverse action and includes the reason for the adverse action to the AHCCCS Clinical Quality Management Unit within one business day.

f. Pay for performance and value-driven health care data/outcomes, if applicable

g. Evidence that the provider's policies and procedures meet AHCCCS requirements

B. Timely approval (or denial) by the Division's Credentialing Committee occurs within 90 days of recredentialing being initiated.

Initial Credentialing of Organizational Providers

A. The Division or its subcontractors ensures the organizational provider has established policies and procedures that meet AHCCCS and Division requirements, as a prerequisite to contracting with an organizational provider. The requirements described in this section are met for all organizational providers in its network, including, but not limited to:

1. Hospitals
2. Home health agencies
3. Attendant care agencies
4. Habilitation providers
5. Group homes
6. Nursing facilities
7. Dialysis centers
8. Dental and medical schools
9. Freestanding surgical centers
10. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
11. State or local public health clinics
12. Community/Rural Health Clinics (or Centers)
13. Air transportation

14. Non-emergency transportation vendor
15. Laboratories
16. Pharmacies
17. Respite homes/Providers
18. Adult/Child Developmental Homes
19. Day/Employment Homes
20. Therapies
21. Behavioral health facilities, including but not limited to:
    a. Independent Clinics
    b. FQHCs
    c. FQHC look-alikes
    d. Community Mental Health Centers
    e. Level 1 Sub-Acute Facility
    f. Level 1 Sub-Acute Intermediate Care Facility
    g. Level 1 Residential Treatment Center (secure and non-secure)
    h. Community Service Agency
    i. Crisis Services Provider/Agency
    j. Behavioral Health Residential Facility
    k. Behavioral Health Outpatient Clinic
    l. Integrated Clinic
    m. Rural Substance Abuse Transitional Agency
    n. Behavioral Health Therapeutic Home
    o. Respite homes/providers
    p. Specialized Assisted Living Centers
    q. Specialized Assisted Living Homes.

B. Prior to contracting with an organizational provider, the Division or its subcontractors:

1. Confirms 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)

2. Confirms 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),when applicable

3. Conducts an onsite quality assessment. The Division uses assessment criteria, for each type of unaccredited organizational provider with which it contracts, that includes, at minimum, confirmation that the organizational provider has:

   a. A process for ensuring that the organizational provider credentials its providers for all employed and contracted providers listed in this policy

   b. Liability insurance

   c. Business license

   d. CMS certification or state licensure review/audit within the past three years of the credentialing date

      If this criterion is met and documentation supports provider passed inspection and meets Division or subcontractors standards, an on-site visit can be waived.

   e. In addition, for Community Service Agencies:

      i. A signed relationship agreement with the contractor whose members they are serving

      ii. An approved application with the contractor

      iii. A signed contract with a Regional Behavioral Health Authority- contracted network provider or with contractor directly as applicable.

      iv. A description of the services provided that matches the services approved on the Title XIX Certificate

      v. Fire inspection reports

      vi. Occupancy permits

      vii. Tuberculosis testing

      viii. CPR certification

      ix. First Aid certification

      x. Respite providers provide and maintain consistently a

signed agreement with an Outpatient Treatment Center.

4. Reviews and approves the organizational provider through the Division's or its subcontractor's Credentialing Committee.

5. For transportation vendors, reviews a maintenance schedule for vehicles used to transport AHCCCS members and the availability of age-appropriate car seats when transporting children.

Reassessment of Organizational Providers

A. The Division or its subcontractors reassess organizational providers at least every three years. The reassessment includes the following information, which must be current:

1. Confirmation the organizational providers remain in good standing with state and federal bodies, and, if applicable, are reviewed and approved by an accrediting body, by validating the organizational provider:

   a. Is licensed to operate in the state, and is in compliance with any other state or federal requirements as applicable

   b. Is reviewed and approved by an appropriate accrediting body.

      If an organizational provider is not accredited or surveyed and licensed by the state, an on-site review is conducted.

2. Review of:

   a. The most current review conducted by the Arizona Department of Health Services (ADHS) and/or summary of findings (date of ADHS review is be documented) and, if applicable, review of the online "Hospital Compare" or "Nursing Home Compare"

   b. Record of on-site inspection of non-licensed organizational providers to ensure compliance with service specifications

   c. Supervision of staff and required documentation of direct supervision/clinical oversight as required, including, if applicable, review of a valid sample of clinical/member charts

   d. Most recent audit results of the organizational provider

   e. Confirmation that the service delivery address is correct

   f. Verification that staff meet the credentialing requirements.

3. Evaluation of organizational provider-specific information, such as but not limited to the following:

   a. Member concerns which include grievances (complaints)

   b. Utilization management information

c. Performance improvement and monitoring

d. Quality of care issues

e. Onsite assessment.

4. The Division's Credentialing Committee reviews and approves all credentialing decisions.

5. The Division reviews and monitors other types of organizational providers in accordance with their contract.

Notification Requirements - Suspensions and Terminations

The Division or its subcontractors must report within one business day issues/quality deficiencies that result in a provider's suspension or termination from the network to the AHCCCS Clinical Quality Management Unit. If the deficiency is determined to have criminal implications, including allegations of abuse or neglect, the Division promptly notifies a law enforcement agency, and Adult Protective Services or the Department of Child Safety. In addition, the Division or it subcontractors have processes in place to report providers to licensing, certification agencies and other regulatory entities, such as medical, nursing boards, etc. when there are allegations of misconduct, prescribing concerns, etc.

The Division or its subcontractors report to the AHCCCS Clinical Quality Management Unit all credentialing, provisional credentialing, recredentialing, and organizational credentialing denials that are based on quality-related issues or concerns.

A. The Division or its subcontractor indicates in its notification to AHCCCS the reason for the denial decision and when restrictions are placed on the provider's contract, such as denials or restrictions which are the result of licensure issues, quality of care concerns, excluded providers, alleged fraud, and waste or abuse. The Division or its subcontractors:

1. Maintains documentation of implementation of the procedures

2. Has an appeal process for instances in when restrictions are placed on the provider's contract based on issues of quality of care and/or service

3. Informs the provider of the Quality Management (QM) dispute process through the QM Department

4. Notifies the AHCCCS Clinical Quality Management (CQM) within one business day for all reported events.

Notification Requirements - Final Adverse Actions

A. Within one business day, the Division or its subcontractors reports to the AHCCCS Clinical Quality Management Unit in writing, any final adverse action for any reason, taken against a health care provider, supplier/vendor, or practitioner.

B. A final adverse action includes:

1. Civil judgments in federal or state court related to the delivery of a health care item or service

2. Federal or state criminal convictions related to the delivery of a health care item or service, and

3. Actions by federal or state agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including:

a. Formal or official actions, such as restriction, revocation or suspension of license (and the length of any such suspension), reprimand, censure or probation,

b. Any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such federal or state agency that is publicly available information,

c. Exclusion from participation in federal or state health care programs as specified in current statute, and

d. Any other adjudicated actions or decisions as necessary.

4. Any adverse credentialing, provisional credentialing, recredentialing, or organizational credentialing decision made based on quality-related issues/concerns or any adverse action from a quality or peer review process, that results in denial of a provider to participate in the Division's or its subcontractors network, provider termination, provider suspension or an action that limits or restricts a provider.

C. A final adverse action does not include an action with respect to a malpractice notice or settlements in which no findings or liability has been made.

D. The Division or its subcontractors submits to the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB):

1. Within 30 calendar days from the date the final adverse action was taken or the date when the Division or its subcontractors became aware of the final adverse action, or

2. By the close of the Division's or its subcontractors next monthly reporting cycle, whichever is later.

E. The Division or its subcontractors immediately notifies the AHCCCS Office of Inspector General (AHCCCS-OIG) regarding any allegation of fraud, waste or abuse of the AHCCCS Program, including allegations of fraud, waste or abuse that were resolved internally but involved AHCCCS funds. The Division or its

subcontractors also reports to AHCCCS, as specified in Attachment F3, Contractor Chart of Deliverables, any credentialing denials issued by the CVO including, but not limited to, those that are the result of licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste or abuse. AHCCCS-OIG conducts a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. The Division or its subcontractors reports, within one business day, the following:

1. The name and Tax Identification Number (TIN) (as defined in section 7701(A)(41) of the Internal Revenue Code of 1986[1121])

2. The name (if known) of any heath care entity with which the health care provider, supplier, or practitioner is affiliated or associated

3. The nature of the final adverse action and whether such action is on appeal

4. A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information determined by regulation, for appropriate interpretation of information reported under this section .The date the final adverse action was taken, its effective date and duration of the action

5. Corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, and

6. Documentation that the following sites have been queried; any provider that is found to be on any of the lists below may be terminated and the identity of the provider is disclosed to AHCCCS/OIG immediately:

    a. The System of Award Management (SAM)/www.sam.gov, formerly known as the Excluded Parties List System (EPLS)

    b. The Social Security Administration's Death Master File

    c. The National Plan and Provider Enumeration System (NPPES)

    d. The List of Excluded Individuals (LEIE)

    e. Any other databases directed by AHCCCS or CMS.

Teaching Physicians and Teaching Dentists

A. AHCCCS permits services to be provided by medical students or medical residents and dental students or dental residents under the direct supervision of a teaching physician or a teaching dentist. In limited circumstances when specific criteria are met, medical residents may provide low-level evaluation and management services to members in designated settings without the presence of the teaching physician.

B. The teaching physicians and teaching dentists must be an AHCCCS registered provider and must be credentialed by the AHCCCS Contractors in accordance with AHCCCS policy as set forth in this Policy.

Credentialing Timeliness

The Division or its subcontractors processes credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing, the number of complete applications processed (approved/denied) during the time period per category is divided by the number of complete applications that were received during the time period per category.

The timeliness standards for approvals/denials, expressed as a percentage of total received, is shown below.

Type of Credentialing	Timeframe	Completion Requirements
Provisional	14 days	100%
Initial	90 days	100%
Organizational Credentialing	90 days	100%
Recredentialing	Every Three Years	100%
Load Times (Time between redentialing Committee approval and loading into claims system.)	30 Days	90%