950 CREDENTIALING AND RECREDENTIALING PROCESSES

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REFERENCES: A.A.C. R9-10-114, A.A.C. R9-10-115; 42 CFR 8.11, CFR 438, 42 CFR 455.1(a)(1), 42 CFR 455.14, 42 CFR 455.17, 42 CFR 455 Subpart B, 42 CFR 457.1201(f), 42 CFR 457.1208, 42 CFR 457.1230(a), 42 CFR 457.1233(a), IRC of 1986 7701(A)(41).

PURPOSE

This policy establishes the requirements for Initial Credentialing, Temporary/Provisional Credentialing, and Recredentialing of Individual and Organizational Providers conducted by the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Adverse Action" means any type of restriction placed on a Provider's practice, including contract termination, suspension, limitations, continuing education requirements, monitoring, supervision.
2. "Completed Application" means when all accurate information and documentation is available to make an informed decision about the Provider.

3. "Credentialing" means a process in which written evidence of qualifications are obtained in order for practitioners to participate under contract with a specific health plan.
4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
5. "Network Provider" means, for the purpose of this policy, an individual or entity which has signed a Provider agreement as specified in A.R.S. § 36-2904 and that has a subcontract, or is authorized through a subcontract, to provide services pursuant to A.R.S. § 36-2901 et seq. for Members served by the AdSS health plan.
6. "Organizational Provider" means a facility providing services to Members and where Members are directed for services rather than being directed to a specific practitioner.
7. "Primary Source Verification" means the process by which an individual Provider's reported credentials and qualifications are confirmed with the original source or an approved agent of that source.
8. "Provider" means any individual or entity that contracts with the AdSS for the provision of covered services, or ordering or referring for those services to Division Members enrolled in an AdSS' health plan, or any

subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.

POLICY

A. CREDENTIALING PROVIDERS

1. The AdSS shall have a written process and a system in place for Credentialing and Recredentialing Providers in its Provider Network.
2. The AdSS shall document Credentialing and Recredentialing for all Providers delivering care and services to Division Members enrolled in the AdSS' health plan.
3. The AdSS shall utilize the Arizona Association of Health Plans' contracted Credentials Verification Organization as part of the Credentialing and Recredentialing process.
4. The AdSS shall ensure the Credentialing and Recredentialing processes:
    a. Do not base Credentialing decisions on an applicant's race, gender, age, sexual orientation, or patient type in which the Provider specializes.
    b. Do not discriminate against Providers who serve high-risk

populations or who specialize in the treatment of costly conditions.

c. Comply 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.

5. If the AdSS delegates any Credentialing and Recredentialing responsibilities to another entity, the AdSS shall retain the right to approve, suspend, or terminate any Provider selected by that entity.

6. The AdSS shall establish a Credentialing Committee to review and make decisions on Provider Credentialing.

7. The AdSS shall have written policies and procedures that:

a. Reflect the direct responsibility of the AdSS' local Chief Medical Officer or designated Medical Director, or in the absence of the Chief Medical Officer or designated Medical Director, another local designated physician to:

i. Act as the Chair of the Credentialing Committee;

ii. Implement the decisions made by the Credentialing Committee; and

iii. Oversee the Credentialing process;

b. Indicate the use of the Division and participating Arizona Medicaid Network Providers in making Credentialing decisions;

c. Describe the methodology to be used by the AdSS' staff and the local Chief Medical Officer or designated Medical Director to provide documentation that each Credentialing/ Recredentialing file was completed and reviewed prior to the presentation to the Credentialing Committee for evaluation; and

d. Notify Providers of their right to:

i. Review information obtained to evaluate the Credentialing application, attestation, or curriculum vitae;

ii. Correct erroneous information; and

iii. Receive the status of their Credentialing application upon request.

8. The AdSS shall maintain an individual electronic or hard copy Credentialing/Recredentialing file for each applying Provider and ensure each file contains:
    a. The Initial Credentialing and all subsequent Recredentialing applications and attestation by the Provider of the correctness and completeness of the application as demonstrated by the signature on the application;
    b. Information gained through Credentialing and Recredentialing queries;
    c. Any other pertinent information used in determining whether the Provider met the AdSS' Credentialing and Recredentialing standards; and
    d. Specific to Recredentialing, utilization data, quality of care concerns, grievances, performance measure rates, value-based purchasing results, and level of Member satisfaction.
9. The AdSS shall enter the credentialed Providers into the AdSS' claims payment system within 30 calendar days of the Credentialing approval with an effective date no later than the

date the Provider was approved by the Credentialing Committee or the contract effective date, whichever is later.

10. The AdSS shall reimburse Providers who submit claims for covered services provided to Members during the Credentialing process on or after the date of the Completed Application as defined in this Policy. If the Provider is subsequently not approved through the Credentialing Committee, the AdSS shall recoup the funding.
11. The AdSS shall have an established process to notify Providers of the Credentialing decisions within 10 calendar days of Credentialing Committee decisions.

B. TEMPORARY/PROVISIONAL CREDENTIALING

1. The AdSS shall have policies and procedures to address granting of Temporary/Provisional credentials when it is in the best interest of Members, as defined in this section, to have Providers available to provide care prior to completion of the entire Credentialing process.
2. The AdSS shall credential the following Providers using the Temporary/Provisional Credentialing process, even if the Provider

does not specifically request their application be processed as Temporary/Provisional:

a. Providers in a Federally Qualified Health Center (FQHC);

b. Providers in a FQHC Look-Alike organization;

c. Rural Health Clinic (RHC);

d. Hospital employed physicians (when appropriate);

e. Providers needed in medically underserved areas;

f. Providers joining an existing, contracted oral health Provider group;

g. Covering or substitute Providers providing services to Members during a contracted Provider's absence from the practice;

h. Providers eligible under the Substance Abuse and Mental Health Services Administration Certified Opioid Treatment Programs as specified in 42 CFR 8.11; and

i. Providers as directed by AHCCCS during federal or state-declared emergencies where delivery systems are or have the potential to be disrupted.

3. The AdSS local Medical Director shall review the Credentialing information obtained and determine whether to grant Temporary/Provisional Credentialing.
4. The AdSS shall render a decision regarding Temporary/Provisional Credentialing within 14 calendar days from the date of request or identified need.
5. Upon approval of the Temporary/Provisional Credentialing, the AdSS shall enter the Provider information into the AdSS' claims system to allow payment to the Provider effective the date the Temporary/Provisional Credentialing is approved.
6. For consideration of Temporary/Provisional Credentialing, at a minimum, the AdSS shall ensure the Provider has a Completed Application, signed and dated, that attests to the following elements:
    a. Reasons for any inability to perform the essential functions of the position with or without accommodation;
    b. Lack of present illegal drug use;
    c. History of loss of license or felony convictions;

d. History of loss or limitation of privileges or disciplinary action;

e. Current malpractice insurance coverage;

f. Attestation by the Provider of the correctness and completeness of the application;

g. Work history for the past five years or total work history if less than five years; and

h. Current Drug Enforcement Agency or Controlled Drug System certificate if a prescriber.

7. The AdSS shall conduct Primary Source Verification of the following:

a. Licensure or certification;

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

c. National Practitioner Data Bank (NPDB) query with:

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

ii. Disciplinary status with regulatory board or agency;

iii. State sanctions or limitations of licenses; and

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

8. If a covering or substitute Provider is used by a contracted Provider, and is approved through the Temporary/Provisional Credentialing process, the AdSS shall ensure that the claims system allows payments to the covering or substitute Provider effective the date the notification was received from the Provider of the need for a covering or substitute Provider.
9. The AdSS shall require covering or substitute Providers to meet the following requirements:
    a. Licensure: Providers and employees rendering services to Members shall be appropriately licensed in Arizona to render such services as required by state or federal law or regulatory agencies, and such licenses shall be maintained in good standing.
    b. Restriction of licensure: Providers shall notify the AdSS within two business days of the loss or restriction of a Drug Enforcement Agency permit or license, or any other action that limits or restricts the Provider's ability to practice or

provide services.

c. Professional Training: Providers and all employees rendering services to Members shall possess the education, skills, training, physical and mental health status, and other qualifications necessary to provide quality care and services to Members.

d. Professional Standards: Providers and employees rendering services to Members shall provide care and services which meet or exceed the standard of care and shall comply with all standards of care established by state or federal law.

e. Continuing education: Providers and employees rendering care or services to Members shall comply with continuing education standards as required by state or federal law or regulatory agencies.

f. Regulatory compliance: Providers shall meet the minimum requirements for participating in the Medicaid program as specified by the state.

10. Following approval of Temporary/Provisional Credentialing, the AdSS shall complete the entire Initial Credentialing process as specified in this policy.
11. The AdSS shall not keep Providers in a Temporary/Provisional Credentialing status for longer than 60 calendar days.

C. INITIAL CREDENTIALING OF INDIVIDUAL PROVIDERS

1. The AdSS shall complete the individual Provider Credentialing for the following provider types:
    a. Medical Doctor;
    b. Doctor of Osteopathic Medicine;
    c. Doctor of Podiatric Medicine;
    d. Naturopathic Doctor and Naturopathic Medical Doctor;
    e. Nurse Practitioner;
    f. Physician Assistant;
    g. Certified Nurse Midwife acting as Primary Care Provider, including prenatal care and delivering Provider;
    h. Doctor of Dental Surgery and Doctor of Medical Dentistry;
    i. Affiliated Practice Dental Hygienist;
    j. Psychologist;

k. Optometrist;

l. Certified Registered Nurse Anesthetist;

m. Occupational Therapist;

n. Speech and Language Pathologist;

o. Physical Therapist; and

p. Independent behavioral health professionals who contract directly with the AdSS;

q. Board Certified Behavioral Analyst (BCBA);

r. Any non-contracted certified or licensed provider that is rendering services and sees 50 or more Members served by the AdSS per contract year; and

s. Any covering/substitute oral health providers that provide care and services to Members served by the AdSS in the absence of the contracted Provider.

2. The AdSS shall have a process for Initial Credentialing of individual Providers that includes:

a. A written application to be completed by the Provider that attests to the following elements:

i. Reasons for any inability to perform the essential

functions of the position with or without accommodation;

ii. Lack of present illegal drug use;

iii. History of loss of license or felony convictions;

iv. History of loss or limitation of privileges or disciplinary action;

v. Current malpractice insurance coverage;

vi. Attestation by the Provider of the correctness and completeness of the application;

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

viii. Electronic Vendor Verification attestation form, if applicable.

b. Drug Enforcement Administration or Chemical Database Service certification if a prescriber.

c. Verification from primary sources of:

i. Licensure or certification; and

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

iii. For Credentialing of Independent Masters Level Behavioral Health Licensed Professionals, Primary Source Verification of:

a) Licensure by the Arizona Board of Behavioral Health Examiners (AZBBHE); and

b) A review of complaints received and disciplinary status through AZBBHE.

iv. For Credentialing of licensed BCBA, Primary Source Verification of:

a) Licensure by the Arizona Board of Psychologist Examiners;

b) A review of complaints received and disciplinary status through the Arizona Board of Psychologist Examiners; and

c) Continuing Education Requirements and Courses.

v. Documentation of graduation from an accredited school and completion of any required internships or residency programs, or other postgraduate training.

A printout of license from the applicable Board's official website denoting that the license is active with no restrictions is acceptable.

vi. National Practitioner Data Bank 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; and

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

vii. Documentation that the following sites have been queried:

a) Health and Human Services Office of Inspector General List of Excluded Individuals/Entities, and

b) The System of Award Management formerly known as the Excluded Parties List System.

3. The AdSS shall ensure affiliated practice dental hygienists provide documentation of the affiliation agreement with an AHCCCS registered dentist.
4. The AdSS may conduct an initial site visit as part of the Credentialing process.
5. For Locum Tenens, the AdSS shall verify the status of the physician with the Arizona Medicaid Board and national databases.
6. The AdSS shall ensure that Network Providers have capabilities to ensure physical access, reasonable accommodations, and accessible equipment for Members with physical and mental disabilities.
7. The AdSS shall ensure that network Providers deliver services in a culturally competent manner, including Members with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

8. The AdSS shall conduct timely verification of information as evidenced by approval or denial of a Provider within 60 days of receipt of a complete application.

D. RECREDENTIALING OF INDIVIDUAL PROVIDERS

The AdSS shall have Recredentialing procedures that address the following requirements:

1. Recredentialing at least every three years.
2. Primary source verification current within 180 days of the Recredentialing decision.
3. An update of information obtained during the Initial Credentialing process as specified within this policy.
4. Verification of continuing education requirements being met.

   A process for monitoring health care Provider specific information, to include:

   a. Member concerns and grievances;
   b. Utilization management information;
   c. Performance Improvement and monitoring;
   d. Results of medical record review audits;
   e. Quality of Care issues; and

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

E. INITIAL CREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. As a prerequisite to contracting with an Organizational Provider, the AdSS shall ensure that the Organizational Provider has established policies and procedures that meet Division and AHCCCS requirements, including policies and procedures for Credentialing if those functions are delegated to the Organizational Provider.
2. Prior to Credentialing and contracting with an Organizational Provider, the AdSS shall:
   a. Confirm the Organizational 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.
   b. Confirm that the Organizational 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.

c. Conduct an onsite quality assessment if the Organizational Provider is not accredited.

d. Develop a process and utilize assessment criteria for each type of unaccredited Organizational Provider that confirms that the Organizational Provider has the following:

   i. A process for ensuring that the Organizational Provider credentials its Providers for all employed and contracted Providers as specified in this policy;

   ii. Liability insurance;

   iii. Business license; and

   iv. CMS certification or state licensure review may be substituted for the required onsite quality assessment if the review was within the past three years prior to the Credentialing date.

      a) If a review was conducted within the past three years, obtain the documentation from CMS or the state licensing agency and verify

that the review was conducted and that the Organizational Provider meets the AdSS' standards.

b) A letter from CMS that states the Organizational Provider was reviewed and passed inspection is sufficient documentation when the AdSS have documented that they have reviewed and approved the CMS criteria and they meet the AdSS' standards.

e. Confirm maintenance schedules for vehicles used to transport Members and the availability of age-appropriate car seats when transporting children.

f. Review and approve the Organizational Provider through the AdSS's Credentialing Committee.

3. The AdSS shall ensure Community Service Agencies are credentialed according to AHCCCS Medical Policy 965.

F. RECREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. The AdSS shall recredential Organizational Providers at least every three years using the following components:

a. Confirmation that the Organizational Provider remains in good standing with state and federal bodies by validating that the Organizational Provider:
    i. Is licensed to operate in the state and is in compliance with any other state or federal requirements, as applicable; and
    ii. Is reviewed and approved by an appropriate accrediting body.
b. Review of the following:
    i. The most current review conducted by the Arizona Department of Health Services (ADHS) or summary of findings, documented by review date, and if applicable, the online Hospital Compare Az Care Check.
    ii. Record of onsite inspection of non-licensed Organizational Providers to ensure compliance with service specifications.

iii. Supervision of staff and required documentation of direct supervision or clinical oversight, including a review of a valid sample of clinical charts.

iv. Most recent audit results of the Organizational Provider.

v. Confirmation that the service delivery address is verified as correct.

vi. Review of staff to verify credentials and that staff meet the Credentialing requirements.

c. Evaluation of Organizational Provider specific information related to:

i Member concerns and grievances;

ii. Utilization management information;

iii. Performance improvement and monitoring;

iv. Quality of care issues;

v. Onsite quality assessment; and

vi. Review of any Adverse Actions.

d. Review and approval by the AdSS' Credentialing Committee with formal documentation that includes

discussion, review of thresholds, and complaints or grievances.

2. The AdSS shall review and monitor other types of Organizational Providers in accordance with the AdSS' contract.
3. If an Organizational Provider is not accredited or surveyed and licensed by the state, the AdSS shall conduct an onsite review.

G. NOTIFICATION REQUIREMENTS

1. The AdSS shall have written procedures for reporting to AHCCCS, Division of Health Care Management (DHCM), Quality Management (QM), the Division's Quality Management Unit (QMU), the Provider's regulatory board or agency, ADHS Licensure Division, the Office of the Attorney General, and any other appropriate agencies.
2. The AdSS shall report any issues or quality deficiencies that result in a Provider's suspension or termination from the AdSS' network to AHCCCS/DHCM/QM and the Division QMU within one business day of the determination to take the Adverse Action.
3. If any issue is determined to have criminal implications, including allegations of abuse or neglect, the AdSS shall notify

the appropriate law enforcement agency and protective services agency no later than 24 hours after identification.

4. The AdSS shall have an implemented process to report Providers to licensing and other regulatory entities for allegations of inappropriate or misuse of prescribing practices.
5. The AdSS shall report any adverse Credentialing decisions made on the basis of quality-related issues or concerns to AHCCCS/DHCM/QM and the Division QMU within one business day of determination to take the Adverse Action and include the reason or cause of the adverse decision and when restrictions are placed on the Provider's contract.
6. The AdSS shall have an appeal process for Providers when restrictions are placed on the Provider's contract and a method to inform the Provider of the appeal process.
7. The AdSS shall have written procedures for reporting to AHCCCS/DHCM/QM and the Division QMU any final Adverse Action, taken against a Provider, supplier, vendor, or practitioner for any quality-related reason.

8. The AdSS shall not consider a final Adverse Action to be malpractice notices or settlements in which no findings or liability have been determined.
9. The Division shall consider the following to be a final Adverse Action:
    a. Civil judgments in federal or state court related to the delivery of a health care item or service;
    b. Federal or state criminal convictions related to the delivery of a health care item or service;
    c. Actions by federal or state agencies responsible for the licensing and certification of health care Providers, suppliers, and licensed health care practitioners, including:
        i. Formal or official actions, such as restriction, revocation, suspension of license and length of suspension, reprimand, censure or probation;
        ii. 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

iii Any other negative action or finding by such federal or state agency that is publicly available information.

iv. Exclusion from participation in federal or state health care programs as defined in 42 CFR 455 Subpart B; and

v. Any other adjudicated actions or decisions that the Secretary of the U.S. Department of Health and Human Services shall establish by regulation.

vi. Any adverse Credentialing decision made on the basis of quality-related issues or concerns.

vii. Any Adverse Action from a quality or peer review process that results in denial of a Provider to participate in the AdSS network, Provider termination, Provider suspension, or an action that limits or restricts a Provider.

10. The AdSS shall submit to the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB) within 30 calendar days from the date the final Adverse Action was taken, or the date when the AdSS became aware of the final Adverse Action, or by the

close of the AdSS' next monthly reporting cycle, whichever is later.

11. The AdSS shall send a notice of final Adverse Action to AHCCCS/DHCM/QM and the Division QMU within one business day and provide the following information:
    a. The name and Tax Identification Number as defined in section 7701(A)(41) of the Internal Revenue Code of 1986 (1121).
    b. The name (if known) of any heath care entity with which the health care Provider, supplier, or practitioner is affiliated or associated.
    c. The nature of the final Adverse Action and whether such action is on appeal.
    d. A description of the acts or omissions and injuries upon which the final Adverse Action was based.
    e. The date the final Adverse Action was taken, its effective date, and duration of the action.

f. Corrections of information already reported about any final Adverse Action taken against a Provider, supplier, or practitioner.

g. Documentation that the following sites have been queried:

i. System of Award Management, formerly known as the Excluded Parties List System;

ii. The Social Security Administration's Death Master File;

iii. The National Plan and Provider Enumeration System;

iv. List of Excluded Individuals/Entities; and

v. Any other databases directed by AHCCCS, the Division, or CMS.

12. In accordance with A.R.S. §36-2918.01 §36-2905.04, §36-2932, the AdSS shall ensure that the AHCCCS OIG is immediately notified regarding any allegation of fraud, waste, or abuse of the Medicaid Program, in accordance with AdSS Operations Policy 103 and as specified in the AdSS' contract, including allegations of fraud, waste, or abuse that were resolved internally but involved Medicaid funds.

13. The AdSS shall report to AHCCCS and the Division QMU any Credentialing denials issued by the Credential Verification Organization that are the result of licensure issues, quality of care concerns, excluded Providers, and which are due to alleged fraud, waste, or abuse.
14. The AdSS shall provide notification regarding Credentialing denials and approvals to the applicable Providers with 10 calendar days of Credentialing Committee decisions.

H. CREDENTIALING TIMELINESS AND REPORTING

1. The AdSS shall process Credentialing applications in a timely manner as shown in the below table.
2. To assess the timeliness of Credentialing, the AdSS shall divide the number of complete applications approved or denied timely during the time period, per category, by the number of complete applications that were received during the time period, per category, as specified in AMPM 950 Attachment A.
3. The AdSS shall submit the Credentialing Report as specified in the AdSS' contract using AMPM 950 Attachment A, including specifying any areas of non-compliance and corrective actions

taken during the reporting quarter in the comments section of the report.

4. The AdSS shall adhere to the timeline requirements listed below by category:

CREDENTIALING ACTIVITY	TIME FRAME	COMPLETION REQUIREMENTS
Temporary/Provisional Credentialing	14 Days	100%
Initial Credentialing of Individual and Organizational Providers	60 Days	100%
Recredentialing of Individual and Organizational Providers	Every three years	100%
Load Times (Time between Credentialing Committee approval and loading into Claims System)	30 Days	95%

SUPPLEMENTAL INFORMATION

A. THERAPEUTIC FOSTER CARE PROVIDERS

1. Therapeutic Foster Care (TFC) Family Providers are licensed through the Department of Child Safety (DCS) and do not require Credentialing by the AdSS.
2. TFC Family Providers require credentialing with the Contractor.

3. For TFC Providers for children, submission of a Foster Home License, as specified in A.A.C. 21, Article 1 through 4, will be accepted as meeting the requirements for Credentialing as an AHCCCS Provider.

B. TEACHING PHYSICIANS AND DENTISTS

1. 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.
2. 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.
3. The teaching physician or teaching dentist must be an AHCCCS registered provider.

C. CONTINUING EDUCATION UNITS

1. Continuing education requirements for a BCBA:

a. BCBA's credentialed under a three-year Cycle: 36 hours every three years (three hours in ethics and professional behavior), and

b. CBA's credentialed under a two-year Cycle: 32 hours every two years (four hours in ethics for all certificates; three hours in supervision for supervisors).

2. Continuing Education Courses for a BCBA:

a. BCBAs providing supervision of individuals pursuing Behavior Analyst Certification Board (BACB) certification or the ongoing practice of Board Certified Assistant Behavior Analysts (BCABAs) or Registered Behavior Technicians (RBTs) will be required to obtain specific training in order to do so. These individuals will also be required to obtain three Continuing Education Unit (CEU)s on supervision in every certification cycle, and

b. Acceptable supervision content is behavior-analytic in nature and covers effective supervision as defined

in the BACB's Experience Standards (in particular, the "Nature of Supervision" section) and the BACB Supervisor Training Curriculum Outline.

	DESCRIPTION	LIMIT	CEU
1	College or university coursework	None – all CE can come from this type	1 hour of instruction = 1 CEU
2	CE issued by approved continuing education (ACE) Providers	None – all CE can come from this type	50 minutes of instruction = 1 CEU
3	Instruction Type 1 or 2	50% can come from this type*	1 hour of instruction = 1 CEU
4	CE issued by the BACB directly	25% can come from this type*	Determined by BACB
5	Take and pass the certification exam again	All CE will be fulfilled by this activity	Passing the exam equals 100% of your required CEUs, except for supervision
6	Scholarly Activities	25% can come from this type*	One publication = 8 CEUs One review = 1 CEU

*A maximum of 75 percent of the total required CE may come from categories 3, 4, 5 and 7. At least 25 percent shall come from Type 1 or Type 2. Passing the examination (Type 6) meets all CE requirements except for supervision.

Signature of Chief Medical Officer: Anthony Dekker (May 24, 2024 08:30 PDT)

Anthony Dekker, D.O.