950 CREDENTIALING AND RECREDENTIALING PROCESSES

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REFERENCES: 42 CFR 8.11, 42 CFR 438, 42 CFR 455, Subpart B, 42 CFR 457.1208, 42 CFR 457.1233(a); A.A.C. 21, Article 1 through Article 4, A.A.C. R9-10-18, R9-10-115, R9-10-1803; A.R.S. §36- 2918.01, §36-2905.04, §36-2932, AMPM Policy 950

PURPOSE

This policy establishes the requirements for initial Credentialing, temporary/provisional Credentialing, and recredentialing of individual and Organizational Providers contracted with the Division of Developmental Disabilities (Division) and oversight of the Credentialing responsibilities delegated to the 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. "Organizational Provider" means a facility providing services to Members and where Members are directed for services rather than being directed to a specific practitioner.
6. "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.
7. "Provider" means any individual or entity that contracts with the Division for the provision of covered services, or ordering or referring for those services to Division Members, or any subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.

POLICY

A. CREDENTIALING PROVIDERS

1. The Division shall verify Providers are properly trained, certified or licensed, and have the required experience to provide care

and services to Division Members.

2. The Division's Credentialing Unit shall credential and recredential individual and Organizational Providers contracted with the Division.
3. The Division shall credential Organizational Providers who have an agreement with the Division to provide residential placements, day and employment programs, Adult and Child Developmental Homes, home community-based services, and occupational, physical, and speech language therapies.
4. The Division shall delegate the Credentialing responsibilities of individual health care Providers to the Division's AdSS, except for occupational, physical, and speech language therapists that contract directly with the Division.
5. The Division shall retain the right to approve, suspend, or terminate any Provider credentialed by the AdSS.
6. The Division 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.

7. The Division shall ensure Providers have capabilities to ensure physical access, reasonable accommodation, and accessible equipment for Members with physical and mental disabilities. [42 CFR.457.1230 (a), 42 CFR 438.206(c)(2) (3)].

8. The Division shall ensure that providers deliver services in a culturally competent manner, including to those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

B. CREDENTIALING COMMITTEE

1. The Division's Credentialing Committee shall be responsible for

the Credentialing process under the purview of the Quality Management Unit (QMU).

2. The Chief Medical Officer (CMO) or Quality Management Medical Director, in the absence of the CMO, shall oversee the Credentialing process and serve as chair of the committee.
3. The Credentialing Committee shall review and approve or deny Credentialing applications presented at each Committee meeting.
4. The Division's Credentialing Unit shall verify the completeness of the file and maintain an individual electronic or hard copy Credentialing/Recredentialing file for each credentialed Provider, including the final determination of the Committee for all initial, temporary/provisional, and recredentialed Providers reviewed by the Committee.
5. The Division's Credentialing Unit shall verify the information for presentation to the Credentialing Committee within 60 calendar days of receipt of all required documentation.
6. The Division shall notify the Providers of the Credentialing decision within 10 calendar days of the Credentialing Committee’s decision.

7. The CMO or Quality Management Medical Director's signature shall serve as evidence of the Credentialing Committee's final decision.
8. The Division shall enter the credentialed Providers in the claims payment system within 30 calendar days of Credentialing Committee 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.

C. TEMPORARY/PROVISIONAL CREDENTIALING

1. The Division shall grant temporary/provisional credentials when it is in the best interest of Members, as defined in this section, to have Providers available to provide care or services prior to the completion of the entire Credentialing process.
2. The Division may credential Providers using the temporary/ provisional Credentialing process, even if the Provider does not specifically request their application be processed as temporary/ provisional, if they meet any of the following criteria:

    a. Providers needed in medically underserved areas.

    b. Covering or substitute Providers rendering services to the

Division's Members during a contracted Provider's absence from the practice.

c. As directed by Arizona Health Care Cost Containment System (AHCCCS) during federal or state declared emergencies where delivery systems are, or have the potential to be, disrupted.

3. The CMO or Medical Director shall review the initial verified and validated Credentialing documents and make a determination within 14 calendar days from the date of request or identified need regarding temporary/provisional Credentialing.

4. If approved by the CMO or Medical Director, the Division's Credentialing Unit shall notify the Provider and the Division's Contract Management Unit of the service(s) approved for temporary/provisional Credentialing.

5. The Division's Contract Management Unit shall enter a service start date in order for the Provider to be uploaded into the claims system.

6. The Division's Credentialing Unit shall inform the Provider, in the Credentialing notification letter, that the entire initial

Credentialing process will be completed within 60 calendar days of issuance of the temporary/provisional Credentialing.

7. The Credentialing Committee shall consider the Provider's Credentialing information at the next Committee meeting for consideration of initial Credentialing.

D. INITIAL CREDENTIALING OF INDIVIDUAL PROVIDERS

1. The Division shall credential the following individual Provider when contracted directly with the Division:
   a. Occupational Therapist,
   b. Physical Therapist, and
   c. Speech and Language Pathologist.

2. The Credentialing Committee shall review a verified completed Credentialing file.

3. The Division's Credentialing Unit shall verify the completeness of the file and maintain an individual electronic or hard copy Credentialing/Recredentialing file for each credentialed Provider that contains:
   a. A Completed Application signed and dated 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 conviction;

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; a copy of the signed attestation shall be included in the Provider's Credentialing file; and

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

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

c. Verification from primary sources of:

i. Licensure or certification.

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

credentials attained.

E. RECREDENTIALING INDIVIDUAL PROVIDERS

1. The Credentialing Unit shall recredential Individual Providers at least every three years and:

   a. Update the information obtained during the initial Credentialing process;

   b. Verify continuing education requirements are met, if applicable;

   c. Monitor Provider specific information related to:

      i. Member concerns and grievances;

      ii. Utilization management information;

      iii. Performance improvement and monitoring, if applicable;

      iv. Results of medical record review audits, if applicable;

      v. Quality of care issues including trend data;

      vi. Pay for performance and value-driven healthcare data and outcomes if applicable; and

      vii. Evidence that the Provider's policies and procedures meet Division requirements.

2. The Credentialing Committee shall make a Recredentialing decision within three years from the previous Credentialing approval date based on Primary Source Verification current within 180 days.

E. INITIAL CREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. As a prerequisite to contract execution of an Organizational Provider, the Division shall ensure the Organizational Provider has established policies and procedures that meet AHCCCS requirements, including policies and procedures for Credentialing and recredentialing when those functions are delegated to the Organizational Provider and meet the requirements specified in this section.

2. The Credentialing Committee shall review a verified completed Credentialing file.

3. The Division's Credentialing Unit shall verify the completeness of the file and maintain an individual electronic or hard copy Credentialing/Recredentialing file for each credentialed Organizational Provider that contains:

a. The Completed Application and signed attestation by the Provider of the correctness and completeness of the application;

b. An executed qualified vendor agreement;

c. AHCCCS Registration;

d. The completed District-level readiness review;

e. Confirmation the Provider has met all the state and federal licensing and regulatory requirements;

f. A completed onsite quality assessment;

g. Central Registry check;

h. Criminal background check;

i. Electronic Visit Verification attestation, if applicable;

j. Office of the Inspector General List of Excluded Individuals or Entities check;

k. Social Security Administration Death Master File check;

l. Completed State of Arizona Substitute W-9;

m. System for Award Management registration;

n. Department of Economic Security, Office of Licensing, Certification, Regulation, and Home and Community Based Services Certificate;

o. Proof of insurance that includes general liability, professional liability, worker's compensation, and sexual abuse and molestation coverage;

p. Business license;

q. A maintenance schedule for vehicles used to transport Members and the availability of age-appropriate car seats when transporting children; and

r. Any other pertinent information used to determine that the Provider meets the Division's Credentialing and recredentialing standards.

F. RECREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. The Credentialing Committee shall recredential Organizational Providers at least every three years.

2. The Credentialing Committee shall review a verified completed Credentialing/Recredentialing file that includes updated and verified status of the initial information.

3. The Division's Credentialing Unit shall verify the completeness of the file for each recredentialed Organizational Provider 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.

        iii. If an Organizational Provider is not accredited or surveyed and licensed by the state, an onsite review is conducted.

    b. Review of the following:

i. Current review conducted by the Arizona Department of Health Services (ADHS) or summary of findings;

ii. Hospital Compare Az Care Check, if applicable;

iii. Record of onsite inspection of non-licensed Organizational Providers to ensure compliance with service specifications;

iv. Supervision of staff and required documentation of direct supervision or clinical oversight as required in A.A.C R9-10-115, including, if applicable, review of a valid sample of clinical Member charts;

v. Most recent audit results of the Organizational Provider;

vi. Confirmation that the service delivery address is correct; and

vii. Verification 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 assessment;

vi. Review of any Adverse Actions;

vii. Value-based purchasing results and level of Member satisfaction for recredentialing;

4. The Credentialing Committee shall review and approve all Credentialing decisions with formal documentation that includes discussion, review of thresholds, and complaints or grievances.

5. The Division shall reviewand monitor other types of Organizational Providers in accordance with the AHCCCS contract.

G. NOTIFICATION REQUIREMENTS

1. The Division's Contract Actions Unit shall report any issues that result in a Provider's suspension or termination from the network

to the AHCCCS/DHMC/QM within one business day of determination to take the Adverse Action.

2. If any issue is determined to have criminal implications, including allegations of abuse or neglect, the Division shall notify the appropriate law enforcement agency and protective services agency no later than 24 hours after identification.
3. The Division's Credentialing Unit shall report allegations of Provider misconduct or misuse of prescribing practices to licensing and other regulatory entities as appropriate.
4. The Division's Credentialing Unit shall report any adverse Credentialing decisions made on the basis of quality-related issues or concerns to AHCCCS/DHMC/QM within one business day of determination to take Adverse Action, and include the reason or cause of the adverse decision and when restrictions are placed on the Provider's contract.
5. The Division shall have an appeal process for Providers when restrictions are placed on the Provider's contract based on issues of quality of care or service and process to inform the Provider of the Quality Management dispute process through the QMU.
6. The Division shall report to AHCCCS/DHMC/QM in writing, any

final Adverse Action taken for any quality-related reason against a Provider, supplier, vendor, or practitioner within one business day of the final Adverse Action taken.

7. The Division shall not consider a final Adverse Action to be malpractice notices or settlements in which no findings or liability have been determined.

8. 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 Division's network, Provider termination, Provider suspension, or an action that

limits or restricts a Provider.

9. 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 by the close of the next monthly reporting cycle, whichever is later.

10. The Division shall immediately notify the AHCCCS Office of Inspector General (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.

11. The Division shall provide notification regarding Credentialing denials to the applicable Provider(s) within 10 calendar days of the Credentialing Committee decisions.

12. The Division shall send a notice of final Adverse Action to AHCCCS/DHCM/QM within one business day and include 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 health 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, and such other information determined by regulation for appropriate interpretation of information reported under this section.

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 health care Provider, supplier, or practitioner.

g. Documentation that the following sites have been queried:

   i. SAM, www.sam.gov, formerly known as the Excluded Parties List Syste;

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

iii. The National Plan and Provider Enumeration System;

iv. List of Excluded Individuals or Entities; and

v. Any other databases directed by AHCCCS or CMS.

H. CREDENTIALING TIMELINESS

The Division's Credentialing Unit shall process Credentialing applications in a timely manner as shown in the following table:

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%

J. OVERSIGHT

1. The Division shall provide monitoring and oversight of the Division's Credentialing process through the following activities:

a. Review of quarterly performance data by the Quality Management/Performance Improvement (QM/PI) Committee.

b. Review of Credentialing data by the QM/PI Committee.

c. Recommendations by the QM/PI Committee regarding opportunities for improvement and monitor ongoing performance.

2. The Division shall monitor and provide oversight of the AdSS' Credentialing and recredentialing processes through annual operational reviews; review of quarterly reports submitted by the AdSS; and the internal quarterly health plan review meetings to ensure adherence to the requirements set forth in AdSS Medical Policy 950.

3. If there are any concerns regarding data reported in the quarterly reports by the AdSS, the Division may require the AdSS to report monthly until three consecutive months of compliance have been achieved.

Signature of Chief Medical Officer: Anthony Dekker (Aug 31, 2023 10:20 PDT)
Anthony Dekker, D.O.