

950 CREDENTIALING AND RECREDENTIALING PROCESS

REVISION DATES: 1/7/2026, 9/17/2025, 5/29/2024, 9/6/2023, 5/18/2022, 5/23/2018, 5/5/2017

REVIEW DATES: 10/2/2025, 11/18/2024

EFFECTIVE DATE: May 3, 2016

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 or Provisional Credentialing, and Recredentialing of Individual and Organizational Providers conducted by 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. "Behavioral Health Services" means physician or practitioner services, nursing services, health-related services, or ancillary services provided to a Member to address the Member's behavioral health issue.
3. "Calendar Day" means every day of the week including weekends and holidays.
4. "Completed Application" means when all accurate information and documentation is available to make an informed decision about the Provider that includes the following:
 - a. A completed application with a current, signed, and dated attestation by the Vendor to the correctness and completeness of the application;
 - b. HCBS certificate issued by OLCR for the services being provided, if applicable;
 - c. AHCCCS ID Approval Letter;
 - d. Readiness Review Report;
 - e. Certificate of Insurance and corresponding endorsements (COI);
 - f. AZ Substitute W-9;

- g. EVV Attestation for Service Codes - ATC, HSK, HAH, HAI, RSP, HHA, LHA, and HN1 only;
 - h. Nursing/Home Health Aid-Licensed Health Aid- requires a Home Health Agency License, if applicable;
 - i. A five-year Work History;
 - j. Reasons for any inability to perform the essential functions of the position, with or without accommodation;
 - k. Lack of present illegal drug use;
 - l. History of loss of license or felony convictions;
 - m. History of loss or limitation of privileges or disciplinary action; and
 - n. Completion of all Primary Source Verifications (PSVs).
5. "Credentialing" or "Recredentialing" means the process of obtaining, verifying, and evaluating information regarding applicable licensure, accreditation, certification, educational, and practice requirements to determine whether a Provider has the required credentials to deliver specific covered services to Members.

6. "Home and Community-Based Services" or "HCBS" means, as defined in A.R.S. § 36-2939, services that may be provided in a Member's Home, at an alternative residential setting as prescribed in A.R.S. § 36-591 or at other behavioral health alternative residential facilities licensed by the Arizona Department of Health Services and approved by the director of AHCCCS.
7. "Member" means the same as "Client", a person receiving developmental disabilities services from the Division, as specified in A.R.S. § 36-551.
8. "Organizational Provider" means a facility providing services to Members and where Members are directed for services rather than being directed to a specific practitioner.
9. "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.
10. "Quality of Care" or "QOC" means an expectation that, and the degree to which the health care services provided to individuals

and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provision.

11. "Service Provider" means an agency or individual operating under a contract or service agreement with the Department to provide services to Division Members.
12. "Utilization Management" or "UM" means a methodology used by healthcare professionals for assessing the medical necessity, appropriateness and cost effectiveness of professional care, services, procedures, and facilities.

POLICY

A. CREDENTIALING SERVICE PROVIDERS

1. The Division shall verify Service Providers are properly trained, certified or licensed, and have the required experience to provide care and services to Division Members.
2. The Division shall require the AdSS' policies address individual and Organizational Service Providers, including Service Providers of:

- a. Physical Health services;
 - a. Behavioral Health Services;
 - b. Treatment of Substance Abuse Disorders (SUD); and
 - c. Longer-Term Services and Supports (LTSS).
3. The Division's Credentialing Unit shall Credential and Recredential Individual and Organizational Service Providers contracted with the Division.
 4. The Division shall Credential Organizational Service Providers who have an agreement with the Division to provide:
 - a. Residential placements,
 - b. Day and employment programs,
 - c. Adult and Child Developmental Homes,
 - d. Home Community-Based Services, and
 - e. Occupational, physical, and speech language therapies.
 5. The Division shall ensure the Credentialing and Recredentialing processes:
 - a. Does not base Credentialing decisions on a Service Provider's race, gender, age, sexual orientation, or patient type in which the Service Provider specializes;

- b. Does not discriminate against Service Providers who serve high-risk populations or who specialize in the treatment of costly conditions; and
 - c. Comply with Federal requirements that prohibit employment or contracts with Service Providers excluded from participation under either Medicare or Medicaid, or that employ individuals or entities that are excluded from participation.
6. The Division shall delegate the Credentialing responsibilities of individual health care Service Providers to the Division's AdSS, except for occupational, physical, and speech language therapists that contract directly with the Division.
7. The Division shall retain the right to approve, suspend, or terminate any Service Provider credentialed by the AdSS.
8. The Division shall meet the requirements regarding delegation as specified in Policy and Contract.
9. The Division shall require that Service Providers have capabilities to ensure physical access, reasonable accommodation, and accessible equipment for Members with physical and mental

disabilities as outlined in 42 CFR.457.1230 (a) and 42 CFR 438.206(c)(2)(3).

10. The Division shall require that Service 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.
11. The Division shall ensure Service Providers are loaded into the Division's claims payment system with an effective date no later than the date the Service Provider was approved by the Credentialing Committee or the contract effective date, whichever is later.
12. The Division shall reimburse providers who are enrolled with AHCCCS and submit claims for covered services provided to members during the credentialing process on or after the date of the provider's Completed Application as defined in this Policy. If the provider is subsequently not approved through the Contractor's credentialing committee, the Contractor shall recoup the funding.

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, implement decisions made by the committee and serve as chair of the committee.
3. The Credentialing Committee shall review and approve or deny Credentialing applications presented at each Committee meeting where representatives from AdSS and the Qualified Vendor network who participate in making Credentialing decisions.
4. The Division's Credentialing Unit shall verify the completeness of the file and maintain an individual electronic or hard copy Credentialing or Recredentialing file for each credentialed Service Provider, including:
 - a. The initial credentialing application and all subsequent recredentialing applications, including attestation by the provider of the correctness and completeness of the

- application as demonstrated by the provider's signature and date on the application;
- b. The information gained through credentialing and recredentialing queries;
 - c. Any other pertinent information used in determining whether the provider met the Contractor's credentialing and recredentialing standards;
 - d. The specific to recredentialing, utilization data, Quality Of Care (QOC) concerns, grievances, performance measure rates, value-based purchasing results, and level of Member satisfaction; and
 - e. Final determination of the Committee for all Initial, Temporary or Provisional, and Recredentialed Service Providers reviewed by the Committee.
5. The Division shall allow providers to be credentialed concurrently with their AHCCCS enrollment process with enrollment being confirmed prior to finalizing credentialing.

6. The Division shall enter the credentialed Service Providers into the claims payment system within 30 Calendar Days of Credentialing Committee approval.
7. 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.
8. The Division shall notify the Service Providers of the Credentialing decision within 10 Calendar Days of the Credentialing Committee's decision.
9. The CMO or Quality Management Medical Director's signature shall serve as evidence of the Credentialing Committee's final decision.
10. The Division shall refer to AMPM Policy 965 for additional requirements and exceptions related to Credentialing of Community Service Agency (CSAs).

C. TEMPORARY OR PROVISIONAL CREDENTIALING

1. The Division shall grant Temporary or Provisional Credentialing when it is in the best interest of Members, as defined in this section, to have Service Providers available to provide care or

services prior to the completion of the entire Credentialing process.

2. The Division shall credential the Service Providers using the Temporary or Provisional Credentialing process, even if the Service Provider does not specifically request their application be processed as Temporary or Provisional, if they meet any of the following criteria:
 - a. Service Providers needed in medically underserved areas;
 - b. Covering or substitute Service Providers rendering services to the Division's Members during a contracted Service 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 completed application and accompanied by the minimum document specified as outlined in section 6 documents and make a determination within 14 Calendar Days from receipt of a

complete application, in which to render a decision regarding Temporary/Provisional credentialing.

4. If approved by the CMO or Medical Director, the Division's Credentialing Unit shall notify the Service Provider and the Division's Contract Management Unit of the services approved or denied for Temporary or Provisional Credentialing.
5. The Division shall notify the provider and contracts manager by a Denial Notification Letter within 10 calendar days of signature and date by CMO if a provider is denied by the CMO.
6. The Division's Contract Management Unit shall enter a service start date in order for the Service Provider to be uploaded into the claims system as outlined in section B.6.
7. The Division shall require a Provider to complete a signed and dated application and include the following for consideration of Temporary/Provisional Credentialing including:
 - 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. A completed application that includes the following:

- i. A completed application with a current, signed, and dated attestation by the Vendor to the correctness and completeness of the application;
- ii. HCBS certificate issued by OLCR for the services being provided, if applicable;
- iii. AHCCCS ID Approval Letter;
- iv. Readiness Review Report;
- v. Certificate of Insurance and corresponding endorsements (COI);
- vi. AZ Substitute W-9;
- vii. EVV Attestation for Service Codes - ATC, HSK, HAH, HAI, RSP, HHA, LHA, and HN1 only;
- viii. Nursing/Home Health Aid-Licensed Health Aid- requires a Home Health Agency License if applicable;
- ix. A five-year Work History;
- x. Reasons for any inability to perform the essential functions of the position, with or without accommodation.;
- xi. Lack of present illegal drug use;

- xii. History of loss of license or felony convictions;
 - xiii. History of loss or limitation of privileges or disciplinary action; and
 - xiv. Completion of all Primary Source Verifications (PSVs).
8. The Division shall conduct Primary Source Verification of the following:
- a. Licensure or certification with a printout of the license from the applicable Boards' official website denoting that the license is active with no restrictions is acceptable;
 - b. Board certification, if applicable, or the highest level of credential attained; and
 - c. National Practitioner Data Bank (NPDB) query including the following:
 - i. A 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 and Medicaid sanctions, Federal and State exclusions, and terminations for cause as reported to CMS.
9. The Division's Credentialing Unit shall inform the Service Provider, in the Credentialing notification letter, that the entire initial Credentialing process will be completed within 60 Calendar Days of issuance of the Temporary or Provisional Credentialing.
10. The Credentialing Committee shall consider the Service Provider's Credentialing information at the next Committee meeting for consideration of initial Credentialing.

D. INITIAL CREDENTIALING OF INDIVIDUAL SERVICE PROVIDERS

1. The Division shall Credential the following individual Service Providers 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 or Recredentialing file for each credentialed Service Provider that contains:
 - a. A completed Application signed and dated by the Service 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 Service Provider of the correctness and completeness of the application; a copy of the signed and dated attestation shall be included in the Service Provider's Credentialing file; and

- vii. Minimum five-year history or total history if less than five years.
- b. Drug Enforcement Administration (DEA) and Chemical Database Service (CDS) certification of a prescriber; and
- c. Verification from primary sources of:
 - i. Licensure or certification; and
 - ii. Board certification, if applicable, or highest level of credentials attained.

E. RECREDENTIALING OF INDIVIDUAL SERVICE PROVIDERS

- 1. The Credentialing Unit shall Recredential Individual Service Providers at least every three years and:
 - a. Review updated ~~the~~ information obtained during the initial Credentialing process;
 - b. Verify continuing education requirements are met, if applicable;
 - c. Monitor Service Provider specific information related to:
 - i. Member complaints and grievances;
 - ii. ~~UM~~ Utilization Management information;
 - iii. Performance improvement and monitoring, if

- applicable;
- iv. Results of medical record review audits, if applicable;
 - v. Quality of Care (QOC) issues including trend data;
 - vi. Review of Adverse Actions;
 - vii. Pay for performance and value-driven healthcare data and outcomes if applicable; and
 - viii. Evidence that the Service Provider's policies and procedures meet AHCCCS and Division requirements.
2. The Credentialing Committee shall make a Recredentialing decision at least within three years from the previous Credentialing approval date based on Primary Source Verification current within 180 days.
3. The Division shall reserve the right, at its sole discretion, to initiate the Recredentialing of any contracted vendor at any time which may be taken as deemed necessary to ensure ongoing compliance with:
- a. Applicable laws,
 - b. Regulations,
 - c. Contractual terms, and

- d. Division operational standards.

F. INITIAL CREDENTIALING OF ORGANIZATIONAL SERVICE PROVIDERS

1. As a prerequisite to contract execution of an Organizational Service Provider, the Division shall ensure the Organizational Service Provider has established policies and procedures that meet AHCCCS and Division requirements, including policies and procedures for Credentialing and Recredentialing when Credentialing or Recredentialing functions are delegated to the Organizational Service Provider, and meet the requirements specified in this section.
2. The Division shall ensure all the requirements specified in this section are met for all Organizational Service Providers in the Division and AdSS' network, including:
 - a. Hospitals;
 - b. Home Health Agencies (HHA);
 - c. Attendant Care Agencies (ATC);
 - d. Habilitation Providers (HAB);
 - e. Group Homes (GH);

- f. Child or Adult Developmental Homes (DH);
- g. Nursing Supported Group Homes (NSGH);
- h. Nursing Facilities (NF);
- i. Assisted Living Facilities (ALF);
- j. Home Delivered Meal Providers;
- k. Dialysis Centers (DC);
- l. Dental and Medical Schools;
- m. Freestanding Surgical Centers (ASC);
- n. Immediate Care Facilities (ICF);
- o. State or Local Health Clinics (HC);
- p. Community or Rural Health Clinics or Centers (CRHC);
- q. Air Transportation Vendors (Trans);
- r. Non-Emergency Medical Transportation Vendors (NEMT);
- s. Laboratories (Labs);
- t. Pharmacies (Pharm);
- u. Respite Homes and Providers (RC);
- v. Behavioral Health Facilities (BHF), including:
 - i. Independent Clinics (IC);
 - ii. Federally Qualified Health Centers (FQHC);

- iii. Community Mental Health Centers (CMHC);
- iv. Level 1 Sub-Acute Facility (IMD and Non-IMD);
- v. Intermediate Care Facility (ICF) (Individuals with Intellectual Disabilities);
- vi. Level 1 Residential Treatment Center Secure (17+ beds, IMD);
- vii. Level 1 Residential Treatment Center Non-Secure (1-16 beds);
- viii. Level 1 Residential Treatment Center Non-Secure (17+ beds, IMD);
- ix. Community Service Agencies (CSA);
- x. Crisis Service Provider or Agency (CSPA);
- xi. Behavioral Health Residential Facility (BHRF);
- xii. Behavioral Health Outpatient Clinic (BHOC);
- xiii. Integrated Clinic (IC);
- xiv. Rural Substance Abuse Transitional Agency (RSATA);
- xv. Behavioral Health Therapeutic Home (BHT); and
- xvi. Respite Homes and Providers (RC).

3. The Credentialing Committee shall review a verified completed Credentialing file.
4. The Division's Credentialing Unit shall verify the completeness of the file and maintain an individual electronic or hard copy Credentialing or Recredentialing file for each credentialed Organizational Service Provider that contains:
 - a. The Completed Application with a signed and dated attestation by the Organizational Provider of the correctness and completeness of the application;
 - b. AHCCCS Registration, which is required per location;
 - c. The completed District-level readiness review;
 - d. Confirmation the Organizational Service Provider has met all the State and Federal licensing and regulatory requirements;
 - e. A completed onsite quality assessment;
 - f. Central Registry query;
 - g. Criminal background query;
 - h. Electronic Visit Verification attestation, if applicable;

- i. Office of the Inspector General List of Excluded Individuals or Entities query;
- j. Social Security Administration Death Master File query;
- k. Completed State of Arizona Substitute W-9;
- l. System for Award Management query;
- m. Department of Economic Security, Office of Licensing, Certification, Regulation, and Home and Community Based Services Certificate, if applicable;
- n. Proof of insurance that includes general liability, professional liability, worker's compensation, and sexual abuse and molestation coverage;
- o. Business license;
- p. A maintenance schedule for vehicles used to transport Members and the availability of age-appropriate car seats when transporting children; and
- q. Any other pertinent information used to determine that the Organizational Service Provider meets the Division's Credentialing and Recredentialing standards.

G. RECREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. The Division's Credentialing Committee shall Recredential Organizational Service Providers at least every three years.
2. The Division's Credentialing Committee shall review a verified completed Credentialing or Recredentialing file that includes updated and verified status of the initial Credentialing information.
3. The Division's Credentialing Unit shall verify the completeness of the file for each Recredentialed Organizational Service 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 Service Provider;
 - i. Is licensed to operate in the State and is in compliance with any other State and Federal requirements as applicable; and
 - ii. Is reviewed and approved by an appropriate accrediting body, if applicable.
 - b. On-site review if an Organizational Service Provider is not accredited or surveyed, and licensed by the State;

- c. 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 Service Providers to ensure compliance with service specifications;
 - iv. Supervision of staff and required documentation of direct supervision or clinical oversight as required in R9-10-115, including, if applicable, review of a valid sample of clinical Member charts;
 - v. Most recent audit results of the Organizational Service Provider;
 - vi. Confirmation that the service delivery address is correct; and
 - vii. Verification that staff meet the Credentialing requirements.
- d. Evaluation of Organizational Service Provider specific information related to:

- i. Member complaints and grievances;
 - ii. UM information;
 - iii. Performance improvement and monitoring;
 - iv. QOC issues;
 - v. On-site quality assessment;
 - vi. Review of any Adverse Actions;
 - vii. The pay for performance and value-driven health care data or outcomes, if applicable; and
 - viii. The evidence that the Service Provider's policies and procedures meet Division and AHCCCS requirements.
4. The Division's Credentialing Committee shall review and approve all Credentialing decisions with formal documentation that includes discussion, review of thresholds, and complaints or grievances.

H. NOTIFICATION REQUIREMENTS

1. The Division's Contract Actions Unit shall report any issues that result in a Service Provider's suspension or termination from the network to the AHCCCS Quality Management (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 Service 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 based on quality-related issues or complaints to AHCCCS QM within one business day of the determination to take Adverse Action.
5. The Division's Credentialing Unit shall send the notification of Adverse Action to AHCCCS QM as specified in the Contract with rationale including:
 - a. Limitations;
 - b. Suspensions;
 - c. Terminations; and
 - d. Denials, including Credentialing or Recredentialing denials.

6. The Division's Credentialing Unit shall indicate the following in its notification to AHCCCS QM:
 - a. Reason or cause of the adverse or denial decision;
 - b. When restrictions are placed on the Service Provider's contract, including denials or restrictions which are the result of:
 - i. Licensure issues,
 - ii. QOC concerns,
 - iii. Excluded providers, and
 - iv. Due to alleged fraud, waste, or abuse.
7. The Division shall have an appeal process for Service Providers when restrictions are placed on the Service Provider's contract based on issues of QOC or service, and a process to inform the Service Provider of the Quality Management dispute process through the QMU.
8. The Division shall report to AHCCCS QM in writing any Service Provider, supplier, vendor, or practitioner within one business day of the final Adverse Action taken.

9. The Division shall not consider a final Adverse Action to be malpractice notices or settlements in which no findings or liability have been determined.
10. 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 Service 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 Service 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 based on quality-related issues or complaints and grievances.
 - vii. Any Adverse Action from a quality or peer review process that results in denial of a Service Provider to participate in the Division's network, Service Provider termination, Service Provider suspension, or an action that limits or restricts a Service Provider.
11. The Division shall submit to the National Practitioner Data Bank (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.

12. The Division shall immediately notify the AHCCCS QM Office of Inspector General (OIG) regarding any allegation of fraud, waste, or abuse (FWA) of the AHCCCS Program, including allegations of FWA that were resolved internally but involved AHCCCS funds.
13. The Division shall provide notification regarding Credentialing denials to the applicable Service Providers within 10 Calendar Days of the Credentialing Committee decisions.
14. The Division shall send a notice of final Adverse Action to AHCCCS 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 Service 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 Service Provider, supplier, or practitioner.
- g. Documentation that the following sites have been queried:
 - i. System of Award Management (SAM), www.sam.gov, formerly known as the Excluded Parties List System (EPLS);
 - ii. The Social Security Administration's Death Master File;
 - iii. The National Plan and Provider Enumeration System (NPPES);

- iv. List of Excluded Individuals or Entities (ELPS);
- v. The CMS Data Exchange (DEX); and
- vi. Any other databases directed by AHCCCS or CMS.

I. 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
Render Decision: Temporary or Provisional Credentialing	14 Days	100%
Render Decision: Initial Credentialing of Individual and Organizational Service Providers	60 Days	100%
Render Decision: Recredentialing of Individual and Organizational Service Providers	Every three years	100%
Entered and 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 complaints 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.

SUPPLEMENTAL INFORMATION

A. THERAPEUTIC FOSTER CARE PROVIDERS

1. Therapeutic Foster Care (TFC) Family Service Providers are licensed by the Department of Child Safety (DCS) and do not require Credentialing by the AdSS.
2. TFC Agencies require licensure by the DCS and Credentialing or Recredentialing with the Contractor.
3. For TFC Family Service 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 enrolled provider.

Vicki D. Copeland

Vicki D. Copeland

Signature of Chief Medical Officer

Name

2025-12-24

Date