SHIAWASSEE COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

POLICY AND PROCEDURE MANUAL

Section: Human Resources Policy Number: 33 Subject: **Credentialing and Privileging of Organizations**	Effective Date: 6/25/07 Last Revision Date: 2/12/10

Policy

It is the policy of the Shiawassee County Community Mental Health Authority (SCCMHA) to ensure that consumers receive the highest quality of care from the provider network through the establishment of a privileging panel and a credentialing process for organizations and licensed independent practitioners.

Purpose

The purpose of this policy and procedure is to establish processes for the verification of credentials for contracted organizations.

Applicability

- SCCMHA Operations
- SCCMHA Contract Providers

Procedure

Organizations interested in entering the Shiawassee County Community Mental Health Authority provider network will be required to submit to the following credentialing process as a component of its overall application procedure:

1. Completion of Provider Network Application and submissions of the information as stated on the application:

   a. Organizations interested in providing clinical services to the SCCMHA consumer population will be required to demonstrate evidence of internal credentialing and privileging policies and procedures per the standards of their accrediting body, e.g. JCAHA, COA, CARF, NCQA. This process must include evidence of criminal background checks on all its employees prior to hire and periodically. In addition, the provider will regularly check the Officer of Inspector General and Medicaid and Medicare excluded providers list to prevent fraudulent activity.

      Compliance with Federal regulations prohibits employment or contracts with providers excluded from participation under either Medicaid or Medicare. Provider Organizations will endeavor to report to appropriate authorities (i.e. MDCH, the

provider's regulatory board or agency, the Office of Attorney General), and SCCMHA, individual practitioner conduct which results in suspension or termination of provider from the organization's network. All SCCMHA organization providers will adhere to all the expectations of Chapter 13, Corporate Compliance policy and procedure; Administrative and Operational Practices; Prohibited Affiliations and / or Exclusion and Conviction and sign a formal attestation to that effect.

b. The organization must demonstrate evidence of a privileging process that ensures competency of its licensed independent practitioners (defined as any individual permitted by law and by organization to provide care and services, without direction or supervision, within the scope of the individual’s license and consistent with individually granted clinical privileges) through review of:

- Licensure, certification or registration and any sanctions
- Current board certification or highest level of credential
- Current competence (peer references, work history)
- The ability to perform clinical responsibilities
- Continuing education
- Documentation of graduation from an accredited school
- Medicare/Medicaid sanctions
- Criminal background checks

The competency standards applied by the organization must be consistent with those adopted by SCCMHA for the service code, professional discipline or population in question. Any SCCMHA contract provider that does not demonstrate evidence of accreditation or certification through an appropriate body will be reviewed according to the SCCMHA’s privileging process.

2. Confirmation that the potential provider organization has met the following requirements initially and every subsequent two years will take place:

a. The provider is in good standing with state and federal regulatory bodies, including Medicare and Medicaid.

b. The provider has been reviewed and approved by an accrediting body or meets and implements standards of participation identified by the Board.

c. The provider adheres to the Board standards regarding productivity and related Performance Improvement issues.

3. The information submitted with Provider Network Application will be reviewed.

4. References listed on the Provider Network Application will be contacted.

5. The organization will be informed of the receipt of any information that varies substantially from its application/attestation. The organization will be given the opportunity to correct any alleged erroneous information.

6. A visit to the business office of the potential provider to evaluate the site according to the current standards of practice and medical record keeping adopted by the organization will be arranged.

7. Information received will be submitted to the Credentialing Committee for a final review. The committee will make the decision about credentialing. Participating providers are not used in making credentialing decisions.

8. Temporary credentialing may be granted by the Chief Executive Officer for up to 120 days, upon receipt of a completed application form, confirmation of appropriate licensure, Medicaid/Medicare sanctions and NPDB queries, while verification of credentials and other processes are pending. Temporary credentialing may be granted on a one time only basis at initial request.

9. If the potential provider is approved to be a provider, a contract agreement and claims processing profile is developed to add the Provider and service to the Board's provider network. If not approved, the potential provider will be notified in writing of the reasons for the denial of participation in the Board's provider network. The SCCMHA retains the right to approve, suspend or terminate any provider.

<u>The process for re-credentialing is as follows:</u>

1. The provider will be notified three months prior to the expiration date of the contract of the need to send in updated information.

2. When the information is received, the submitted information is reviewed and verified.

3. A visit to the organization's business office is arranged to reevaluate the site according to the current standards of practice and medical record keeping adopted by the provider.

4. The provider files are undated as indicated.

5. If approved, the contract document will be renewed for an additional term. If not approved, the provider will be notified and a determination will be made whether the services will be publicly bid.

<u>Credentialing / Privilege Revocation or Suspension:</u> Privileges to practice may be suspended at any time and at the discretion of the Chief Executive Officer pending the investigation of allegations of consumer abuse or neglect, negligence, malpractice, incompetence, violations of professional or Board ethics, loss of license, certification or

registration, exclusion from Medicare or Medicaid, or any other circumstances which interferes with the provider organization's capacity to render professional services.

Requests for Reconsideration or Appeal: Provider organizations may ask for a reconsideration of decisions to deny, suspend, or terminate privileges.

1. The request for reconsideration must be writing and must be filed with the Chief Executive Officer within ten (10) calendar days of receipt of the notice of action provided by the Board.

2. The Chief Executive Officer may consult with the medical director and/or any other person who may have information bearing on the request for reconsideration.

3. The request for reconsideration shall be reviewed by the Human Resources Committee of the Board at their next scheduled meeting and recommendation made to the entire Board for review and action.

   a. Both the provider organization and the Board can be represented by advocates at this meeting

   b. Both the provider organization and the Board may present a reasonable number of witnesses at the meeting.

   c. Both the provider organization and the Board may file written documents at this meeting.

   d. The Board of Directors shall review the evidence presented and the recommendations of the Human Resources Committee of the Board and shall be solely responsible for determining the outcome of the appeal. Notice of the Board's determination shall be provided to the practitioner with ten (10) days of the review meeting.

Reference Standards

1. JCAHO (1997) Comprehensive Accreditation Manual for Managed Behavioral Health Care, Management of Human Resources Standards HR 1-14, page 548-553.

2. MDCH (2002) Proposed PHP Contract for 2002, Quality Assessment and Performance Improvement programs for Specialty pre-paid health plans, Pages 166-167.

3. CMS and HHS (2001) Proposed Rules regarding Medicaid Managed Care; 42 CFR 400, 430, 431, 434, 435, 438, 440 and 447; 66 FR 32776; Sections 438.206, 438.214 and 438.230.

Approved by: ___Signed by Jerry Walden___________ _____02/12/10______
Board Chairperson Date

_____Signed by Scott Gilman____________ _____02/12/10_______
Chief Executive Officer Date

Review/Revision Dates:

Date:	By:
10/9/08	Revised by George Drozd
2/12/10	Revised from AAM audit
4/14/11	Reviewed by Human Resources Committee
4/12/12	Reviewed by Human Resources Committee
8/13/13	Reviewed by Human Resources Committee
07/24/14	Reviewed by Human Resources Committee
10/08/15	Annual Review by the Human Resources Committee