Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration

CREDENTIALING AND RE-CREDENTIALING PROCESSES

Revised: June, 2021

A. Overview:
This policy covers credentialing, temporary/provisional credentialing, and re-credentialing processes for those individual and organizational providers directly or contractually employed by Prepaid Inpatient Health Plans (PIHPs), as it pertains to the rendering of specialty behavioral healthcare services within Michigan's Medicaid program. The policy does not establish the acceptable scope of practice for any of the identified providers, nor does it imply that any service delivered by the providers identified in the body of the policy is Medicaid billable or reimbursable. PIHPs are responsible for ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual (MPM) requirements. Please reference the applicable licensing statutes and standards, as well as the MPM should you have questions concerning scope of practice or whether Medicaid funds can be used to pay for a specific service.

NOTE: The individual practitioner and organizational provider credentialing process contains two primary components: initial credentialing and re-credentialing. The Michigan Department of Health and Human Services (MDHHS) recognizes that PIHPs may have a process that permits initial credentialing on a provisional or temporary basis while required documents are obtained or performance is assessed. The standards that govern these processes are in the sections that follow.

B. Credentialing Individual Practitioners:
The PIHP must have a written system in place for credentialing and re-credentialing individual practitioners included in their provider network who are not operating as part of an organizational provider.

1. Credentialing and re-credentialing must be conducted and documented for at least the following health care professionals:

    a. Physicians (M.D.s and D.O.s)

    b. Physician's Assistants

    c. Psychologists (Licensed, Limited License, and Temporary License)

    d. Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Limited License Social Workers, and Registered Social Service Technicians

    e. Licensed Professional Counselors

    f. Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses

g. Occupational Therapists and Occupational Therapist Assistants

h. Physical Therapists and Physical Therapist Assistants

i. Speech Pathologists

2. The PIHP must ensure:

   a. The credentialing and re-credentialing processes do not discriminate against:

      i. A health care professional, solely based on license, registration, or certification; or

      ii. A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

   b. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid. A complete list of Centers for Medicare and Medicaid Services (CMS) sanctioned providers is available on their website at http://exclusions.oig.hhs.gov. A complete list of sanctioned providers is available on the MDHHS website at www.michigan.gov/MDHHS. (Click on Providers, then click on Information for Medicaid Providers, then click on List of Sanctioned Providers)

3. If the PIHP delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by this policy, it must retain the right to approve, suspend, or terminate from participation in the provision of Medicaid funded services, a provider selected by that entity, and meet all requirements associated with the delegation of PIHP functions. The PIHP is responsible for oversight regarding delegated credentialing or re-credentialing decisions.

4. Compliance with the standards outlined in this policy must be demonstrated through the PIHPs policies and procedures. Compliance will be assessed based on the PIHPs policies and standards in effect at the time of the credentialing/re-credentialing decision.

5. The PIHPs written credentialing policy must reflect the scope, criteria, timeliness, and process for credentialing and re-credentialing providers. The policy must be approved by the PIHPs governing body, and

   a. Identify the PIHP administrative staff member and/or entity (e.g., credentialing committee) responsible for oversight and implementation of the process and delineate their role;

   b. Describe any use of participating providers in making credentialing decisions;

c. Describe the methodology to be used by PIHP staff members or designees to provide documentation that each credentialing or re-credentialing file was complete and reviewed, as per (1.) above, prior to presentation to the credentialing committee for evaluation; and

d. Describe how the findings of the PIHPs Quality Assessment Performance Improvement Program (QAPIP) are incorporated into the re-credentialing process.

6. PIHPs must ensure that an individual credentialing/re-credentialing file is maintained for each credentialed provider. Each file must include:

   a. The initial credentialing and all subsequent re-credentialing applications;

   b. Information gained through primary source verification; and

   c. Any other pertinent information used in determining whether the provider met or did not meet the PIHPs credentialing and re-credentialing standards.

C. Initial Credentialing

At a minimum, policies and procedures for the initial credentialing of the individual practitioners must require:

1. A written application that is completed, signed, and dated by the provider and attests to the following elements:

   a. Lack of present illegal drug use.

   b. Any history of loss of license and/or felony convictions.

   c. Any history of loss or limitation of privileges or disciplinary action.

   d. Attestation by the applicant of the correctness and completeness of the application.

2. An evaluation of the provider's work history for the prior five years.

3. Verification from primary sources of:

   a. Licensure or certification.

   b. Board Certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training.

   c. Documentation of graduation from an accredited school.

   d. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all the following must be verified:

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

ii. Disciplinary status with regulatory board or agency; and

iii. Medicare/Medicaid sanctions.

e. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of (a.), (b.), and (c.) above.

4. The PIHP must ensure that the initial credentialing of all providers applying for network provider status shall be completed within 90 calendar days. The start time begins when the PIHP has received all necessary credentialing materials from the provider. Completion time ends when written communication is mailed or faxed to the provider notifying them of the PIHP's decision.

D. Temporary/Provisional Credentialing of Individual Practitioners:

Temporary or provisional credentialing of individual practitioners is intended to increase the available network of providers in underserved areas, whether rural or urban. PIHPs must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of Medicaid Beneficiaries that providers be available to provide care prior to formal completion of the entire credentialing process. Temporary or provisional credentialing shall not exceed **150 days**.

The PIHP shall have up to **31 days** from receipt of a complete application, accompanied by the minimum documents identified below, within which to render a decision regarding temporary or provisional credentialing.

For consideration of temporary or provisional credentialing, at a minimum, a provider must complete a signed application that must include the following items:

1. Lack of present illegal drug use.

2. History of loss of license, registration, certification, and/or felony convictions.

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

4. A summary of the provider's work history for the prior five years.

5. Attestation by the applicant of the correctness and completeness of the application.

The PIHP must conduct primary source verification of the following:

1. Licensure or certification;

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

3. Medicare/Medicaid sanctions.

The PIHPs designee must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification as outlined in this Section, should be completed.

E. Re-credentialing Individual Practitioners:
At a minimum, the re-credentialing policies for physicians and other licensed, registered, or certified health care providers must identify procedures that address the re-credentialing process and include requirements for each of the following:

1. Re-credentialing at least every two years.

2. An update of information obtained during the initial credentialing.

3. A process for ongoing monitoring, and intervention, if appropriate, of provider sanctions, complaints, and quality issues pertaining to the provider, which must include, at a minimum, review of:

    a. Medicare/Medicaid sanctions.

    b. State sanctions or limitations on licensure, registration, or certification.

    c. Member concerns which include appeals and grievances (complaints) information.

    d. PIHP quality issues.

F. Credentialing Organizational Providers:
For organizational providers included in its network:

1. Each PIHP must validate and re-validate at least every two years that the organizational provider is licensed or certified as necessary to operate in the State has not been excluded from Medicaid or Medicare participation and is approved by an accredited body, or an on-site quality assessment is completed if the provider is not accredited. For solely community-based providers (e.g. ABA or CLS in private residences) an on-site review is not required, an alternative quality assessment is acceptable.

2. The PIHP must ensure that the contract between the PIHP and any organizational provider requires the organizational provider to credential and re-credential their directly employed and subcontract direct service providers in accordance with the PIHPs credentialing/re-credentialing policies and procedures (which must conform to MDHHS credentialing process).

G. Deemed Status:
Individual practitioners or organizational providers may deliver healthcare services to more than one PIHP. A PIHP may recognize and accept credentialing activities conducted by any other PIHP in lieu of completing their own credentialing activities. In those instances where a PIHP

chooses to accept the credentialing decision of another PIHP, they must maintain copies of the credentialing PIHPs decisions in their administrative records.

H. Notification of Adverse Credentialing Decision:
An individual practitioner or organizational provider that is denied credentialing or re-credentialing by the PIHP shall be informed of the reasons for the adverse credentialing decision in writing by the PIHP.

I. Appeal of Adverse Credentialing Decision:
Each PIHP shall have an appeal process that is available when credentialing or re-credentialing is denied, suspended, or terminated for any reason other than lack of need. The appeal process must be consistent with applicable federal and state requirements.

J. Reporting Requirements:
The PIHP must have procedures for reporting improper known organizational provider or individual practitioner conduct that results in suspension or termination from the PIHPs provider network to appropriate authorities (i.e., MDHHS, the provider's regulatory board or agency, the Attorney General, etc.). Such procedures shall be consistent with current Federal and State requirements, including those specified in the MDHHS Medicaid Managed Specialty Supports and Services Contract.

Definitions

National Practitioner Databank (NPDB) and the Healthcare Integrity and Protection Databank (HIPDB): The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Office of Workforce Evaluation and Quality Assurance, Practitioner Data Banks Branch is responsible for the management of the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. They can be located on the Internet at www.npdb-hipdb.hrsa.gov/.

Organizational providers: entities that directly employ and/or contract with individuals to provide health care services. Examples of organizational providers include, but are not limited to, Community Mental Health Services Programs (CMHSPs); hospitals; nursing homes; homes for the aged; psychiatric hospitals, units, and partial hospitalization programs; substance abuse programs; and home health agencies.

PIHP: Prepaid Inpatient Health Plan under contract with MDHHS to provide managed behavioral health services to eligible individuals.

Provider: any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the State in which he/she delivers the services.