

POLICIES AND PROCEDURE MANUAL

Chapter:	Provider Network Management		
Title:	Credentialing and Recredentialing – Individual Practitioners		
Policy: <input type="checkbox"/> Procedure: <input checked="" type="checkbox"/> Page: 1 of 9	Review Cycle: Biennial Author: Deputy Director	Adopted Date: 01.12.21 Review Date: 03.05.2024	Related Policies: Provider Network Management Credentialing/Re-credentialing Compliance Disqualified Providers

Purpose

The purpose of this operating procedure is to detail the process for credentialing and recredentialing activities to ensure compliance with the Michigan Department of Health & Human Services (MDHHS) Credentialing and Recredentialing Processes for Individual Practitioners, and include at minimum:

- Physicians (MDs or DOs);
- Physician assistants;
- Psychologists (licensed, limited licensed and temporary licensed);
- Social workers (licensed master’s, licensed bachelor’s, limited licensed and registered social work technician);
- Licensed professional counselors;
- Nurse practitioners, registered nurses and licensed practical nurses;
- Occupational therapists and occupational therapist assistants;
- Physical therapists and physical therapist assistants;
- Speech pathologists;
- Board Certified Behavior Analysts;
- Licensed Family and Marriage Therapists; and
- Other behavioral healthcare specialists that are licensed, certified, or registered by the State.

Primary Source Verification (PSV)

Individual practitioner credentials must be verified by primary source, prior to any consumer contact. Any information found to vary from the application must be communicated to the applicant in writing within 30 days of application submission, prior to proceeding with the application process. The notice must include a timeframe for making corrections and the method/manner for submitting corrections.

Valid credentials are a condition of employment/contract and ongoing participation in the provider network. As applicable, the following require PSV – refer to Attachment A for PSV Guidelines:

- State Licensure or certification in good standing.
- Board Specialty Certification or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training. (e.g., MCBAP, AMA, APA, ABMS, etc.)
- Official transcript of graduation from an accredited school and or Licensing and Regulatory Affairs (LARA) license.
- Drug Enforcement Agency (DEA)/Controlled Dangerous Substances (CDS);
- Professional Liability/Malpractice Coverage;
- Background Checks (refer to MSHN Background Check procedure);
- National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following must be verified:
 - Minimum 5-year history of professional liability claims resulting in judgement or settlement;
 - Disciplinary status with regulatory board or agency; and
 - Medicare/Medicaid Sanctions

Note: If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association (AMA) or American Osteopathic Association (AOA) may be used to satisfy state licensure, Board Certification, and Educational and academic status.

Initial Credentialing

Initial credentialing decisions will be made within 90 calendar days from the date the completed signed and dated application is received from the provider. This will be calculated based on the application received date to the date of the notice to the provider of the credentialing decision. Completion time is indicated when written communication is sent to the individual practitioner notifying them of the credentialing decision. 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.
 - c. Any history of felony convictions.
 - d. Any history of loss or limitation of privileges or disciplinary action.
 - e. The correctness and completeness of the application.
 - f. The applicant is able to perform the essential functions of the position with or without accommodation.
2. An evaluation of the provider's work history for the prior five years. Gaps in employment of six (6) months or more in the prior five (5) years must be addressed in writing during the application process.
3. Verification from primary sources of items listed in the Primary Source section above, as applicable to the individual practitioner applying for credentialing.

Temporary/Provisional Credentialing Status

Credentialing organizations may conduct a one-time temporary/provisional credentialing of practitioners who are applying to the organization for the first time, prior to initial credentialing. Temporary/Provisional Status of individual practitioners is intended to increase the available network of providers in underserved areas, whether rural or urban and when it is in the best interest of Medicaid beneficiaries that providers be available to provide care prior to formal completion for the entire credentialing process. CMHSPs must have written policies and procedures to address the granting of temporary or provisional credentials.

The credentialing organization shall have up to 31 days from the receipt of the completed application, accompanied by the minimum documents identified below, to render a decision regarding temporary credentialing. An individual practitioner may be considered for temporary credentialing if the following minimum requirements are met:

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. History of loss of license, registration, certification
 - c. History of felony convictions,
 - d. History of loss or limitation of privileges or disciplinary action,
 - e. Correctness and completeness of the application;
 - f. The applicant is able to perform the essential functions of the position with or without accommodation.
2. Evaluation of the providers work history for the prior five years. Gaps in employment of six (6) months or more in the prior five (5) years must be addressed in writing during the application process.
3. Proof of liability and/or malpractice insurance consistent with contractual requirements, and
4. In addition, upon receipt of the initial credentialing application the credentialing designee shall

perform primary source verification of the following before recommending the application for temporary/provisional status:

- a. State Licensure, certification, or registration;
- b. Board certification, if applicable, or the highest level of credential attained;
- c. Medicare/Medicaid Sanctions;
- d. Criminal background check(s).

The credentialing committee must review the information obtained and determine whether to grant provisional credentials and evidence of this review and determination must be maintained in the credentialing file. If temporary status is granted, it shall expire one hundred and fifty (150) calendar days after the temporary credentialing decision effective date. Following approval of temporary status, completion of the full verification/initial credentialing process by the credentialing committee must be completed.

Recredentialing

Recredentialing of individual practitioners must take place at least every two years (calculated from mm/yy to mm/yy) and will be calculated from the date of the last credentialing decision to the date the notice is sent to the provider informing him or her of the recredentialing decision. Recredentialing must include:

1. Submission of current credentialing application including attestations:
 - a. Lack of present illegal drug use
 - b. Loss of license, registration, or certification since last credentialing cycle Any felony convictions since last credentialing cycle
 - c. Any loss or limitation of privileges or disciplinary status since last credentialing cycle
 - d. Correctness and completeness of the application;
 - e. The applicant is able to perform the essential functions of the position with or without accommodation.
 - f. A process for ensuring that ongoing monitoring and interventions , are reviewed and considered within the decision making process.

Ongoing Credentialing Monitoring

Ongoing monitoring and verification of individual practitioners, and intervention, if appropriate, as it relates to sanctions, complaints, and quality issues. The process must include, at a minimum, review of:

- Monthly Medicare/Medicaid sanction checks;
- Monthly state sanction checks;
- Any limitations on licensure, registration, or certification;
- Subsequent verification(s), as applicable, must be conducted, documented, dated, and verified by the credentialing designee upon expiration/renewal of credential;
- Beneficiary concerns which include appeals and grievances (complaints) information;
- Noted quality issues.

Credentialing Committee or Designated Authority:

It is recommended that a credentialing committee be established and include members qualified to assess a practitioner's competencies and qualifications. The role of the credentialing committee is to:

- review the credentials of practitioners who do not meet the agency's criteria for participation in the network;
- give thoughtful consideration to credentialing information;
- document discussions about credentialing and recredentialing decisions.

Credentialing files that meet all necessary criteria constitute a "clean file" and may be approved by the agency's Clinical/Medical Director or qualified practitioner and do not require credentialing committee approval. Evidence of clinical/medical director or qualified practitioner approval is a handwritten signature or initials, electronic approval from agency issued email account (e.g., voting feature or email response) or unique electronic signature identified if the agency has appropriate controls for ensuring that only the designated medical director or qualified practitioner can access the email account or enter the electronic

signature. The medical director or designated qualified practitioner's approval date is considered the "credentialing decision date."

In instances where a credentialing committee is not feasible due the size of an organization, at minimum a qualified practitioner shall be designated with the authority to evaluate and approve credentialing files.

Suspension and Revocation

Circumstances that automatically result in suspension or revocation :

- *Lack of current licensure* – The practitioner does not possess a current, valid license to practice in Michigan or the bordering state in which they reside and provide services, including because a previously valid license has expired, lapsed, or has been suspended or revoked, or otherwise ceases to meet the qualification.
- *Lack of DEA/CDS registration* - The practitioner does not possess a current, valid registration with the DEA/CDS, including because a previously valid registration has lapsed, expired, or been suspended or revoked or otherwise ceases to meet the qualification. This criterion applies only to a practitioner's who prescribe controlled substances.
- *No malpractice insurance* - The practitioner does not currently have professional liability insurance in the amounts required by the agency policy or otherwise ceases to meet the qualification. This criterion applies only to a Practitioner's required to carry professional liability insurance and is not covered under the agency policy.
- *Exclusion from government programs* - The practitioner is excluded from or limited in participation in a federal or state health care program.
- *Criminal charges* - The practitioner is convicted of an exclusionary crime as outlined in the MSHN Disqualified Providers Policy.

Credentialing suspension/revocation decisions will not include any information regarding an applicant's status related to allegations or pending investigations in process associated with licensure or registration; MSHN and its CMHSPs support due process for all independent applicants in matters pertaining to unsubstantiated allegations of misconduct.

Applies to:

All MSHN Staff

Selected MSHN Staff, as follows:

MSHN CMHSP Participants: Policy Only Policy and Procedure

Other: subcontracted providers

Definitions:

AMA: American Medical Association

AOA: American Osteopathic Association

CDS: Controlled Dangerous Substances

CMHSP: Community Mental Health Services Participant in the MSHN Region with delegated authority to manage a network of behavioral health providers; responsible for conducting credentialing and recredentialing activities.

Credentialing: The administrative process for reviewing, verifying, and evaluating the qualifications and credentials to ensure individuals meet the necessary criteria to provide healthcare services.

Credentialing Committee: A group of individuals, selected by an organization, to review the professional backgrounds and qualifications of applicants to make the determination if individual meets the criteria to provide healthcare services.

DEA: Drug Enforcement Agency

HIPDB: Healthcare Integrity and Protection Databank

Individual Practitioner: An individual who 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.

LARA: Licensing and Regulatory Affairs

MDHHS: Michigan Department of Health and Human Services

MSHN: Mid-State Health Network, the Pre-Paid Inpatient Health Plan responsible for oversight of

delegated functions, including credentialing activities.

NPDB: National Practitioner Databank

PSV: Primary Source Verification: The process by which an organization/entity corroborates the accuracy and validity of an individual provider's reported credentials and qualifications with the original source or allowable alternative source. Refer to Attachment A.

Re-credentialing: The ongoing administrative process for updating, reviewing, verifying, and evaluating the qualifications and credentials to ensure individuals meet the necessary criteria to provide healthcare services. This is required at minimum every two years.

Other Related Materials

Compliance: Disqualified Provider Policy

Provider Network Management: Background Check Procedure

Provider Network Management: Disclosure of Ownership, Control and Criminal Convictions Procedure

Provider Network Management: Provider Appeal Procedure

Human Resources: MSHN Personnel Manual

References/Legal Authority:

- MDHHS Credentialing & Re-credentialing Processes
- MDHHS Medicaid Provider Manual
- Public Act 282 of 2020
- 42 CFR 438.214
- 42 CFR 438.12

Change Log:

Date of Change	Description of Change	Responsible Party
09.2020	New - Annual Review – Revised credentialing procedure entirely to create procedure for LIPs	Director, Provider Network Management Systems
11.2021	Biennial Review – Removed attachment references to MDHHS contract	Contract Specialist
05.2023	Revised and updated language in accordance with MDHHS Credentialing and Recredentialing Processes revision 3/24/23.	Compliance Administrator/Deputy Director
12.2023	Procedure Update	PNMC, Contract Specialist

Attachment A: Primary Source Verification (PSV) Guidelines

A primary source is the original source of a specific credential that can verify the accuracy of a credential reported by an individual practitioner. PSV is received directly from the issuing source. For example, if information on state licensure status is verified directly with the licensing body, this is PSV. A copy of the license is not considered PSV.

PSV can be performed in several ways:

- Electronically through agency website (i.e. State licensure, NPDB, etc.). If verified electronically, a screenshot or PDF version of the screen shall include the date the information was verified.
- Letters requesting the appropriate information are written to the primary source and responses are received directly from the primary source.
- Documentation of verification via telephone including the name of the agency called, date, the person contacted, the questions asked and responses, the name, date, and signature of the person receiving the response.

Designated Equivalent Sources: Verification of credentials through an agent that contracts with an approved source to provide credentialing information is allowed. Prior to using this method documentation must be obtained from the agent indicating that there is a contractual relationship between it and the approved source (i.e. National Student Clearinghouse).

The following are MDHHS standards which align with NCQA standards for credentialing. Verification time limit will be calculated from the date of verification to the date of the credentialing decision.

Information to Verify	Verification Source	When	Criteria	Verification Time Limit
Application	Agency Application	<input checked="" type="checkbox"/> C <input checked="" type="checkbox"/> R <input type="checkbox"/> E <input type="checkbox"/> O	Completed, signed, and dated application with no positively answered attestation questions.	365 days from date of signature
Work History	PSV not required. A minimum of 5 years of relevant work history must be obtained through the application, resume, or CV. Documentation of review can include the signature/initials of staff who reviewed the work history and date of review.	<input checked="" type="checkbox"/> C <input type="checkbox"/> R <input type="checkbox"/> E <input type="checkbox"/> O	Gaps exceeding 6 months or more in the prior 5 years must be addressed in writing during the application process. Best Practice: dates in month/year format for beginning and end of employment.	365 days
Professional State Licensure	Any of the following: <ul style="list-style-type: none"> • LARA – Department of Licensing and Regulatory Affairs to verify a valid, current license • NPDB can be used to verify licensing sanctions 	<input checked="" type="checkbox"/> C <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/> E <input type="checkbox"/> O	Current, valid, unrestricted license in the state where the practitioner practices is in effect at the time of credentialing committee decision.	180 days

<p>Board Certification appropriate to the license and area of practice, or highest level of credentials attained if applicable, or completion of any required internships/residency programs, or other postgraduate training. (MD/DO)</p>	<p>Any of the following:</p> <ul style="list-style-type: none"> • AMBS, its member boards and its approved Display Agents • AMA/AOA Physician Masterfile • AOA Physician Profile Report • Confirmation from Specialty Board • State licensing agency if there is confirmation that this agency conducts PSV of board status. • MCBAP website verification/screenshot <p>If practitioner claims to be board certified, it must be verified. Verification of Board Certification meets the requirement for verification of education and residency training. Must document the expiration date of board certification in the credentialing file. If it is a lifetime certification status with no expiration date, verify that the certification is current and document date of verification. Must verify at recertification. If the board does not provide an expiration date, must verify that it is current.</p>	<input checked="" type="checkbox"/> C <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/> E <input type="checkbox"/> O		180 days
<p>Graduation from an accredited school; other training</p>	<p>Verification can include:</p> <ul style="list-style-type: none"> • sealed official transcript sent directly from the institution to verifying agency • State licensing agency or specialty board or registry <p>Other sources for MDs</p> <ul style="list-style-type: none"> • AMA Physician Masterfile • AOA Physician Profile or AOA Physician Master File • ECFMG for international medical grads after 1986 • FCVS for closed residency programs 	<input checked="" type="checkbox"/> C <input type="checkbox"/> R <input type="checkbox"/> E <input type="checkbox"/> O	<p>Verification of highest level of credentials attained. For physicians Residency is the highest level of training, not fellowship.</p>	Prior to credentialing decision
<p>National Provider Data Bank</p> <p><i>(acceptable source for sanctions or limitations on</i></p>	<p>NPDB – National Provider Databank OR:</p> <ul style="list-style-type: none"> • Minimum 5-year history of professional liability claims resulting in a judgment or settlement; and 	<input checked="" type="checkbox"/> C <input checked="" type="checkbox"/> R <input type="checkbox"/> E <input type="checkbox"/> O	No adverse findings	180 days

<i>licensure, Medicaid/Medicare sanctions, and malpractice history)</i>	<ul style="list-style-type: none"> • Disciplinary status with regulatory board or agency; and • Medicare/Medicaid sanctions (OIG/SAM) 			
Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) for those prescribing controlled substances (MD, DO, mid-levels)	<p>Any of the following:</p> <ul style="list-style-type: none"> • Copy of the DEA or CDS Certificate • Confirmation on National Technical Information Service (NTIS Database) • Documented visual inspection and copy of the original certificate • Confirmation with DEA or CDS agency • AMA Masterfile (DEA only) • AOA physician profile report or AOA Physician Masterfile. 	<input checked="" type="checkbox"/> C <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/> E <input type="checkbox"/> O	Current, valid, unrestricted license	180 day time limit does not apply providing the DEA/CDS is current at the time of action/transmittal
Professional liability insurance/Malpractice Coverage, if applicable	<p>Copy of Policy Certificate face sheet from carrier</p> <p><i>Not required for practitioners covered under the agency policy</i></p>	<input checked="" type="checkbox"/> C <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/> E <input type="checkbox"/> O	Coverage meets agency requirements	
Malpractice Claims/Professional Liability History	<p>Any of the following:</p> <ul style="list-style-type: none"> • NPDB Query • Written confirmation of past five years history of malpractice history and verify with carrier 	<input checked="" type="checkbox"/> C <input checked="" type="checkbox"/> R <input type="checkbox"/> E <input type="checkbox"/> O	An attestations is not acceptable PSV.	180 days
Medicaid/Medicare Exclusions	<p>Any of the following:</p> <ul style="list-style-type: none"> • NPDB Query • List of Excluded Independents and Entities maintained by the OIG; SAM, and MDHHS List of Sanctioned Providers • AMA Physician Master File • FSMB <p>Refer to MSHN Background Checks Procedure</p>	<input checked="" type="checkbox"/> C <input checked="" type="checkbox"/> R <input type="checkbox"/> E <input checked="" type="checkbox"/> O	Agency develops and implements policies and procedures for ongoing monitoring of sanctions. Evidence of verification at time of credentialing must be included in the credentialing file. Evidence of monthly verification must be maintained.	180 days
Criminal History	<p>iChat for Michigan</p> <p><i>Refer to MSHN CBC Procedure & Disqualified Providers Policy</i></p>	<input checked="" type="checkbox"/> C <input checked="" type="checkbox"/> R <input type="checkbox"/> E <input type="checkbox"/> O	If criminal history is present, verification that provider verified history does not disqualify the provider as outlined in the MSHN Disqualified Providers Policy	180 days
Michigan State Public Sex Offender Registry	MSPSOR	<input checked="" type="checkbox"/> C <input type="checkbox"/> R <input type="checkbox"/> E <input type="checkbox"/> O	Evidence of verification at time of initial credentialing must be included in the credentialing file.	180 days
United States Department of	NSOPW	<input checked="" type="checkbox"/> C <input type="checkbox"/> R	Evidence of verification at time initial of	180 days

Justice National Sex Offender Registry		<input type="checkbox"/> E <input type="checkbox"/> O	credentialing must be included in the credentialing file.	
Central Registry Check	MDHHS Required for individuals working directly with children.	<input checked="" type="checkbox"/> C <input type="checkbox"/> R <input type="checkbox"/> E <input type="checkbox"/> O	Evidence of verification at time initial of credentialing must be included in the credentialing file.	180 days
Quality Issues	<p>Documentation of ongoing monitoring of quality and intervention, if appropriate.</p> <p>Assess the practitioner's ability to deliver care based on the credentialing information collected and verified prior to making a credentialing decision.</p>	<input type="checkbox"/> C <input checked="" type="checkbox"/> R <input type="checkbox"/> E <input checked="" type="checkbox"/> O	Agency develops and implements policies and procedures for ongoing monitoring of quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality. For recredentialing, evidence this was reviewed and used in the decision-making process.	
Beneficiary Concerns- Appeals, Grievances, Complaints	Documentation of ongoing monitoring of beneficiary concerns and intervention if appropriate.	<input type="checkbox"/> C <input checked="" type="checkbox"/> R <input type="checkbox"/> E <input checked="" type="checkbox"/> O	Agency develops and implements policies and procedures for ongoing monitoring of beneficiary concerns, appeals, grievances, and complaints between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality. For recredentialing, evidence this was reviewed and used in the decision-making process.	

* C- Initial credentialing, R- Recredentialing, E- Upon expiration O- Ongoing