950 – CREDENTIALING AND RECREDENTIALING PROCESSES

EFFECTIVE DATES: 10/01/94, 01/25/19, 09/01/20, 10/01/21, 10/01/22, 01/01/23[1]

APPROVAL DATES: 10/01/16, 10/01/15, 09/01/14, 04/01/14, 10/01/13, 10/01/12, 04/01/12, 02/01/11, 10/01/10, 10/01/09, 10/01/08, 05/01/07, 02/01/07, 04/01/05, 08/13/03, 10/01/01, 10/01/97, 01/25/19, 06/23/20, 03/18/21, 04/21/22, 11/17/22[2]

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS/CHP (CHP), and DES/DDD (DDD) Contractors. This Policy establishes requirements for initial credentialing, temporary/provisional credentialing, and recredentialing of individual and organizational providers.

II. DEFINITIONS

For purposes of this policy:

ADVERSE ACTION Any type of restriction placed on a provider's practice by the Contractor such as, but not limited to:

1. Contract termination.
2. Suspension.
3. Limitation.
4. Continuing education requirement.
5. Monitoring.
6. Supervision.

COMPLETED APPLICATION[3] When all information is available to make an informed decision about the provider and requires at least the following to be present and accurate: A completed, signed, and dated Council for Affordable Quality Healthcare (CAQH) application.

The CAQH application must be up to date and contain the following:

1. Current Attestation (not expired),
2. Current Certificate of Insurance (COI),
3. Current DEA Certification for the applicable provider types,
4. Five-year Work History (if a gap in work history exceeds six months, the provider must explain the gap in writing), and
5. Completed Questionnaire and supporting documentation, if applicable.

[1] Date policy is effective
[2] Date approved by APC
[3] Added to clearly outline state requirements for credentialing; added agreed upon definition at the request of Arizona Association of Health Plans to specify policy provisions in relation to NCQA Accreditation Credentialing Standards.

ORGANIZATIONAL PROVIDERS[4]	Facilities providing services to members and where members are directed for services rather than being directed to a specific practitioner. Organizational Providers also include providers listed in Section E of this policy, as credentialing for these providers is completed at the organizational level.

Additional definitions are located on the AHCCCS website at: AHCCCS Contract and Policy Dictionary.

III. POLICY

The Contractor shall have a written process and a system in place for credentialing and recredentialing providers in its contracted provider network. Policies shall address individual providers and Oorganizational Pproviders, including but not limited to providers of physical health services, behavioral health services, treatment of Substance Use Disorders (SUD), and Long-Term Services and Supports (LTSS), as specified in this Policy, 42 CFR 457.1208, 42 CFR 457.1233(a), 42 CFR 438.206(b)(6), 42 CFR 438.12(a)(2), and 42 CFR 438.214(b)(1).

A. CREDENTIALING PROVIDERS[5]

1. Credentialing and recredentialing shall be conducted and documented for providers delivering care and services to AHCCCS members.

2. The Contractor shall utilize the Arizona Association of Health Plan's contracted Credential Verification Organization (CVO) as part of the credentialing and recredentialing process as specified in Contract.

3. The Contractor shall ensure the credentialing and recredentialing processes:
   a. Do not base credentialing decisions on an applicant's race, ethnic/national entity, 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 [42 CFR 457.1208, 42 CFR 457.1233(a), 42 CFR 438.12(a)(2), 42 CFR 438.214(c)], and
   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 [42 CFR 457.1233(a), 42 CFR 438.214(d)].

4. If the Contractor delegates to another entity any of the responsibilities of credentialing/ recredentialing that are required by this Policy, it shall retain the right to approve, suspend, or terminate any provider selected by that entity and meet the requirements of this Policy regarding delegation. Refer to ACOM Policy 438 for delegation requirements.~~,~~

5. The Contractor shall establish a credentialing committee to review and make decisions on provider credentialing. ~~and~~

[4] Adding definition; definition is in alignment with NCQA Credentialing standards (CR 7: Element A, Explanation), including clarification on providers outlined in this policy as Organizational Providers.
[5] Updated formatting of the items in this section.

~~4.~~6. Written policies shall reflect the scope, criteria, timeliness, and process for credentialing and recredentialing providers. The policies and procedures shall be reviewed and approved by the Contractor's executive management and shall:
   a. Reflect the direct responsibility of the Contractor's local medical director or in the absence of the local medical director, other local designated physician to:
      i. Act as the chair of the credentialing committee,
      ii. Implement the decisions made by the credentialing committee, and
      iii. Oversee the credentialing process~~,~~.
   b. Indicate the use of participating Arizona Medicaid enrolled providers in making credentialing decisions,
   c. Describe the methodology to be used by Contractor staff and the Contractor's local medical director to provide documentation that each credentialing or recredentialing file was completed and reviewed, as specified in this Policy, prior to presentation to the credentialing committee for evaluation,
   d. Notify providers of their right to[6]:
      i. Review information it has obtained to evaluate their credentialing application, attestation, or Curriculum Vitae (CV),
      ii. Correct erroneous information, and
      iii. Receive the status of their credentialing application, upon request.

~~5.~~7. The Contractor shall maintain an individual electronic or hard copy credentialing/ recredentialing file for each applying provider. Each file shall include:
   a. The initial credentialing and all subsequent recredentialing applications, including attestation by the provider of the correctness and completeness of the application as demonstrated by the signature on the application,
   b. Information gained through credentialing and recredentialing queries,
   c. Any other pertinent information used in determining whether or not the provider met the Contractor's credentialing and recredentialing standards, and
   d. Specific to recredentialing, utilization data, quality of care concerns, grievances, performance measure rates, value-based purchasing results, and level of member satisfaction.

~~6. The Contractor shall have written policies and procedures for notifying practitioners of their right to:~~
   ~~i. Review information it has obtained to evaluate their credentialing application, attestation, or Curriculum Vitae (CV),~~
   ~~ii. Correct erroneous information, and~~
   ~~iii. Receive the status of their credentialing application, upon request.~~[7]

8. Providers may be credentialed concurrently with their AHCCCS registration process; AHCCCS registration shall be confirmed prior to finalizing a contract for Medicaid services.

9. Credentialed providers shall be entered/loaded into the Contractor's claims payment system within 30 calendar days of credentialing committee approval~~.~~.

[6] Moved this information into this subsection to condense policy requirements.
[7] Moved up under #6 to condense policy requirements.

10. Credentialed providers shall be entered/loaded into the Contractor's claims payment system with an effective date no later than the date the provider was approved by the credentialing committee or the contract e~~E~~ffective date, whichever is later.~~, and~~

11. The Contractor shall reimburse providers back to the date of the Completed Application (as defined in this Policy) for covered services provided to members during the credentialing process, if the provider is subsequently approved through the credentialing committee.[8]

~~7.~~12. The Contractor shall have an established process to notify providers of their credentialing or recredentialing[9] decision (approved or denied) within 10 days of Credentialing Committee decision.

B. TEMPORARY/PROVISIONAL CREDENTIALING

1. The Contractor shall have policies and procedures to address granting of temporary/provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.

   The following providers shall be credentialed using the temporary/provisional credentialing process, even if the provider does not specifically request their application be processed as temporary/provisional:
   a. Providers in a Federally Qualified Health Center (FQHC),
   b. Providers in a FQHC Look-Alike organization,
   c. Rural Health Clinic (RHC),
   d. Hospital employed physicians (when appropriate),
   e. Providers needed in medically underserved areas, whether rural or urban,
   f. Providers joining an existing and contracted oral health provider group,
   g. Covering/substitute providers providing services to the Contractor's members during a provider's absence from the practice,
   h. Providers eligible under the Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Opioid Treatment Programs (OTPs) as specified in 42 CFR 8.11, and
   i. Providers as directed by AHCCCS during federal and/or state-declared emergencies where delivery systems are, or have the potential to be, disrupted.

2. The Contractor shall have 14 calendar days from receipt of a complete application, accompanied by the minimum documents specified in this section, in which to render a decision regarding temporary/provisional credentialing. The Contractor's local Medical Director shall review the information obtained and determine whether to grant temporary/provisional credentials. Once temporary/provisional credentialing is approved, provider information shall be entered into the Contractor's information system to allow payment to the provider.~~ effective the date the temporary/provisional credentialing is approved.~~[10]

[8] Added to clearly outline state requirements for credentialing and retro payment and to specify policy provisions in relation to NCQA Accreditation Credentialing Standards.
[9] Added for clarity
[10] Revised to align with language added to first section in policy regarding retro-payments.

For consideration of temporary/provisional credentialing, at a minimum, a provider shall complete a signed application that includes the following items:

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. History of loss of license and/or felony convictions,
d. History of loss or limitation of privileges or disciplinary action,
e. Current malpractice insurance coverage,
f. Attestation by the provider of the correctness and completeness of the application (a copy of the most current signed attestation shall be included in the provider's credentialing file),
g. Work history for the past five years or total work history if less than five years, and
h. Current Drug Enforcement Agency (DEA) or Controlled Drug System (CDS) certificate if a prescriber.

3. The Contractor shall conduct primary source verification of the following:
   a. Licensure or certification: A print out of 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,
   c. National Practitioner Data Bank (NPDB) query including the following:
      i. 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/Medicaid sanctions, exclusions, and terminations for cause.

4. In situations where a covering/substitute provider shall be utilized by a contracted provider and is approved through the temporary/provisional credentialing process, the Contractor shall ensure that its system allows payments to the covering/substitute provider effective when the date notification was received from the provider of the need for a covering/substitute provider. Covering/substitute providers shall also meet the following requirements:
   a. Licensure: Providers and employees rendering services to Members shall be appropriately licensed in Arizona to render such services as required by state or federal law or regulatory agencies, and such licenses shall be maintained in good standing,
   b. Restriction of Licensure: Providers shall notify the Contractor within two business days of the loss or restriction of their Drug Enforcement Administration (DEA) permit or license or any other action that limits or restricts the Provider's ability to practice or provide services,
   c. Professional Training: Providers and all employees rendering services to Members shall possess the education, skills, training, physical, and mental health status, and other qualifications necessary to provide quality care and services to Members,
   d. Professional Standards: Providers and employees rendering services to Members shall provide care and services which meets or exceeds the standard of care and shall comply with all standards of care established by state or federal law,
   e. Continuing education: Providers and employees rendering care or services to Members shall comply with continuing education standards as required by state or federal law or regulatory agencies, and
   f. Regulatory compliance: Providers shall meet the minimum requirements for participating in the Medicaid program as specified by the State.

Following approval of temporary/provisional credentialing, the Contractor shall complete the entire initial credentialing process, as specified in this Policy. The Contractor shall not keep providers in a temporary/provisional credentialing status for longer than 60 calendar days.

C. INITIAL CREDENTIALING OF INDIVIDUAL PROVIDERS

1. Individual provider credentialing (and recredentialing) shall be completed for at least the following provider types:
   a. Physicians (Medical Doctor [MD]),
   b. Doctor of Osteopathic Medicine (DO),
   c. Doctor of Podiatric Medicine (DPM),
   d. Naturopaths (Naturopathic Doctor [ND] or Naturopathic Medical Doctor [NMD]),
   e. Nurse Practitioners (NP),
   f. Physician Assistants,
   g. Certified Nurse Midwives acting as Primary Care Providers (PCP), including prenatal care/delivering providers,
   h. Dentists (Doctor of Dental Surgery [DDS] and Doctor of Medical Dentistry [DMD]),
   i. Affiliated Practice Dental Hygienists,
   j. Psychologists,
   k. Optometrists,
   l. Certified Registered Nurse Anesthetists,
   m. Occupational Therapists,
   n. Speech and Language Pathologists,
   o. Physical Therapists,
   p. Independent behavioral health professionals who contract directly with the Contractor including:
      i. Licensed Clinical Social Worker (LCSW),
      ii. Licensed Professional Counselor (LPC),
      iii. Licensed Marriage/Family Therapist (LMFT),
      iv. Licensed Independent Substance Abuse Counselor (LISAC), and
      v. Clinical Nurse Specialist.
   q. Board Certified Behavioral Analysts (BCBAs),
   r. Any non-contracted certified or licensed provider that is rendering services and sees 50 or more of the Contractor's members per contract year, and
   s. Covering/substitute oral health providers that provide care and services to the Contractor's members in an absence of the contracted provider. Covering/substitute oral health providers shall indicate on the claim form that they are the rendering provider of the care or service.

2. At a minimum, policies, and procedures for the initial credentialing of individual providers shall include:
   a. A written application to be completed, 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 and/or felony convictions,
      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 work history or total work history if less than five years.

b. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) 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,
   iii. For credentialing of Independent Masters Level Behavioral Health Licensed Professionals, including:
      1) LCSW,
      2) LPC,
      3) LMFT, and
      4) LISAC.
   iv. Primary source verification of:
      1) Licensure by Arizona Board of Behavioral Health Examiners (AZBBHE), and
      2) A review of complaints received and disciplinary status through AZBBHE.
   v. For credentialing of Licensed BCBA, primary source verification of:
      1) Licensure by the Arizona Board of Psychologist Examiners,
      2) A review of complaints received, board and disciplinary status through the Arizona Board of Psychologist Examiners,
      3) Continuing education requirements:
         a) BCBA's credentialed under a three-year Cycle: 36 hours every three years (three hours in ethics and professional behavior), and
         b) BCBA's credentialed under a two-year Cycle: 32 hours every two years (four hours in ethics for all certificates; three hours in supervision for supervisors).
      4) Continuing Education Courses:
         a) BCBAs providing supervision of individuals pursuing Behavior Analyst Certification Board (BACB) certification or the ongoing practice of Board Certified Assistant Behavior Analysts (BCABAs) or Registered Behavior Technicians (RBTs) will be required to obtain specific training in order to do so. These individuals will also be required to obtain three Continuing Education Unit (CEU)s on supervision in every certification cycle, and
         b) Acceptable supervision content is behavior-analytic in nature and covers effective supervision as defined in the BACB's Experience Standards (in particular, the "Nature of Supervision" section) and the BACB Supervisor Training Curriculum Outline.

TYPE	DESCRIPTION	LIMIT	CEU
1	College or university coursework	None – all Continuing Education (CE) can come from this type	1 hour of instruction = 1 CEU
2	CE issued by Approved Continuing Education (ACE) providers	None – all CE can come from this type	50 minutes of instruction = 1 CEU
3	Instruction of Type 1 or Type 2	50% can come from this type*	1 hour of instruction = 1 CEU
4	CE issued by the BACB directly	25% can come from this type*	Determined by BACB
5	Take and pass the certification exam again	All CE will be fulfilled by this activity	Passing the exam equals 100% of your required CEUs, except for supervision
6	Scholarly Activities	25% can come from this type*	One publication = 8 CEUs One review = 1 CEU

**A maximum of 75 percent of the total required CE may come from categories 3, 4, 5 and 7. At least 25 percent shall come from Type 1 or Type 2. Passing the examination (Type 6) meets all CE requirements except for supervision.*

vi. Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training. A printout of license from the applicable Board's official website denoting that the license is active with no restrictions is acceptable,

vii. NPDB query including the following:
   1) Minimum five-year history of professional liability claims resulting in a judgment or settlement,
   2) Disciplinary status with regulatory Board or Agency,
   3) State sanctions or limitations of licenses, and
   4) Medicare/Medicaid sanctions, and exclusions and terminations for cause.

viii. Documentation that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated and the identity of the provider shall be disclosed to AHCCCS/Office of the Inspector General (AHCCCS/OIG) immediately as specified in ACOM Policy 103:
   1) Health and Human Services/Office of Inspector General (HHS/OIG) List of Excluded Individuals/Entities (LEIE) www.oig.hhs.gov, and
   2) The System of Award Management (SAM) www.sam.gov formerly known as the Excluded Parties List System (EPLS).

3. Affiliated practice dental hygienists shall provide documentation of the affiliation agreement with an AHCCCS registered dentist. Acceptable documentation includes a notice from the Arizona State Board of Dental Examiners confirming the affiliation agreement between the dental hygienist and the registered dentist.[11]

4. [12]~~Contracted p~~Providers, including licensed or certified behavioral health providers, may be subject to an initial site visit as part of the credentialing process.

~~5. Initial site visits for PCP and Obstetrics/Gynecology (OB/GYN) providers shall include but are not limited to verification of compliance with the following:~~
~~a. Vaccine and drug storage regulations,~~
~~b. Emergency and resuscitation equipment policy, and~~
~~Americans with Disabilities Act (ADA) requirements [42 CFR 457.1201(f), 42 CFR 457.1220, 42 CFR 438.3(f)(1), 42 CFR 438.100(d)].~~[13]

~~6.~~5. For Locum Tenens, it is each Contractor's responsibility to verify the status of the physician with the Arizona Medical Board and national databases.

~~7.~~6. The Contractor shall ensure that network providers have capabilities to ensure physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities [42 CFR 457.1230(a), 42 CFR 438.206(c)(2)(3)]. The Contractor shall also 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 [42 CFR 457.1230(a), 42 CFR 438.206(c)(2)].

~~8.~~7. The Contractor shall conduct timely verification of information, as evidenced by approval (or denial) of a provider within 60 days of a receipt of a C~~c~~ompleted A~~a~~pplication.

D. RECREDENTIALING OF INDIVIDUAL PROVIDERS

At a minimum, the recredentialing policies for individual providers shall identify procedures that address the recredentialing process and include requirements for:

1. Recredentialing at least every three years.

2. An update of information obtained during the initial credentialing process, as specified in this Policy.

3. Verification of continuing education requirements being met.

[11] Added for clarification of what documentation should be accepted in this instance.
[12] Removed for clarification as these providers may not be contracted during the initial credentialing process.
[13] Removed this requirement, duplication of NCQA accreditation activities and licensure review for providers.

4. A process for monitoring health care providers specific information such as, but not limited to, the following:
   a. Member concerns which include grievances (complaints),
   b. Utilization management information (e.g., emergency room utilization, hospital length of stay, disease prevention, pharmacy utilization),
   c. Performance improvement and monitoring (e.g., performance measure rates),
   d. Results of medical record review audits, if applicable,
   e. Quality of care issues (including trend data). If an Aadverse Aaction is taken with a provider, including non-renewal of a contract, the Contractor shall report the Aadverse Aaction and include the reason for the Aadverse Aaction to the AHCCCS/Division of Health Care Management, Quality Management (AHCCCS/DHCM, QM) as specified in Contract and this Policy,
   f. Pay for performance and value driven health care data/outcomes, if applicable, and
   g. Evidence that the provider's policies and procedures meet AHCCCS requirements.

5. Timely approval (or denial) by the Contractor's Credentialing Committee within three years from the previous credentialing approval date. Primary Source Verification shall also be current, within 180 days, for the Committee's decision.

E. INITIAL CREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. As a prerequisite to contracting with an Oorganizational Pprovider, the Contractor shall ensure that the Oorganizational Pprovider has established policies and procedures that meet AHCCCS requirements, including policies and procedures for credentialing and recredentialing if those functions are delegated to the Oorganizational Pprovider. The requirements specified in this section shall be met for all Oorganizational Pproviders included in the Contractor's network including, but not limited to:
   a. Hospitals,
   b. Home health agencies,
   c. Attendant care agencies,
   d. Habilitation providers,
   e. Group homes,
   f. Child/Adult developmental homes,
   g. Nursing supported group homes,
   h. Nursing facilities,
   i. Dialysis centers,
   j. Dental and medical schools,
   k. Freestanding surgical centers,
   l. Intermediate care facilities,
   m. State or local public health clinics. County Health Departments, that are not a part of the Contractor's provider network, are not required to go through the credentialing process for administration of immunizations to mM,embers (Refer to AMPM Policy 310-M),
   n. Community/rural health clinics (or centers),
   o. Air transportation vendors,
   p. Non-Eemergency Medical Ttransportation (NEMT) vendors,
   q. Laboratories,
   r. Pharmacies,
   s. Respite homes/providers,

t. Behavioral health facilities, including but not limited to:
   i. Independent clinics,
   ii. FQHCs,
   iii. Community mental health centers,
   iv. Level 1 Sub-Acute Facility (Institution for Mental Disease [IMD] and non-IMD),
   v. Intermediate Care Facility/Individuals with Intellectual Disabilities,
   vi. Level 1 Residential Treatment Center (IMD),
   vii. Level 1 Residential Treatment Center Non-Secure (non-IMD),
   viii. Level 1 Residential Treatment Center Non-Secure (IMD),
   ix. Community Sservice Aagency (CSA),
   x. Crisis services provider/agency,
   xi. Behavioral health residential facility,
   xii. Behavioral health outpatient clinic,
   xiii. Integrated clinic,
   xiv. Rural substance abuse transitional agency,
   xv. Behavioral health therapeutic home,
   xvi. Respite homes/providers,
   xvii. Specialized assisted living centers, and
   xviii. Specialized assisted living homes.

2. Prior to credentialing and contracting with an Oorganizational Pprovider, the Contractor shall:
   a. Confirm that the Organizational Pprovider has met all the state and federal licensing and regulatory requirements, including business licensure requirements as applicable[14], (a copy of the license or letter from the regulatory agency will meet this requirement),
   b. Confirm that the Organizational Pprovider is reviewed and approved by an appropriate accrediting body as specified by the Centers for Medicare and Medicaid Services (CMS) (a copy of the accreditation report or letter from the accrediting body will meet this requirement). The Contractor shall state in policy which accrediting bodies it accepts that is in compliance with federal requirements,
   c. Conduct an onsite quality assessment if the Organizational Pprovider is not accredited. The Contractor shall develop a process and utilize assessment criteria for each type of unaccredited Oorganizational Pprovider for which it contracts that shall include, but is not limited to, confirmation that the Oorganizational Pprovider has the following:
      i. A process for ensuring that the Oorganizational Pprovider credentials its providers for all employed and contracted providers as specified in this Policy,
      ii. Liability insurance, and
      ~~iii. Business license, and~~
      ~~iv.~~iii. CMS certification or state licensure review/audit may be substituted for the required onsite quality assessment~~visit~~, as long as the ~~site visit~~review/audit[15] was within the past three years prior to the credentialing date. In this circumstance, the Contractor shall obtain the review/audit documentation from CMS or the state licensing agency and verify that the review/audit was conducted, and that the provider meets the Contractor's standards. A letter from CMS that states the Oorganizational Pprovider was reviewed/ audited and passed inspection is sufficient documentation

[14] Moved up from section c in line with other licensure requirements.
[15] Revised for clarity and to align with NCQA language.

when the Contractor has documented that they have reviewed and approved the CMS criteria and they meet the Contractor's standards.

d. Confirm maintenance schedules for vehicles used to transport AHCCCS members and the availability of age-appropriate car seats when transporting children, and
e. Review and approve the Oorganizational Pprovider through the Contractor's Credentialing Committee.

For information regarding credentialing of CSAs ~~community service agencies~~ refer to AMPM Policy 965.

F. RECREDENTIALING OF ORGANIZATIONAL PROVIDERS

The Contractor shall recredential Oorganizational Pproviders at least every three years. The recredentialing shall include the following components and all information utilized by the Contractor shall be current.

1. Confirmation that the Oorganizational Pprovider remains in good standing with State and Federal bodies, and, if applicable, are reviewed and approved by an accrediting body. To meet this component the Contractor shall validate that the Oorganizational Pprovider meets the conditions listed below:
   a. Is licensed to operate in the State, and is in compliance with any other State or Federal requirements as applicable, and
   b. Is reviewed and approved by an appropriate accrediting body. If an Oorganizational Pprovider is not accredited or surveyed and licensed by the State an on-site review shall be conducted.

2. Review of the following:
   a. The most current review conducted by the Arizona Department of Health Services (ADHS) and/or summary of findings (date of ADHS review shall be documented). If applicable, review the online Hospital Compare AZz Care Check,
   b. Record of on-site inspection of non-licensed Oorganizational Pproviders to ensure compliance with service specifications,
   c. Supervision of staff and required documentation of direct supervision/clinical oversight as required in A.A.C. R9-10-115. This process shall include a review of a valid sample of clinical charts,
   d. Most recent audit results of the Oorganizational Pprovider,
   e. Confirmation that the service delivery address is verified as correct, and
   f. Review of staff to verify credentials, and that the staff person meets the credentialing requirements.

3. Evaluate Oorganizational Pprovider specific information such as, but not limited to, the following:
   a. Member concerns which include grievances (complaints),
   b. Utilization management information,
   c. Performance improvement and monitoring,
   d. Quality of care issues,
   e. Onsite quality assessment, and
   f. Review of any Aadverse Aactions.

4. Review and approval by the Contractor's Credentialing Committee with formal documentation that includes discussion, review of thresholds, and complaints or grievances.

5. In addition to the requirements in this Policy, ALTCS Contractors shall review and monitor other types of Oorganizational Pproviders as specified in their Contract.

G. THERAPEUTIC FOSTER CARE PROVIDERS

Therapeutic Foster Care (TFC) Family Providers are licensed through the Department of Child Safety (DCS) and do not require AHCCCS credentialing.

TFC Agency Providers require credentialing with the Contractor.

For TFC Providers for children, submission of a Foster Home License, as specified in A.A.C. 21, Article 1 through Article 4, will be accepted as meeting the requirements for credentialing as an AHCCCS provider.

For information regarding AHCCCS responsibilities related to TFC settings, refer to AMPM Policy 320-W.

H. TEACHING PHYSICIANS AND TEACHING DENTISTS

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. 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.

The teaching physician or teaching dentist shall be an AHCCCS registered provider and shall be credentialed by the AHCCCS Contractors in accordance with this Policy.

I. NOTIFICATION REQUIREMENTS

1. The Contractor shall have procedures for prompt reporting in writing to appropriate authorities including AHCCCS/DHCM, QM, the provider's regulatory Board or Agency, the ADHS Licensure Division, and the Office of the Attorney General.

2. The Contractor shall report within one business day to AHCCCS/DHCM, QM, issues/quality deficiencies that result in a provider's suspension or termination from the Contractor's network. If the issue is determined to have criminal implications, including allegations of abuse or neglect, a law enforcement agency, as well as Adult Protective Services (APS) or the Department of Child Safety (DCS), shall also be promptly notified, no later than 24 hours after identification. The Contractor shall have an implemented process to report providers to licensing and other regulatory entities, all allegations of inappropriate or misuse of prescribing practices. This shall include allegations of adverse outcomes that may have been avoided if the provider had reviewed the Controlled Substance Prescription Monitoring Program (CSPMP) and coordinated care with other prescribers.

3. The Contractor shall report any adverse individual credentialing, temporary/provisional credentialing, organizational credentialing or recredentialing decisions made on the basis of quality related issues or concerns to AHCCCS/DHCM, QM within one business day of the determination to take an Aadverse Aaction. The Contractor shall provide notification to AHCCCS of any quality of care concerns within 24 hours of an event, as specified in AMPM Policy 960.

4. The Contractor shall indicate in its notification to AHCCCS/DHCM, QM, the reason or cause of the adverse/denial decision and when restrictions are placed on the provider's contract, including, but not limited to denials or restrictions which are the result of, licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste, or abuse.

   The Contractor shall:
   a. Maintain documentation of implementation of the procedures,
   b. Have an appeal process for instances in which the Contractor places restrictions on the provider's contract based on issues of quality of care and/or service,
   c. Inform the provider of the QM dispute process through the Contractor's QM Department,
   d. Notify AHCCCS/DHCM, QM, of all reported events as specified in this Policy,
   e. Have procedures for reporting to AHCCCS/DHCM, QM, in writing any final Aadverse Aaction for any quality-related reason, taken against a health care provider, supplier/vendor, or practitioner. A "final Aadverse Aaction" does not include an action with respect to a malpractice notice or settlements in which no findings or liability has been made. A final Aadverse Aaction includes:
      i. Civil judgments in Federal or State court related to the delivery of a health care item or service,
      ii. Federal or State criminal convictions related to the delivery of a health care item or service,
      iii. Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including:
         1) Formal or official actions, such as restriction, revocation, or suspension of license (and the length of any such suspension), reprimand, censure, or probation,
         2) 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
         3) Any other negative action or finding by such Federal or State agency that is publicly available information,
         4) Exclusion from participation in Federal or State health care programs (as defined in 42 CFR 455 Subpart B, and
         5) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.
      iv. Any adverse credentialing, provisional credentialing, recredentialing or organizational credentialing decision made on the basis of quality-related issues/concerns or any Aadverse Aaction from a quality or peer review process, that results in denial of a provider to participate in the Contractor's network, provider termination, provider suspension or an action that limits or restricts a provider, and
   f. Submit to the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB):
      i. Within 30 calendar days from the date the final Aadverse Aaction was taken or the date when the Contractor became aware of the final Aadverse Aaction, or
      ii. By the close of the Contractor's next monthly reporting cycle, whichever is later.

5. Notice of a Contractor's final Aadverse Aaction should be sent to AHCCCS/DHCM, QM, within one business day. The Contractor shall report the following information:
   a. The name and Tax Identification Number (TIN) (as defined in 26 U.S. Code ~~section~~ §[16] 7701(A)(41)), ~~of the Internal Revenue Code of 1986[1121]),~~
   b. The name (if known) of any heath care entity with which the health care provider, supplier, or practitioner is affiliated or associated,
   c. The nature of the final Aadverse Aaction and whether such action is on appeal,
   d. A description of the acts or omissions and injuries upon which the final Aadverse Aaction was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section,
   e. The date the final Aadverse Aaction was taken, its effective date and duration of the action,
   f. Corrections of information already reported about any final Aadverse Aaction taken against a health care provider, supplier, or practitioner, and
   g. Documentation that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated and the identity of the provider shall be disclosed to AHCCCS/OIG immediately in accordance with ~~the AHCCCS~~ ACOM Policy 103:
      i. The SAM 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. The LEIE, and
      v. Any other databases directed by AHCCCS or CMS.

6. In accordance with A.R.S. § 36-2918.01 § 36-2905.04, § 36-2932, and ACOM Policy 103, the Contractor, its subcontractors, and providers shall immediately notify the AHCCCS/OIG regarding any allegation of fraud, waste, or abuse of the AHCCCS Program. Notification to AHCCCS/OIG shall be as specified in ACOM Policy 103 and as specified in Contract. This shall include allegations of fraud, waste, or abuse that were resolved internally but involved AHCCCS funds. The Contractor shall also report to AHCCCS, as specified in any credentialing denials issued by the CVO including, but not limited to, those which are the result of licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste, or abuse. AHCCCS/DHCM, QM, shall refer cases, as appropriate, to the AHCCCS/OIG, in accordance with 42 CFR 455.14. The AHCCCS/OIG will then conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation [42 CFR 455.14; 42 CFR 455.17; 42 CFR 455.1(a)(1)].

7. The Contractor shall provide notification regarding credentialing or recredentialing[17] denials and approvals to the applicable provider(s) within 10 days of Credentialing Committee decision.

[16] Added for clarification
[17] Added for clarification

J. CREDENTIALING TIMELINESS AND REPORTING[18]

The Contractor shall process credentialing applications in a timely manner. To assess the timeliness of credentialing, the Contractor shall divide the number of complete applications approved or denied timely during the time period, per category, by the number of complete applications that were received during the time period, per category, as specified in Attachment A.

The Contractor shall submit the Credentialing Report as specified in Contract, ~~and~~ using Attachment A, including ~~outlining~~ specifying any areas of non-compliance and corrective actions taken during the reporting quarter in the comments section of the report. [19]~~Processing t~~Timeline requirements are listed by category below:

CREDENTIALING ACTIVITY	TIME FRAME	COMPLETION REQUIREMENTS
Temporary/Provisional Credentialing	14 Days	100%
Initial Credentialing of Individual Providers	60 Days	100%
Initial Credentialing of 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%

Should AHCCCS have concerns regarding the data reported during the reporting quarter, AHCCCS may require the Contractor to begin submitting this report monthly. The Contractor may submit a request to its designated Operations Compliance Officer to return to quarterly reporting after three consecutive months of compliance having been achieved.[20]

[18] Including 'Reporting' to the header as this section speaks to both items.
[19] Revised as not all timelines are related to 'processing'.
[20] Added language to outlined monthly reporting requirements may be implemented.