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, 09/27/24, 10/01/25, 10/01/26

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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

Refer to the AHCCCS ~~Contract and~~ACOM and AMPM Policy Dictionary[1] for common terms found in this Policy.

For purposes of this policy, the following terms are defined as:

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.

[1] Revised to align with title change.

COMPLETED APPLICATION

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 Drug Enforcement Agency (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).
5. Completed Questionnaire and supporting documentation, if applicable.

CREDENTIALING

The process of obtaining, verifying, and evaluating information regarding applicable licensure, accreditation, certification, educational, and practice requirements to determine whether a provider has the required credentials to deliver specific covered services to members.

ORGANIZATIONAL PROVIDERS

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.

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 Organizational Providers, 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)~~[2].

A. CREDENTIALING PROVIDERS

1. The Contractor shall conduct and document credentialing and recredentialing for providers delivering care and services to AHCCCS members.

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

[2] Removed as the entire 42 CFR 438.214(b) applies.

3. The Contractor shall ensure the credentialing and recredentialing processes:
   a. Do not base credentialing decisions on a provider'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, the Contractor shall retain the right to approve, suspend, or terminate any provider selected by that entity and the Contractor shall 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.

6. The Contractor shall have written policies that 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 verify that each credentialing or recredentialing file was completed and reviewed, as specified in this Policy, prior to the presentation to the credentialing committee for evaluation, and
   d. Include a process for notifying providers of their right to:
      i. Review information the Contractor 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. The Contractor shall maintain an individual electronic or hard copy credentialing/~~-~~recredentialing file for each provider. Each file shall include:
   a. The initial credentialing application and all subsequent recredentialing applications, including attestation by the provider of the correctness and completeness of the application as demonstrated by the provider's signature on the application,
   b. The information gained through credentialing and recredentialing queries,
   c. Any other pertinent information used in determining whether the provider met the Contractor's credentialing and recredentialing standards, and
   d. The specific to recredentialing, utilization data, Quality Of Care (QOC) concerns, grievances, performance measure rates, value-based purchasing results, and level of member satisfaction.

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

9. ~~The~~ For initial c~~C~~redentialing,[3] ~~ed~~ providers shall be entered/loaded into the Contractor's claims payment system within 30 calendar days of Contractor's credentialing committee approval.

10. The 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 Contractor's credentialing committee or the contract effective date, whichever is later.

11. The Contractor shall reimburse providers who are enrolled with AHCCCS and submit claims for covered services provided to members during the credentialing process on or after the date of the provider's Completed Application (as defined in this Policy). If the provider is subsequently not approved through the Contractor's credentialing committee, the Contractor shall recoup the funding.

12. The Contractor shall have an established process to notify providers of the Contractor's credentialing decision (approved or denied) as specified in this Policy.

13. In addition to the information outlined in this Policy, refer to AMPM Policy 965 for additional requirements and exceptions related to credentialing of a Community Service Agency (CSA).

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. The providers in a Federally Qualified Health Center (FQHC),
   b. The providers in a FQHC Look-Alike organization,

[3] Revised to specify credentialing type due to new requirement below (Section B(2)).

c. The Rural Health Clinic (RHC),
d. The hospital employed physicians (when appropriate),
e. The providers needed in medically underserved areas, whether rural or urban,
f. The providers joining an existing and contracted oral health provider group,
g. The covering/substitute providers providing services to the Contractor's members during a provider's absence from the practice,
h. The 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. The 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, the providers ~~information~~ shall be entered/loaded into the Contractor's claims payment ~~information~~ system ~~to allow payment to the provider~~within 7 calendar days to allow payment to the provider.[4]

   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 printout of the license from the applicable Boards' official website denoting that the license is active with no restrictions is acceptable,
   b. Board certification, if applicable, or the highest level of credential attained, and
   c. National Practitioner Data Bank (NPDB) query including the following:
      i. A minimum five-year history of professional liability claims resulting in a judgment or settlement,
      ii. Disciplinary status with regulatory board or agency,
      iii. State sanctions or limitations of licenses, and
      iv. Medicare and Medicaid sanctions, Federal and State exclusions, and terminations for cause as reported to Centers for Medicare and Medicaid Services (CMS).

[4] Added new requirement to ensure timeliness and revised structure for consistency.

4. In situations where a covering/substitute provider shall be utilized by a contracted provider and the covering/substitute provider 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 contracted provider of the need for a covering/substitute provider. The covering/substitute providers shall also meet the following requirements:
   a. Licensure: The providers and employees rendering services to members shall be appropriately licensed in Arizona to render such services as required by Federal or State law or regulatory agencies, and such licenses shall be maintained in good standing,
   b. Restriction of Licensure: The providers shall notify the Contractor within two business days of the loss or restriction of their DEA permit or license or any other action that limits or restricts the Provider's ability to practice or provide services,
   c. Professional Training: The 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: The providers and employees rendering services to members shall provide care and services which meet or exceeds the standard of care and shall comply with all standards of care established by Federal or State law,
   e. Continuing education: The providers and employees rendering care or services to members shall comply with continuing education standards as required by Federal or State law or regulatory agencies,
   f. Regulatory compliance: The providers shall meet the minimum requirements for participating in the Medicaid program as specified by the State and by the Federal government, and
   g. AHCCCS policies: The providers shall comply with all applicable AHCCCS policies and all applicable contractual requirements.

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

Following approval of temporary/provisional credentialing, the Contractor shall complete the entire initial credentialing process for the temporarily/provisionally credentialed provider, 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. The Contractor shall complete individual provider credentialing (and recredentialing) ~~for at least~~that includes but is not limited to[5] ~~-~~the following provider types:
   ~~a.~~ Physicians (~~e.g.,~~ Medical Doctors [MD] and ~~),~~
   ~~b.~~a. Doctors of Osteopathic Medicine [~~(~~DO])[6] ~~)~~,
   ~~c.~~b. Doctor of Podiatric Medicine (DPM),
   ~~d.~~c. Naturopaths (Naturopathic Doctor [ND] or Naturopathic Medical Doctor [NMD]),
   ~~e.~~d. Nurse Practitioners (NP),
   ~~f.~~e. Physician Assistants,

[5] Revised to clarify that this is not an exhaustive list.
[6] Revised for clarity.

f. Certified Nurse Midwives ~~acting as Primary Care Providers (PCP), including prenatal care/delivering providers~~[7],
g. Licensed Midwi~~f~~ves,[8]
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 and Family Therapist (LMFT),
    iv. Licensed Independent Addiction Counselor (LIAC), 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. The covering/substitute oral health providers shall indicate on the claim form that they are the rendering provider of the care or service.

2. T~~At a minimum, t~~he Contractor shall have policies, and procedures for the initial credentialing of individual providers that includes but is not limited to:
    a. A written application to be completed, signed, and dated by the provider that attests to the following elements:
        i. The reasons for any inability to perform the essential functions of the position, with or without accommodation,
        ii. The lack of present illegal drug use,
        iii. The history of loss of license and/or felony convictions,
        iv. The 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. A minimum five-year work history or total work history if less than five years.
    b. The Drug Enforcement Administration (DEA) or Chemical Database Service certification if a prescriber,
    c. The verification from primary sources of:
        i. Licensure or certification,
        ii. Board certification, if applicable, or highest level of credentials attained,

[7] Removed to align with the AHCCCS Provider Enrollment Screening Glossary.
[8] Added to align with the AHCCCS Provider Enrollment Screening Glossary.

iii. For credentialing of Independent Masters Level Behavioral Health Licensed Professionals, including:
   1) Licensed Clinical Social Worker (LCSW),
   2) Licensed Professional Counselor (LPC),
   3) Licensed Marriage/Family Therapist (LMFT), and
   4) Licensed Independent Addiction Counselor (LIAC).

iv. The 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) Current Licensure in good standing by the Arizona Board of Psychologist Examiners,
   2) A review of complaints received, board and disciplinary status through the Arizona Board of Psychologist Examiners, and
   ~~3) Continuing education requirements:~~
      ~~a) All BCBA's credentialed under a three-year Cycle: 36 hours every three years (three hours in ethics and professional behavior), and~~
      ~~b) All 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).~~[9]
   ~~4)~~3) Continuing Education Courses. The BCBAs who supervise the ongoing practice of RBTs or the BCABAs on record or trainees pursuing BCBA or BCABA certification at any point during their recertification cycle must obtain and enter 3 supervision CEUs to recertify. The supervision is behavior analytic in nature and covers effective supervision as described in the Behavioral Analyst Certification Board Supervisor Training Curriculum Outline (2.0) and the Nature of Supervision section.

vi. The 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. An NPDB query including the following:
   1) A 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 and 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).

[9] Removed as it is duplicative and covered under v.(1).

3. The affiliated practice dental hygienists shall provide documentation of the affiliation agreement with an AHCCCS enrolled dentist. Acceptable documentation includes a notice from the Arizona State Board of Dental Examiners confirming the affiliation agreement between the dental hygienist and the enrolled dentist.

4. The providers, including licensed or certified behavioral health providers, may be subject to an initial site visit as part of the credentialing process.

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.

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)].

7. The Contractor shall conduct timely verification of information, as evidenced by the Contractor's credentialing Committee approval (or denial) of a provider within 60 days of a receipt of a Completed Application.

D. RECREDENTIALING OF INDIVIDUAL PROVIDERS

T~~At a minimum, t~~he Contractor shall have recredentialing policies for individual providers that address the recredentialing process and includes but not is not limited to procedures for:

1. Recredentialing at least every three years.

2. A review of updated information obtained during the initial credentialing process, as specified in this Policy.

3. Verifying continuing education requirements being met.

4. Monitoring provider specific information including but not limited to:
   a. The member concerns which include grievances (complaints),
   b. The utilization management information (e.g., emergency room utilization, hospital length of stay, disease prevention, pharmacy utilization),
   c. The performance improvement and monitoring (e.g., performance measure rates),
   d. The results of medical record review audits, if applicable,
   e. The quality Of Care (QOC) issues (including trend data),
   f. The review of any Adverse Actions,
   g. The pay for performance and value driven health care data/outcomes, if applicable, and
   h. The evidence that the provider's policies and procedures meet AHCCCS requirements.

5. Issuing timely approval (or denial) by the Contractor's Credentialing Committee within three years from the previous credentialing approval date.

6. The Primary Source Verification shall also be current, within 180 days, for the Contractor's Credentialing Committee's decision.

E. INITIAL CREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. As a prerequisite to a Contractor contracting with an Organizational Provider, the Contractor shall ensure that the Organizational Provider has established policies and procedures that meet AHCCCS requirements, including policies and procedures for credentialing and recredentialing if credentialing/recredentialing functions are delegated to the Organizational Provider.

2. The requirements specified in this section shall be met for all Organizational Providers included in the Contractor's network including but not limited to:
   a. Hospitals,
   b. Home Health Agencies (HHAs),
   c. Attendant care agencies,
   d. Habilitation providers,
   e. Group homes,
   f. Child/Adult developmental homes,
   g. Nursing supported group homes,
   h. Nursing Facilities (NFs),
   i. Assisted Living Facilities (ALF),
   j. Home delivered meal providers,
   k. Dialysis centers,
   l. Dental and medical schools,
   m. Freestanding surgical centers,
   n. Intermediate Care Facilities (ICFs),
   o. State or local public health clinics. The 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 members (Refer to AMPM Policy 310-M),
   p. Community/rural health clinics (or centers),
   q. Air transportation vendors,
   r. Non-Emergency Medical Transportation (NEMT) vendors,
   s. Laboratories,
   t. Pharmacies,
   u. Respite homes/providers, ~~and~~
   ~~v. Behavioral health facilities, including but not limited to:~~[10]
   ~~w.~~ Independent clinics,
   v.
   ~~x.~~ Federally Qualified Health Centers (FQHCs),
   w.
   ~~y.~~ Community mental health centers,
   x.
   ~~z.~~ Level 1 Sub-Acute Facility (Institution for Mental Disease [IMD] and non-IMD),
   y.

[10] Removed sub-header for consistency and clarity.

~~aa.~~ Intermediate Care Facility/Individuals with Intellectual Disabilities,
z.
~~bb.~~ Level 1 Residential Treatment Center Secure (17+ beds) (IMD),
aa.
~~cc.~~ Level 1 Residential Treatment Center Non-Secure (1-16 beds),
bb.
~~dd.~~ Level 1 Residential Treatment Center Non-Secure (17+ beds) (IMD),
cc.
~~ee.~~ Community Service Agency (CSA),
dd.
~~ff.~~ Crisis services provider/agency,
ee.
~~gg.~~ Behavioral health residential facility,
ff.
~~hh.~~ Behavioral health outpatient clinic,
gg.
~~ii.~~ Integrated clinic,
hh.
~~jj.~~ Rural substance abuse transitional agency, and
ii.
~~kk.~~ Behavioral health therapeutic home~~, and~~.
jj.
~~ll. Respite homes/providers.~~[11]

3. Prior to credentialing and contracting with an Organizational Provider, the Contractor shall:
   a. Confirm that the Organizational Provider has met all the Federal and State licensing and regulatory requirements, including business licensure requirements as applicable, (a copy of the license or letter from the regulatory agency will meet this requirement),
   b. Confirm that the Organizational Provider 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 Provider is not accredited. The Contractor shall develop a process and utilize assessment criteria for each type of unaccredited Organizational Provider for which it contracts that shall include, but is not limited to, confirmation that the Organizational Provider has the following:
      i. A process for ensuring that the Organizational Provider credentials its providers for all employed and contracted providers as specified in this Policy,
      ii. Liability insurance, and

[11] Removed as it is a duplicate; refer to u.

~~ii.~~iii. The CMS certification or State licensure review/audit may be substituted for the required onsite quality assessment, as long as the review/audit 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 Organizational Provider was reviewed/ audited and passed inspection is sufficient documentation 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 Organizational Provider through the Contractor's Credentialing Committee.

F. RECREDENTIALING OF ORGANIZATIONAL PROVIDERS

~~At a minimum, t~~The Contractor shall have recredentialing policies for organizational providers that address the recredentialing process and includes but is not limited to procedures for:

1. Recredentialing at least every three years.

2. A review of updated information obtained during the initial credentialing process.

3. Confirming that the Organizational Provider remains in good standing with Federal and State bodies, and, if applicable, are reviewed and approved by an accrediting body.

4. Confirming that the Organizational Provider is licensed to operate in the State.

5. If an Organizational Provider is not accredited or surveyed and licensed by the State an onsite review shall be conducted.

6. Reviewing 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 AZ Care Check,
   b. The record of onsite inspection of non-licensed Organizational Providers to ensure compliance with service specifications,
   c. The supervision of staff and required documentation of direct supervision/clinical oversight as required in AAC R9-10-115. This process shall include a review of a valid sample of clinical charts,
   d. The most recent audit results of the Organizational Provider,
   e. The confirmation that the service delivery address is verified as correct, and
   f. The review of staff to verify credentials, and that the staff person meets the credentialing requirements.

7. Evaluating Organizational Provider specific information ~~such as,~~that includes but is 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 (QOC) issues,
   e. Onsite quality assessment, and
   f. Review of any Adverse Actions.

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

G. THERAPEUTIC FOSTER CARE PROVIDERS

The Therapeutic Foster Care (TFC) Agencies require credentialing/recredentialing with the Contractor.

The TFC Family Providers are licensed by the Department of Child Safety (DCS) and do not require credentialing/recredentialing with the Contractor.

The~~For~~ TFC Family Providers for children~~,~~ is a submission of a Foster Home License, as specified in AAC Title 21, Chapter 6, Article 1 through Article 4~~, will be accepted as meeting the requirements for credentialing/recredentialing as an AHCCCS provider~~[12].

For information ~~regarding AHCCCS responsibilities~~ related to linking TFC Family Providers to TFC Agencies ~~settings~~, refer to AMPM Policy 320-W.

H. ~~TEACHING~~ SUPERVISING PHYSICIANS AND ~~TEACHING~~ SUPERVISING DENTISTS

AHCCCS permits covered medical services to be furnished in Accreditation Council for Graduate Medical Education (ACGME)-accredited teaching settings by medical residents or by medical students, when services are provided under the appropriate level of supervision by a licensed Arizona physician and in accordance with applicable state and federal laws.

AHCCCS permits covered dental services to be furnished in Commission On Dental Accreditation (CODA)-accredited teaching settings by dental residents or by dental students, when services are provided under the appropriate level of supervision by a licensed Arizona dentist and in accordance with applicable state and federal laws.

Direct supervision occurs when the supervising physician or dentist is physically present with the resident or student and the patient. For medical services, direct supervision may also occur through a synchronous telehealth visit where permitted by applicable law and program requirements.

[12] Revised language in this section to clarify requirements around credentialing for TFC family versus agency providers.

Indirect supervision occurs when the supervising physician or dentist is not physically present with the resident or student and the patient but is immediately available to provide direct supervision. For medical services and telehealth visits, the supervising physician is immediately available to join the synchronous telehealth encounter upon request where permitted by applicable law and program requirements.

Regardless of whether supervision is direct or indirect, the supervising physician or supervising dentist retains the ultimate responsibility for the medical or dental services provided. The supervising physician or supervising dentist shall ensure that services are appropriately delegated, fall within the supervising physician's or supervising dentist's scope of practice, and are commensurate with the education, training, and experience of the resident or student.

~~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~~ supervising licensed physician or ~~teaching~~ supervising licensed dentist shall be an AHCCCS enrolled provider and shall be credentialed by the AHCCCS Contractor(s) in accordance with this Policy.[13]

I. NOTIFICATION REQUIREMENTS

1. The Contractor shall have procedures for prompt reporting in writing to appropriate authorities including AHCCCS, 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, 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, the Contractor shall notify the appropriate agency which may include~~a~~ law enforcement ~~agency~~, ~~as well as~~ Adult Protective Services (APS), or the DCS, within~~shall also be promptly notified, no later than~~ 24 hours ~~after~~ of identification[14]. 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.~~2.

[13] Revised this section for clarity.
[14] Revised for clarity.

~~4.~~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 within one business day of the determination to take an Adverse Action. The notification "Adverse Action to the Provider with rationale (such as but not limited to limitations, suspensions, terminations, and denials, including credentialing/recredentialing denials)" will be sent to AHCCCS QM as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables and this Policy. The Contractor shall provide notification to AHCCCS of any QOC concerns within 24 hours of an event, as specified in AMPM Policy 960.

~~5.~~4. The Contractor shall indicate in its notification to AHCCCS 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, QOC 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 QOC and/or service,
c. Inform the provider of the ~~QM dispute process through the Contractor's QM Department~~ Contractor's appeal process[15],
d. Notify AHCCCS of all reported events as specified in this Policy,
e. Have procedures for reporting to AHCCCS in writing any final Adverse Action for any quality-related reason, taken against a health care provider, supplier/vendor, or practitioner. A "final Adverse Action" does not include an action with respect to a malpractice notice or settlements in which no findings or liability has been made. A final Adverse Action includes:
    i. Civil judgments in Federal or State courts 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,
        3) Any other negative action or findings 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.

[15] Revised to provide clarity that this is referencing the Contractor's appeals process and not Quality Management (QM) dispute process

~~iv.~~ Any adverse credentialing, provisional credentialing, recredentialing or organizational credentialing decision made on the basis of quality-related issues/concerns or any Adverse Action 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.

~~v.~~iv.

f. Submit to the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB):
   i. Within 30 calendar days from the date the final Adverse Action was taken or the date when the Contractor became aware of the final Adverse Action, or
   ii. By the close of the Contractor's next monthly reporting cycle, whichever is later.

~~6.~~5. The Notice of a Contractor's final Adverse Action should be sent to AHCCCS, within one business day. The Contractor shall report the following information:
   a. The name and Tax Identification Number (TIN) (as defined in 26 US Code 7701(A)(41)),
   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 Adverse Action and whether such action is on appeal,
   d. A description of the acts or omissions and injuries upon which the final Adverse Action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section,
   e. The date the final Adverse Action was taken, its effective date and duration of the action,
   f. The corrections of information already reported about any final Adverse Action taken against a health care provider, supplier, or practitioner, and
   g. The 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 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,
      v. The CMS Data Exchange (DEX), and
      vi. Any other databases directed by AHCCCS or CMS.

~~7.~~6. In accordance with ARS 36-2918.01, 36-2905.04, 36-2932, and ACOM Policy 103, the Contractor, its subcontractors, and providers shall notify the AHCCCS OIG regarding any allegation of Fraud, Waste, or Abuse (FWA) of the AHCCCS Program. The notification to AHCCCS OIG shall be as specified in ACOM Policy 103 and as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables. This shall include allegations of FWA 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, QOC concerns, excluded providers, and which are due to alleged FWA. AHCCCS 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)].

~~8.~~7. For Temporary/Provisional and Initial Credentialing, the Contractor shall provide notification regarding credentialing denials and approvals to the applicable provider(s) within 10 days of the Contractor's Credentialing Committee decision.

~~9.~~8. For Recredentialing, the Contractor shall provide notification regarding recredentialing denials to the applicable provider(s) within ~~1~~30[16] days of the Contractor's Credentialing Committee decision.

J. CREDENTIALING TIMELINESS AND REPORTING

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 and 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 AHCCCS Contractor Credentialing Report as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables using Attachment A, including specifying any areas of non-compliance and corrective actions taken during the reporting quarter in the comments section of the report. Attachment A reporting ~~quarter~~ shall be for the current quarter and shall include~~s~~ providers who complete contracting with the Contractor's Arizona Medicaid lines of businesses.[17]
~~.~~Timeline requirements are listed below:

CREDENTIALING ACTIVITY	TIMEFRAME	COMPLETION REQUIREMENTS
RENDER DECISION: TEMPORARY PROVISIONAL CREDENTIALING	14 Days	100%
RENDER DECISION: INITIAL CREDENTIALING OF INDIVIDUAL PROVIDERS	60 Days	100%
RENDER DECISION: INITIAL CREDENTIALING OF ORGANIZATIONAL PROVIDERS	60 Days	100%
RENDER DECISION: RECREDENTIALING OF INDIVIDUAL AND ORGANIZATIONAL PROVIDERS	Every three years	100%

[16] Aligned requirement with NCQA.
[17] Added to clarify AHCCCS' expectations.

INITIAL CREDENTIALING[18] **ENTER/LEAD TIMES: (TIME BETWEEN CREDENTIALING COMMITTEE APPROVAL AND LOADING INTO CLAIMS SYSTEM)**	30 Days	95%
TEMPORARY/PROVISIONAL ENTER/LEAD TIMES: (TIME BETWEEN APPROVAL AND LOADING INTO CLAIMS SYSTEM)	7 Days	95%[19]

~~Should~~ If AHCCCS identifies ~~have~~ concerns with~~regarding~~ the data ~~reported~~ submitted ~~during~~ for the reporting quarter, ~~AHCCCS~~ it may require the Contractor to begin submitting the AHCCCS Contractor Credentialing Report on a monthly basis. If~~Should~~ this occurs, the Contractor may ~~submit a~~ request ~~to its~~approval from its designated Operations Compliance Officer (OCO) to return to quarterly reporting after achieving three consecutive months of compliance ~~having been achieved~~.[20]

[18] Added to clarify the specific type of credentialing this requirement applies to.
[19] New requirement added, refer to section B(2).
[20] Revised for clarity.