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| **MONTCALM CARE NETWORK PROCEDURE**  **611 North State Street, Stanton, MI 48888** | |
| SUBJECT: Credentialing and  Privileging | Section: 7152A |
| Effective Date: November 28, 1995 | Revised Date: December 27, 2023 |

The purpose of this procedure is to ensure that all staff and contracted clinical providers possess the credentials required to perform in their assigned role prior to beginning employment and/or the provision of services.

Management will submit forms to Human Resources (HR) after the candidate accepts a verbal offer of employment. HR will then conduct initial credentialing as outlined below in Section A for all employed staff. The Clinical Director will send selected candidate information to the Provider Network Coordinator if individual will be a contracted provider. Initial privileging (or temporary privileging) is initiated by sending the candidates information to the Provider Network Specialist to complete the process as outlined below in Section C.

These staff and contract providers may include, but are not limited to, professionals such as: Physicians (M.D.'s or D.O.'s); Physician Assistants; Psychologists (licensed, limited license or temporary license); Social workers (licensed master’s, licensed bachelor’s, limited license or registered social service technicians); Licensed or Limited Licensed Professional Counselors; Nurse Practitioners, Registered Nurses or Licensed Practical Nurses; Occupational Therapists or Occupational Therapist Assistants; Physical Therapists or Physical Therapist Assistants; and, Speech Pathologists.

MCN will not, through the credentialing, re-credentialing, and privileging processes outlined, discriminate against staff or contracted clinical providers: solely on the basis of license, registration or certification; or those who serve high-risk populations or specialize in the treatment of conditions that require costly treatment.

Primary source verification guidelines are as defined in Section G below.

# A. Initial Credentialing of Staff

As a condition of hire, the competency of the selected candidate shall be determined as follows:

1. Signed application attesting to not having a condition or impairment that would interfere with duties; no current illegal drug use; no felony convictions; no loss of license or privileges; and the accuracy and completeness of said application.
2. Evaluation of work history for the past five (5) years, or if less than five years, the Entire duration of professional experience.
3. Criminal background check consistent with policy #7251 and procedure #7251A.
4. Primary source verification of terminal transcripts and degree from an accredited school.
5. For licensed staff, the following will also be verified:
   1. Primary source verification of the status of all licenses, certifications, or registrations, including licenses to prescribe medication/controlled substances.
   2. Primary source verification of board certification or highest level of credentials obtained, if applicable, or completion of any required internships/residency programs or other postgraduate training
   3. Review of any citations included on the National Practitioners Data Bank.
   4. Absence from Medicaid/Medicare sanctioned providers lists.
   5. MCN will accept credentialing decisions made by other CMH’s. MCN will request a copy of all the documents used for the decision. MCN will review the documentation at initial hire and upon recredentialing to verify that all Midstate Health Network required documents are part of the package. If the package is incomplete the HR/Provider Network department will contact the CMH to discuss what documentation is missing and ask for the CMH to attain the documents and forward them to the person/department that requested the information.
   6. Network providers residing and/or providing services in bordering states shall meet all applicable licensing and certification requirements within their state of residence and states where they provide services. MCN shall verify all out-of-state licensures and credentials of its utilizing the same processes for in-state verifications.

Documentation of staff credentialing will be gathered by designated staff under the direction of the Fiscal Manager and maintained within the personnel file.

The results of credentialing will be reviewed by supervisory staff. If credentials cannot be verified, staff may be subject to termination from employment and will be notified in writing of such.

# B. Re-Credentialing of Staff

The Provider Network Specialist determines the competency of staff every 24 months as follows

1. Primary source verification of the status of renewed licenses, certifications, registrations, board certifications or highest level of credentials obtained, within thirty (30) days of renewal as applicable.
2. Annual supervisor's appraisal including a review of performance against the requirements of the job description and an update of initial credentialing information to include Medicare/Medicaid sanctions; state sanctions or limitations on licensure, registration, or certification; consumer grievances or appeals; and any relevant quality issues.

The results of credentialing of clinical staff will be reviewed and approved by the Clinical Director. If credentials cannot be verified, staff may be subject to termination from employment and will be notified of such in writing.

# C. Privileging

Privileges to practice will be granted initially and renewed every two years by the Board of Directors for the following clinical providers:

* Contracted licensed independent practitioners
* Staff clinical supervisors
* Staff physicians
* Staff psychologists providing psychological testing

To qualify for initial and renewal of privileges, competence will be determined through a credentialing process as follows:

1. Signed application for privileges attesting to having no condition or impairment that would interfere with duties; no current illegal drug use; no felony convictions; no loss of license or privileges; and the accuracy and completeness of said application.
2. Evaluation of work history for the past five (5) years, or if less than five years, the entire duration of professional experience as provided on a curriculum or vitae (initially only with updates as needed).
3. Primary source verification of terminal transcripts and degree from an accredited school (initially only).
4. Criminal Background check consistent with policy #7251 and procedure #7251A.
5. Primary source verification of the status of all licenses, certifications, or registrations, including licenses to prescribe medication/controlled substances. Network providers residing and/or providing services in bordering states shall meet all applicable licensing and certification requirements within their state of residence and states where they provide services. MCN shall verify all out-of-state licensures and credentials of its network providers utilizing the same processes for in-state verifications.
6. Primary source verification of board certification or highest level of credentials obtained, if applicable, or completion of any required internships/residency programs or other postgraduate training.
7. Review of any citations included on the National Practitioners Data Bank.
8. Absence from Medicaid/Medicare sanctioned providers lists.
9. Verification of liability insurance and review of claims history, if applicable.

Feedback, references, and recommendations from professional peers knowledgeable of the practitioner's work and/or from customers served by the practitioner in the prior twelve months and/or as generated by activities of the Quality Assessment and Performance Improvement program will also be considered as relevant and applicable.

Documentation for privileges will be gathered by designated staff under the direction of the Fiscal Manager and maintained within the personnel or contractor file. Only credentialing files verified as complete by the Executive Director will be forwarded for review and approval of privileges.

A summary of the findings from the privileging process will be forwarded for review by the Personnel Committee and recommendation to the Board of Directors. Providers will be notified in writing within thirty-one (31) days from receipt of completed application as to whether privileges are approved or denied.

# D. Temporary Privileges

Temporary privileges may be granted by the Clinical Director for a period of up to one hundred-fifty (150) days when immediate service delivery is in the best interest of the consumer(s). Minimum competence will be established through the following credentialing process:

1. Signed application for privileges attesting to: No condition or impairment that would interfere with duties; no current illegal drug use; no felony convictions; no loss of license or privileges; and the accuracy and completeness of said application.
2. Evaluation of work history for previous five (5) years as provided on a curriculum or vitae.
3. Primary source verification of the status of all licenses, certifications registrations.
4. Review of any citations included on the National Practitioners Data Bank.
5. Absence from Medicaid/Medicare sanctioned providers lists.

A decision will be made as to the granting of temporary privileges within thirty-one (31) days from receipt of a completed application and will be communicated in writing to the provider. If approved, remaining documentation and verifications for regular privileges will be obtained.

# E. Denial, Suspension, or Termination of Privileges

Privileges to practice may be suspended at any time and at the discretion of the Executive Director pending the investigation of allegations of consumer abuse or neglect, negligence, malpractice, incompetence, violations of professional or Board ethics, loss of license, certification or registration, exclusion from Medicare or Medicaid, or any other circumstances which interfere with the practitioner’s capacity to render professional services.

In the event that such adverse action occurs, the revocation or suspension decision, including the reasons for the action, will be communicated in writing to the provider within ten (10) calendar days of the decision. This action will be reported to the appropriate regulatory body, State and/or Federal authorities, etc., in accordance with current law and as specified in the Medicaid Managed Specialty Supports and Services Contract.

# F. Appeal Process

Staff and Independent Practitioners may request a reconsideration of decisions to deny, suspend, or terminate privileges.

1. The request for reconsideration must be in writing and must be filed with the Executive Director within ten (10) calendar days.
2. The request for reconsideration shall be reviewed by the Personnel Committee of the Board at their next scheduled meeting and a recommendation made to the entire Board for review and action.
3. Both the Practitioner and the Agency can be represented by advocates at this meeting.
4. Both the Practitioner and the Agency may present a reasonable number of witnesses at this meeting.
5. Both the Practitioner and the Agency may file written documents at this meeting.

The Board of Directors shall review the evidence presented and the recommendations of the Personnel Committee and shall be solely responsible for determining the outcome of the appeal.

Notice of the Board's determination shall be provided to the Practitioner within ten (10) calendar days of the review meeting.

G. 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 organizational provider. 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.

Verification time limit will be calculated from the date of verification to the date of the credentialing decision.

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| **Information to Verify** | **Verification Source** | **When** | **Criteria** | **Verification Time Limit** |
| **Application** | Agency Application | ☒ C   * R * E | Completed, signed, and dated application with no positively answered  attestation questions | 365 days |
| **State licensure, if applicable** | LARA – Department of Licensing and Regulatory Affairs | ☒ C  ☒ R  ☒ E | Free from licensing violations and free from special state investigations in the past five (5) years for initial credentialing and two  (2) years for recredentialing. | 180 days |
| **Medicaid/Medicare Exclusions** | List of Excluded Individuals and Entities maintained by the OIG; SAM, and MDHHS List of  Sanctioned Providers or NPDB | ☒ C  ☒ R   * E | Provider is not on the Medicaid/Medicare or MDHHS sanction provider  lists. | 180 days |
| **Malpractice Claims/Professional Liability History** | Any of the following:   * NPDB Query * Written confirmation of past five years history of malpractice history and verify with carrier | ☒ C  ☒ R   * E | Provider attestation is not sufficient. | 180 days |
| **Accreditation, if applicable. *Required* for *SUD Treatment Providers.***  ***CMHSPs must follow accreditation requirements to determine which subcontracted providers must be accredited.*** | Copy of Survey Report | ☒ C  ☒ R  ☒ E | Full accreditation status during the last accreditation review.  For SUD providers, the following accrediting bodies are recognized: CARF, AOA, AAAHC, COA, JC, JCQA.  Clubhouse International Accreditation required for Clubhouse programs Private Duty Nursing: CHAP, ACHC, JC (Home  Health), CARF | 180 days |

C = credentialing R = recredentialing E = upon expiration