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| **MONTCALM CARE NETWORK PROCEDURE 611 North State Street, Stanton, MI 48888** | |
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| SUBJECT: Assurance of Competent  Service from Organizational  Providers | Section: 7152B |
| Effective Date: May 2, 2007 | Revised Date: June 19, 2014 |
| Version: 4 | Status: Current |

Organizations interested in providing services to consumers are required to provide the following documentation:

1. Evidence of internal credentialing and privileging policies and procedures per the standards of their accrediting and/or licensing body, as applicable. This process must minimally include evidence of criminal background checks on all its employees prior to hire and periodically. In addition, the provider will regularly check the Officer of Inspector General and Medicaid and Medicare excluded providers list to prevent fraudulent activity.

a. The organization must demonstrate evidence of a system to ensure competency of its licensed independent practitioners (defined as any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges) through review of:

i. licensure, certification or registration and any sanctions ii. current board certifications or highest level of credential iii. current competence (peer references, work history) iv. the ability to perform clinical responsibilities v. continuing education vi. documentation of graduation from an accredited school vii. Medicare/Medicaid sanctions viii. Criminal background checks

The competency standards applied by the organization must be consistent with those required by Medical Services Administration and Michigan Department of Health & Human Services requirements for the service code, professional discipline or population in question. Any contract provider that does not demonstrate evidence of accreditation, licensure or certification through an appropriate body may be subject to review based on the standards outlined in the PIHP Provider Manual.

1. The organization will be informed of the receipt of any information that varies substantially from expectations and the organization will be given the opportunity to correct any alleged erroneous information.
2. If the provider is approved to be a provider, a contract agreement and claims processing profile is developed to add the provider and service to the Board's Provider Network. If not approved, the potential provider will be notified in writing of the reasons for the denial of

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participation in the Board's Provider Network. The PIHP retains the rights to approve, suspend or terminate any provider.

1. Providers that are denied participation may appeal the decision within seven (7) calendar days of notification by submitting to the Executive Director, in writing, the following:
   1. Statement indicating that a reconsideration is being requested
   2. Explanation/reasoning for the request
   3. Any substantiating documentation relevant to the request

The Executive Director or designee will review all available information and either confirm or rescind the original decision. The provider will be notified in writing within seven (7) calendar days as to the outcome of the appeal.

1. Confirmation that a provider organization continues to meet contractual requirements will occur as established in the Contract Monitoring procedure #7123E.