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Credentialing of Practitioners

I. Purpose:

MHMR operating procedure to define the credentialing and re-credentialing processes for evaluating and selecting qualified, licensed independent practitioners to provide care on behalf of the agency and to ensure processes align with the requirements set forth by all regulatory bodies. This includes, but is not limited to, the National Committee for Quality Assurance Standards (NCQA), Texas Health and Human Services (HHS), Centers for Medicare and Medicaid (CMS), and the Commission on Accreditation of Rehabilitation Facilities (CARF).

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II. Scope:

All MHMR programs with licensed practitioners (credentialed employees/contractors).

III. Responsibility:

All MHMR licensed practitioners (credentialed employees/contractors).

IV. Overview:

A. Application and Verification Process
B. Approval, Notification and Appeal Process
C. Credentialing and Supervision Requirements For Qualified Mental Health Professionals (QMHP)
D. Provisional Privileging
E. Self-Reporting
F. Ongoing Monitoring
G. Reappointment Process
H. Compliance and Training

V. Procedure:

A. Application and Verification Process

1. Credentialing is required for licensed clinical practitioners prior to the licensed clinical practitioner

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providing medical, dental, mental or behavioral health direct care services in any setting.

2. Credentialing is required for clinical supervisors of staff who provide medical, dental, mental or behavioral health direct care services in any setting; and for any staff member for whom credentialing is deemed appropriate.
3. The following list is of licensed practitioner types participating in the MHMR network. All of whom are subject to credentialing:
    a. Advanced Practice Registered Nurse (APRN)
    b. Behavioral Analysts (BCBA)
    c. Dentist
    d. Dietician
    e. Psychologist or Provisionally Licensed Psychologist
    f. Licensed Chemical Dependency Counselor (LCDC) and LCDC-Interns
    g. Licensed Clinical Social Worker (LCSW)
    h. Licensed Baccalaureate Social Worker (LBSW)
    i. Licensed Master Social Worker (LMSW)
    j. Licensed Marriage and Family Therapist (LMFT)
    k. Licensed Psychological Associate (LPA)
    l. Licensed Professional Counselor (LPC) and LPC-Interns
    m. Licensed Vocational Nurse (LVN)
    n. Occupational Therapist (OT)
    o. Physical Therapist (PT)
    p. Physician (MD/DO)
    q. Physician Assistants (PA)
    r. Podiatrist (DPM)
    s. Qualified Mental Health Professional (QMHP)
    t. Registered Dietitian (RDLD)
    u. Registered Nurse (RN)
    v. Speech Language Pathologist (CCC-SLP and SLP-Intern)/Audiologist
4. Each licensed practitioner applicant is provided with the credentialing policy prior to credentialing, and is informed of his/her rights to: review information submitted to support their credentialing application excluding references, recommendations and/or peer-review protected information; to correct erroneous information; to be informed of the status of their credentialing application; and to appeal the credentialing decision.
5. For Credentialing Committee consideration, each practitioner applicant is required to complete and submit the Texas Standardized Credentialing Application (TSCA) and supply the additional supporting documentation outlined in Section A, 4 - 7.
6. As stated on the TSCA, the practitioner applicant is required to submit an answer to each of the disclosure questions on pages 8-9 of the TSCA and must, if applicable, attach the appropriate supporting

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documents regarding any of the following: 1. Reasons for Inability to perform the essential functions of the position; 2. Lack of present illegal drug use; 3. History of loss of license and felony convictions; 4. History of loss or limitation of privileges or disciplinary actions.

7. The application must include a current signed attestation, pages 12-13 of the TSCA, confirming the correctness and completeness of the application. Electronic signatures are accepted, but signature stamps are not acceptable. The attestation must be signed and dated within 90 days of credentialing decision.
8. Additional credentialing documents that must be submitted by the applicant are as follows:
    a. Resume, Curriculum Vitae, or other written documentation of work history for the past five years, which includes the beginning and ending month and year for each position of employment or experience, unless the practitioner has had continuous employment for five years or more with no gap. In such case, providing the year meets the intent of this factor.
    b. Practitioners must provide an explanation, written or verbal, for gaps in employment that exceeds 6 months or greater. The organization documents a verbal clarification in the practitioner's credentialing file. Employment gaps that exceeds 12 months or more must be in writing.
    c. Current malpractice insurance coverage.
    d. Copies of all professional licenses, certifications, Drug Enforcement Agency (DEA) (if applicable), board certifications. All licensed practitioners must present with a current and active Texas state issued license from the relevant Texas board of authority. Practitioners who present with an out-of-state compact license covering their work in the state of Texas are required to provide verifiable documentation via the form of a receipt and application number from the relevant Texas licensing authority/board at the time of application for credentialing/clinical privileging. For military spouse applicants with an out-of-state multi-state compact license covering their work in Texas, if permanent residency is maintained by the spouse in the out-of-state license state then they are eligible.
    e. Copy of the Collaborative Agreement between Supervising Physician and PA's, NP's and APRN. The Collaborative Agreements are reviewed and re-signed at least annually, or as changes are made, and are maintained in the practice setting of the PA or APRN and made available as necessary to verify authority to provide medical aspects of care. The Collaborative agreement must contain the following:
        i. Signature of both the PA, NP or APRN and the Physician(s)
        ii. Prescriptive authority protocol
        iii. Frequency of supervision and medication monitoring, if applicable, must be outlined in the protocol.
9. The Credentialing Manager or designee, reviews the applications and verifies the following information from the designated primary sources occur within 180 days prior to the credentialing decision:

Credentialing Area	Source
Clinical Privileges and Affiliations	Granting institution
Education and Training	Granting educational institution; National Student Clearinghouse; AMA or AOA; ECFMG for foreign graduates licensed after 1986; or the state licensing agency,

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	specialty board or registry if it performs primary source verification and the organization obtains written confirmation of primary source verification from the primary source at least annually or provides a printed, dated screen shot of the state licensing agency specialty board or registry website displaying the statement that it performs primary source verification of practitioners education and training information or provides evidence of a state statute requiring the licensing agency, specialty board or registry to obtain verification of education and training directly from the institution. Only residency programs accredited by the ACGME, AOA, CFPC or Royal College of Physicians and Surgeons of Canada are recognized training institutions.
Practitioner License	State licensing boards from which license(s) was/were issued
National Certifications/ Board Certification	Board Certification issuing board; or, if applicable, AMA or AOA. Certification is required for RDLD, APRN, CRNA, PA, BCBA, OT.
Medicare and Medicaid sanctions	NPDB, Novitas –Medicare/Medicaid Opt-Out, SAM-EPLS and OIG exclusion listings, and/or state reports for previous three years.
Nurse Aide Registry and Employee Misconduct Registry	Texas Department of Aging and Disability Services (DADS) - CARE
Professional liability claims	National Practitioner Data Bank or issuing malpractice carrier under whom the claim was filed.
Other	Reports Provided By: National Plan & Provider Enumeration System (NPPES), Social Security Administration-Business Services Online (SSO-BSO), Death Master File (DMF), Texas Department of Public Safety Criminal History Search, Client Abuse and Neglect Reporting System, MHMR Quality Department reports, MHMR Compliance Officer, MHMR Electronic Health Record Monitor, MHMR Clinical Supervision, Contract Monitor, Auditor and Surveyors listed on Addendum E, Licensing boards.

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10. The Credentialing Manager/Designee ensures that:
    a. All documentation submitted by the applicant is date stamped upon receipt.
    b. All verifications contain the citing of the verification source, verification date and reviewers initials or signature, and are received within 180 days prior to the credentialing decision. Verbal verifications are documented in writing by the credentialing department personnel who received the verification and contain the previously listed elements.
    c. All verifications and credentialing documentation submitted by applicant are included in the credentials file and presented for review by Medical Director or designee and/or Credentialing Committee.
    d. Practitioner license is active and current and in good standing with the state licensing board.

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e. NPDB report is obtained from the National Practitioner Data Bank.

f. DEA certificate is current at the time of the credentialing decision and DEA registration status is verified with the DEA or NTIS. If DEA registration is pending, evidence of an agreement with another practitioner/source to prescribe until DEA registration is confirmed. Physician Assistants and Advanced Practice Nurses must have prescriptive authority agreements in the State of Texas with a sponsoring physician.

g. Highest level of education and training obtained by the practitioners is verified as appropriate; Board Certifications are verified through the applicable board website or the AMA, if applicable.

h. Applicant has never been convicted of a criminal offense related to health care or that are listed by a federal or state agency as debarred, excluded, or ineligible for participation in federally or state funded health care programs. Any such conviction makes applicant ineligible for employment and thusly, privileges at MHMR.

i. The credentialing checklist is complete and includes for each verification: the source, the date, the signature or initials of the person who verified the information, and the report date, if applicable.

11. If verification data conflicts with information reported on the credentialing application:

    a. Right to Correct Erroneous Information,when credentialing information from other sources differs from or does not support information provided, the practitioner has the right to correct the erroneous information or information creating the discrepancy. The process of correction includes:

        i. A notification of discrepancy or error within 5 calendar days of identifying an incomplete application via telephone or email will be sent by a member of the credentialing office.

        ii. The practitioner shall respond to the member of the credentialing office with corrected documentation or information within five (5) calendar days of receipt of notification.

        iii. If the practitioner requests a copy of the documentation provided by the external source, the request for the release must be written and signed by the practitioner.

            ▪ The documentation released will be sent via certified or registered mail to the practitioner.

            ▪ Corporate counsel will have approved the type of information or documentation to be released.

        iv. Corrected information or documentation will be submitted to Credentialing Committee with the completed application if the practitioner does not meet baseline credentialing requirements.

        v. The practitioner will then be notified of the final decision in accordance with this policy.

    b. Right to be informed of Application Status

        i. Practitioners may request the status of their application by telephone, fax, email, or U.S. mail by contacting the credentialing office.

        ii. The credentialing office will respond to the application status request within three business days of the request.

12. Non-Discrimation Practices

    a. MHMR will not discriminate against any practitioner due to race; color; national or ethnic origin; age; religion; disability; sex; sexual orientation; gender; gender identity and expression, including a transgender identity; genetics; veteran status; retaliation; and any other characteristic protected under applicable federal or state law, herein called “protected categories.

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b. Monitor activities to ensure non-discrimination during the credentialing process will include:
    i. Maintain a heterogeneous committee membership and the requirement for those responsible for credentialing decisions to sign a non discriminatory confidentiality statement affirming that they do not discriminate annually.
    ii. Periodic audits of practitioners of credentialing files (In-process and approved).
    iii. Annual audits of practitioner complaints for evidence of alleged discrimination.

B. Approval, Notification, and Appeal Process

1. A. Upon initial credentialing, a file must be fully credential and submitted for approval to either the Medical Director or Committee and a decision made within 90 days of receiving the completed credentialing application.
2. Credentialing Manager/Designee reviews completed credentials file and channels it for approval in one of two directions: Clean File Review Process for Initial and Reappointment Files or the Standard Credentialing Committee Review Process for Initial and Reappointment Files.
3. Clean File Criteria:
    a. No history of malpractice claims settlements or judgments as reported by the National Practitioner Data Bank or by self- attestation within the most recent 5 years.
    b. No history of substance abuse or an incomplete substance abuse program within the most recent five years. Completed programs must be accompanied by a letter of advocacy from the appropriate agency.
    c. No history of exclusions, sanctions, revocations, involuntary relinquishments, terminations, suspensions, or limitations within the most recent five years and no related unresolved issues greater than five years for the following:
        i. Licensure
        ii. Drug Registration
        iii. Clinical Privileges
        iv. Participation in Manage Care Organization Networks
        v. Medicare/Medicaid
        vi. Board Certification
        vii. Professional Certification
        viii. Mal Practice Insurance
        ix. Social Security or Office of Foreign Assets Control
4. Clean File Review Process routing is for files which have no negative reporting from verification sources or ongoing monitoring.
5. Clean File Process below:
    a. The Credentialing Manager or designee presents the credentials file and credentialing checklist to the Medical Director/Designee for review.
    b. Medical Director or designee reviews credentials file and may approve the applicant file by signing and dating the credentialing checklist or privileging review form.

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c. The Credentialing Manager or designee executes the privileging approval on the date signed/ approved by the Medical Director and notifies the applicant, Network Management, Billing, Purchasing, and Clinic Director of the privileging decision within 60 days of the credentialing decision.

d. Alternatively, the Credentialing Manager/Designee executes the Medical Director's request to present the credentials file to the Credentialing Committee for full review as outline in Section B, 'Standard Credentialing Committee Review Process for Initial and Reappointment Files.

6. Standard Credentialing Committee Review Process:

   a. The Credentialing Manager/Designee presents the credentials file and credentialing checklist to the Credentialing Committee for review.

   b. The Credentialing Committee reviews the credentials file and determines, with a majority vote, to take one of the following actions on each application: approve the request for credentialing; deny the request for credentialing, cite in writing reasons for the denial; or table the decision in lieu of clarification or additional information request.

7. The Credentialing Manager or designee ensures that committee determinations and activities are documented through published minutes and maintains application records.

8. The Credentialing Manager or designee executes the privileging decision made by the Credentialing Committee on the date of the Credentialing Committee determination and notifies applicant, Network Management, Billing, Purchasing, and Clinic Director of the privileging decision within 60 days of Credentialing Committee decision.

9. Credentialing Applicant may appeal the decision of the Credentialing Committee. To appeal, the applicant must submit a written appeal by mail, email or fax, with any necessary additional documentation for the Credentialing Committee to review and consider within 30 working days of the date of privileging decision notification.

10. Within 30 days of receipt of the written appeal from the applicant, the Credentialing Committee convenes to hear the applicant and to allow the applicant the opportunity to ask/answer questions about the credentialing and privileging decision, and to discuss any relevant information which applicant believes may affect the Credentialing Committee's determination.

11. Within 30 days of the hearing of the information presented by the applicant during the appeals process, the Credentialing Committee convenes to decide, by majority vote, whether to uphold their original decision or to reverse it and approve the applicant's request for credentialing. If necessary, the Credentialing Committee may summon the review and input from a licensed, credentialed practitioner on staff who holds the same license as the applicant.

12. Within 60 days of the Credentialing Committee decision, the Credentialing Manager/Designee provides written notification of the Credentialing Committee's decision and reasons for the appeal decision to the applicant, Network Management, Billing, Purchasing, and Clinic Director.

13. The appeal process outlined above may be restarted by the applicant if the original decision by the Credentialing Committee is not overturned. No additional appeal opportunity may be given after the second appeal of the original credentialing decision. The outcome of the second appeal is final.

14. Within 60 days of the Credentialing Committee decision, the Credentialing Manager/Designee provides written notification of the Credentialing Committee's decision and reasons for the appeal decision to the applicant, Network Management, Billing, Purchasing, and Clinic Director.

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C. Credentialing and Supervision Requirements For Qualified Mental Health Professional (QMHP)

1. Credentialing is required for a Qualified Mental Health Professional (QMHP) prior to the QMHP providing medical, dental, mental or behavioral health direct care services in any setting; is required for Clinical Supervisors of QMHP staff who provide medical, dental, mental or behavioral health direct care services in any setting; and for any staff member for whom credentialing is deemed appropriate.
2. The following criteria must be met in order for the applicant to qualify for QMHP certification and privileges:
   a. Must have obtained a Bachelor's Degree from an accredited college or university with a major in social, behavioral, or human services (as defined by Department of State Health Services (DSHS) and outlined on Addendum D, 'Educational Requirements for QMHP Credentialing;' Or in place of a qualifying degree, may hold a Registered Nurse license in the state of Texas and be supervised in accordance with operating procedure PSY-011, Supervision of Nurses.
   b. Are clinically supervised by a physician, psychologist, LCSW, LPC, or LMFT; or a Certified QMHP who is supervised by a physician, doctoral level psychologist, LCSW, LPC, or LMFT; RNs are supervised by Advanced Nurse Practitioners or, in the absence of an APRN, by physicians.
   c. Have demonstrated competency in the work to be performed through completion of the training outlined on the QMHP Training Checklist and successful completion of the 'QMHP Clinical Supervision Summary Form,' aka Privileging Review conducted by the Clinical Supervisor after training completion. The Clinical Supervisor evaluates via the 'QMHP Clinical Supervision Summary Form,' the following areas of competency:
      i. Adequate screening and crisis intervention skills, including knowledge of MHMR procedures
      ii. Appropriate display of respect and concern for the dignity of the individuals we serve and their family members
      iii. Cultural awareness and sensitivity
      iv. Ability to recognize, report, and record side effects of psychotropic medications
      v. Proper completion of the Uniform Assessment – Texas Resiliency and Recovery (UATRR)
      vi. Achieves established benchmarks with measurable outcomes in the comprehensive treatment plan
      vii. Maintaining progress notes in the clinical record which reflect progress toward outcomes in the treatment plan and other clinically significant activities or events
      viii. Integration of the UATRR, treatment plan, and progress note information as evidenced in documentation and QMHP interventions
      ix. Consistent professional therapeutic boundaries, ethical behavior, and consultation with clinical or administrative supervisor as needed
      x. Note: Clinical supervisors may deem a competency area not applicable, based on the job duties of the QMHP, documenting with an “N/A” notation and signature.
3. Within 45 days of the QMHP candidate hire date, the QMHP candidate must submit a completed Application for Certification and documentation of the completed training (QMHP Training Checklist) and demonstrated competency with recommendation from Clinical Supervisor ('QMHP Clinical Supervision

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Summary Form' aka Privileging Review) to the Credentialing Manager/Designee to initiate the credentialing process. If documentation is not received within 45 days of hire date, the QMHP candidate is referred to Human Resources for an Employment Status Review for non-conformity to Credentialing Criteria.

4. The applicable primary source verifications outlined in Section A are conducted by the Credentialing Manager/Designee within 180 days prior to the credentialing decision.
5. If verification data conflicts with information reported on the QMHP candidate application, the Credentialing Manager/Designee notifies the applicant in writing via mail, fax, or e-mail of the discrepancies, unless the information is protected by law, and of the process to correct the information in question. Applicant must submit a written response with supporting documentation within 30 days of the notification letter date. If the applicant does not respond within the 30 days, the Credentialing Manager/ Designee voids the application and reports non-compliance to Human Resources.
6. Credentialing Manager/Designee reviews completed credentials file and channels it for approval in one of two directions: Clean File Review Process for Initial and Reappointment Files or the Standard Credentialing Committee Review Process for Initial and Reappointment Files as defined in Section B of this Policy.
7. Within 60 days of the decision, the Credentialing Manager/Designee notifies the QMHP applicant, clinical supervisor, and administrative supervisor, Client Accounting, Behavioral Health (BH) Continuous Quality Improvement (CQI) Program Director and the Program Director in writing of the Credentialing Committee's determination.
8. The applicant may appeal the decision according to the process described in Section B of this operating procedure.
9. The QMHP Clinical Supervisor is responsible for notifying the administrative supervisor of identified clinical issues. The Clinical Supervisors is responsible for collaborating and communicating with each other regarding operating procedures and information needed to integrate the supervision functions. Additionally, after initial appointment by the Credentialing Committee, the QMHP and QMHP Clinical Supervisor are jointly responsible for submitting proper documentation of clinical supervision activities and demonstrated competency annually to the Credentialing Manager/Designee to verify the completion of the following ongoing supervision requirements:
    a. 12 hours of Clinical Supervision, minimally, per year; four of those hours must be one-on-one supervision. The remaining eight hours may be provided in a group format QMHP at the supervisors discretion. QMHP who hold licenses in the behavioral sciences, or who are licensed as a RN, are exempt from clinical supervision activities, but are subject to peer review processes according to the Nursing Peer Review Policy and the credentialing license verification process which requires that the license be kept current, active and in good-standing with the applicable licensing board.
    b. Clinical chart review conducted by Clinical Supervisor of at least one patient record per QMHP, per quarter. The clinical supervisor's must ensure that the QMHP is providing clinically appropriate interventions and services and properly documenting those actions, and provide ongoing education and training as necessary.
    c. Each QMHP must participate in at least four hours of training per year beyond that required for their job, and one of those hours must be in ethics or professional boundaries.

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D. Provisional Privileging

1. A practitioner may apply for one-time provisional privileges.
2. Provisional credentialing applications are subject to the credentialing process defined in Sections A and B of this operating procedure.
   a. Verifies the following required time limits:
      i. A current, valid license to practice
      ii. The past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank
      iii. A current and signed application with attestation
3. Provisionally credentialed practitioners are held in provisional status for no longer than 60 calendar days.
4. Provisional providers will be granted provisional credentialing privileges only once and for no more than 60 days. If provider will be working beyond the 60-day provisional limit, provider must go through the regular credentialing process outlined in this operating procedure to include on-going monitoring and sanctions.
5. The Credentialing Manager or designee executes the privileging decision made by the Credentialing Committee on the date of the Credentialing Committee determination and notifies applicant, Network Management, Billing, Purchasing, and Clinic Director of the privileging decision within 60 days of Credentialing Committee decision.
6. The applicant may appeal the decision according to the process described in Section B of this policy.

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E. Self-Reporting

1. Employees, volunteers, contractors, and consultants must report to their immediate supervisor and the Credentialing Department:
   a. A conviction or offense with which an individual is charged after employment begins or volunteer status or after execution of the contractor's contract.
   b. An individual is listed as revoked in the Nurse Aide Registry or as unemployable in the Employee Misconduct Registry after starting employment or volunteer status or after execution of the contractor's contract.
   c. Any new requirements for monitoring, new investigations, sanctions, restrictions or professional liability claims, settlements, or suites to the Credentialing Department.
2. Individuals failing to self-report will be subject to progressive discipline or termination, per MHMR operating procedures.

F. Ongoing Monitoring

1. The Credentialing Manager or designee ensures all practitioners who hold privileges continue to meet the credentialing criteria defined in Section A and B of this operating procedure, and the ongoing monitoring requirements as it pertains to their privileges and scope of practice:
   a. Verification is collected prior to the expiration of the practitioner's current license. Additionally, the Credentialing Manager or designee requests a copy of the renewed license from the practitioner. In the case that the practitioner license is not renewed, or no longer current, active and in good-

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standing with the board, then the practitioner privileges and practitioner access to the Electronic Health Record (EHR) are suspended until the license status is renewed and verified as current, active and in good-standing with the licensing board.

   b. The Credentialing Manager or designee provides written notification on the day of the suspension to the Practitioner, Clinical Supervisor, Administrative Supervisor, Director of Patient Financial Services (PFS), the Medical Director, Program Director, and Contract Administrator if applicable. Once the licensing requirements have been fulfilled the practitioner privileges and access to the EHR are reactivated. The Credentialing Manager or designee provides written notification on the day of the reactivation to the practitioner, clinical supervisor, and administrative supervisor, Director of PFS, the Medical Director, Program Director, and Contract Administrator if applicable.

2. Practitioner privileges may be suspended for administrative reasons at the discretion of the Credentialing Manager or designee. The Credentialing Manager or designee provides written notification on the day of the suspension to the Practitioner, Clinical Supervisor, Administrative Supervisor, Director of PFS, the Medical Director, and the Program Director. Once the administrative requirements have been fulfilled the practitioner privileges are reactivated. The Credentialing Manager or designee provides written notification on the day of the reactivation to the practitioner, clinical supervisor, and administrative supervisor, Director of PFS, the Medical Director, Program Director, and Contract Administrator if applicable.

3. Credentialing Manager or designee monitors the state licensing boards applicable to the scope of practice at MHMR each month for sanctions, exclusions and/or disciplinary action information and ensures appropriate action is taken when practitioners who hold privileges at MHMR are reported.

   a. The reports are downloaded each month and maintained in PDF format on the credentialing drive.

   b. The State Sanction Review Form is completed monthly after all board websites have been reviewed and maintained on the credentialing drive.

   c. MHMR reviews information within 30 calendar days of its release by the reporting entity. If the reporting entity does not publish sanction information on a set schedule, the organization will document that the reporting entity does not release information on a set schedule and will query for this information at least every six months. If the reporting entity does not release sanction information reports, the organization will conduct individual queries of credentialed practitioners every 12-18 months.

4. The Novitas-Medicare/Medicaid Opt-Out, Office of Inspector General (OIG) and System for Award Management (SAM) websites are monitored each month and the results are maintained on the Sanction Review Report.

   a. The MHMR Information Technology (IT) department will match any hits of "names only" from the OIG State and Federal database list to condense the exclusions list to a possible match with MHMR employees and contractors and forward to Credentialing Manager for further review.

   b. The Billing Manager and the Credentialing Manager monitor the monthly Texas Medicaid Bulletin listing of Excluded Providers to identify any potential OIG exclusions.

   c. Any confirmed hits are reported and addressed according to Addendum E, ‘Office of Inspector General (OIG) BEFORE the applicant is Hire and when doing Monthly checks.

5. The nursing staff and medical staff adhere to an established peer review process that is conducted as per the requirements of the state licensing body, and are intended to promote sound clinical practice, promote professional growth and comply with applicable state laws unique to each professional peer group.

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6. The Credentialing Manager/Designee maintains current information regarding practitioner performance through membership in the BH CQI Committee and ongoing consultation with staff from the areas of Utilization Review (UR), Network Management, Provider Relations, Rights, and the Compliance Officer.
7. Contract Monitoring is conducted by the QM Department in each division of MHMR. The QM Department conducts quality monitoring in accordance with the laws and standards set forth by the bodies of regulatory oversight and participates in regulatory oversight audits. QM and/or the Contract Monitor will provide written notification of any actions taken to the practitioner. The notification will inform the practitioner of the action, reason for the action, a summary of appeal rights if applicable, time line to appeal (30 days from the receipt of notice), and notification of their right to representation.
8. MHMR investigates practitioner-specific patient/member complaints and adverse events upon their receipt and evaluates the practitioner's history of complaints and adverse advents, if applicable. MHMR also evaluate the history of complaints/adverse events for all practitioners at least every 6 months. The organization may limit monitoring of adverse events to primary care practitioners and high-volume health care practitioners. If there is evidence of poor quality that could affect the health and safety of people served, this information is moved forward to the Medical Director. At the discretion of the Medical Director, intervention may be assigned, and/or the practitioner may be referred to and reviewed by Credentials Committee for a recommendation on intervention.
9. MHMR detects and evaluates complaints related to the quality of all provider sites. A Site Assessment is performed after three site-specific complaints are received within 60 consecutive calendar days. Complaints may be related to physical accessibility, appearance and space. The Site Assessor evaluates the site's physical accessibility, physical appearance, appointment availability, and exam/waiting room space. A minimum passing score of 95% is required for all Annual Site Assessments. Site Assessments that do not meet the requirement of 95% of higher are evaluated every six months until deficiencies are resolved.
10. MHMR requires all employment related disputes to be settled by binding arbitration and to waive all rights which either party may have regarding taking employment-related disputes to state or federal courts; in addition, waive the right to participate in class or collective action lawsuits.
11. Sub-Delegation – MHMR does not currently sub-delegate any of its credentialing functions.

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G. Reappointment Process

1. Practitioners are credentialed every 36 months, with the credentialing decision made effective prior to the last day of the month in which the 36th month falls.
    a. Re-credentialing cycle time frame can be extended for a practitioner (Beyond 36 Months) if:
        i. On active military assignment
        ii. On medical leave (Ex. Maternity Leave)
        iii. On Sabbatical
    b. MHMR will document this and re-credential the practitioner within 60 calendar days of the practitioners return to practice.
2. At least 60 days prior to the expiration of the current credentialing status, the Credentialing Manager or designee notifies the practitioners of expiring appointment and makes available the forms required to apply for reappointment.
3. The Credentialing Manager or designee completes the Reappointment Tracking Form with information

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collected from the QM/UM Department for Chart Review Outcome collection, Compliance Officer for Complaint/Investigation information collection, Peer Review Committee Chairperson for Peer Review Outcomes (where applicable), Clinical Practice Transformation Program Director for Electronic Health Record and Charting Deficiency collection, and to the Clinical Supervisor for final review of provider performance outcomes.

4. Credentialing Manager or designee conducts the following primary source verifications (from the sources cited in Section A) within 180 days prior to the credentialing decision:
   a. State License
   b. Professional liability proof of coverage with a minimum of $500,000/$1,000,000 for contractors and $1,000,000/$3,000,000 for MHMR employees, volunteers and interns.
   c. APRN/NP/PA Collaborative Agreement, prescriptive authority and protocols.
   d. Hospital affiliations and external memberships.
   e. All applicable board certifications.
   f. SAM and Novitas – Medicare/Medicaid Opt-Out - Medicare and/or Medicaid sanctions.
   g. Sanction/licensure limitations.
   h. PDB professional liability claims.
   i. Ongoing Monitoring Reports via The Reappointment Tracking Form and/or Supervision Reports for QMHP.
5. Any quality issues identified are recorded by the supervisor, and when applicable, the contract monitor is notified. The supervisor and if applicable, the contract monitor prepare may submit a plan of improvement proposal to the Credentialing Manager or designee for the reappointment file.
6. The Credentialing Manager or designee reviews the reappointment file and channels it for approval in one of two directions: Clean File Review Process or the Standard Credentialing Committee Review Process described in Section B of this policy.
7. The Credentialing Manager or designee executes the privileging decision made by the Credentialing Committee on the date of the Credentialing Committee meeting and notifies applicant, Network Management, Billing, Purchasing, and Clinic Director of the privileging decision within 60 days of Credentialing Committee decision.
8. Any applicant may appeal the decision according to the process described in Section B of this policy.
9. Termination and Reinstatement
   a. If the organization terminates a practitioner for administrative reasons (example the practitioner fails to provide a complete credentialing application)and not for quality reasons. It may reinstate the practitioner within 30 calendar days of termination and is not required to perform initial credentialing. The organization performs initial credentialing if reinstatement is more than 30 calendar days after termination.

H. Compliance & Training

1. All persons, including employees, temporary workers, volunteers, and governing body members, involved in administering or delivering Medicare Advantage benefits must, at a minimum, receive general compliance training within 30 days of initial hiring, and annually thereafter.
2. All persons, including employees, temporary workers, volunteers, and governing body members, who

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have involvement in the administration or delivery of Parts C and D benefits must, at a minimum, receive Fraud Waste and Abuse (FWA) training within 30 days of initial hiring (or contracting in the case of First Tier, Downstream and Related Entities (FDRs)), and annually thereafter. Additional, specialized or refresher training may be provided on issues posing FWA risks based on the individual's job function (e.g., pharmacist, statistician, customer service, etc.).

3. The MHMR Training Department ensures compliance of employee training. Tracking and managing of training compliance is done in the agency electronic training management system.
4. Prior to hire date and on a monthly basis, MHMR reviews the HHS OIG list of excluded individuals and SAM list of excluded parties for any new or temporary employee, volunteer, consultant, governing body member, or FDR to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs is required.
    a. MHMR will neither knowingly employ nor contract with individuals or businesses that have been convicted of a criminal offense related to health care or that are listed by a federal or state agency as debarred, excluded, or ineligible for participation in federally or state funded health care programs.
    b. If any employee or contractor is charged with criminal offenses related to health care or is being evaluated for debarment or exclusion, such individuals or businesses will be removed from direct responsibility for any federally or state funded health care program. Upon conviction, debarment or exclusion action, MHMR will terminate the employment or contractual relationship with such individuals or businesses.
    c. The Human Resources (HR) Department and Contracts Management will coordinate with the Compliance Officer to develop appropriate screening procedures for job applicants, employees and contractors.
5. Standards of Conduct and Compliance Policies and procedures are available for review within 90 days on the MHMR intranet website at hire, annually, and when there are updates.
6. All credentialing operating procedures will be reviewed annually. Review Dates should be included within your policies. If policies are not signed then minutes should be presented as evidence and or review and approval.
7. The agency does not utilize offshore contractors or subcontractors. Should MHMR wish to utilize offshore resources in the future, the agency will agree to request health plan approval 30 days prior to entering any agreement to utilize offshore contractors or subcontractors.
8. The Credentialing Manager or designee ensures committee determinations and activities are documented through published minutes and securely maintains application records as follows: Approved applicants' files are maintained indefinitely. Denied applicants' and incomplete files are maintained for two years.
9. Credentialing Files are 5% paper files and 95% electronic files. Paper files are stored in locked file cabinets in the Credentialing Department. Electronic files are stored on the MHMR H Drive, which is kept securely by the IT Department's multi-layered security system that is HIPAA and FERPA compliant.

VI. Definitions:

- Credentialing: The process of assessing and validating the qualifications of licensed professionals and QMHP who provide publicly-funded direct care or of licensed professionals who provide clinical supervision of direct-care services. Credentialing is based on the evaluation of the practitioner's current license or certification, education, training, and professional experience.
- Re-credentialing: The process of assessing and validating the qualifications of licensed professionals and

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QMHP who provide publicly-funded direct care or of licensed professionals who provide clinical supervision of direct-care services. Re-credentialing is based on the evaluation of the practitioner's current license or certification, training, and professional experience, as well as information obtained since the last Credentialing period in the areas of consumer complaints; quality reviews and/or quality improvement activities; utilization management, including provider profiling; member satisfaction through satisfaction surveys; clinical record reviews; and site visits.

VII. References:

A. National Committee for Quality Assurance Standards

B. Nursing Practice Act

C. MHMR Operating Procedure Credentialing Committee

D. MHMR Operating Procedure Quality Reviews for Network Providers

E. MHMR Operating Procedure Background Clearance

F. MHMR Operating Procedure Supervision of Nurses

G. MHMR Operating Procedure HR-035

H. Texas Standardized Credentialing Application

I. Texas State Board of Medical Examiners Rules

J. Texas State Board of Nursing

K. Texas Administrative Code, Mental Health Community Services Standards, Chapter 412, Subchapter G

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Attachments

No Attachments

Approval Signatures

Approver	Date
Catherine Carlton: Chief of Staff	04/2020
Stacey Durr: Managing Director of Serv	04/2020
Lucas Wilson: Chief Financial Officer	04/2020
Janet Davis: Director of Electronic He	04/2020
Brandi Brooks: Provider Enrollment Manag	04/2020
Karri Collins: Director of PFS and Crede	04/2020
Kristin Alonzo: Financial Compliance Mana	02/2020

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