

Behavioral HealthCare, Inc.

155 Inverness Drive West, Englewood CO 80112-1411

Credentialing

Subject: Provider Credentialing & Recredentialing		Effective Date: 1/1/98
Authorized by: Teresa Summers Director of Provider Relations	Page: 1 of 23	Review Date: 04/01/99, 04/01/00, 12/31/01, 11/03/03, 11/05/04, 06/22/05, 02/3/06, 09/11/06, 06/18/07, 12/31/07

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Purpose

To direct the credentialing and recredentialing of behavioral health professionals with whom it contracts or employs, and who render services or authorize services to members, and who fall within the Contractor's scope of authority and action.

CR1 A1. Types of Practitioners Credentialed and Re-credentialed by BHI

BHI's provider network generally consists of, but is not limited to, Doctors of Medicine (MDs), Doctors of Osteopathic Medicine (DOs), PhD, PsyD, LPsy, LCSW, LPC, LMFT, RN NP or CNS or RXN and other licensed independent practitioners with whom it contracts or employs, and who render services or authorize services to members, and who fall within the Contractor's scope of authority and action.

BHI will assess organizational providers with which it intends to contract. These providers include hospitals, residential care facilities, Community Mental Health Centers, outpatient provider groups, and child placement agencies. Please see Facility Credentialing Below.

CR1 A2. Criteria for Credentialing and Recredentialing

BHI will utilize this criterion to outline the minimum requirements to be met by an applying network practitioner.

Psychiatrists

- Must be a Doctor of Medicine (MD) or Doctor of Osteopathy (DO)
- Must be board certified or eligible, as defined by the American Board of Psychiatry and Neurology
- Must be licensed by the state of Colorado
- Must possess current DEA certificate
- Must possess current State Controlled Substance Registration certificate
- Must complete a training program approved by the American Council of Graduate Medical Education (ACGME) or Osteopathic approved training program in psychiatry
- Must possess an Education Council for Foreign Medical Graduates (ECFMG) certificate, if graduate of foreign medical school

Psychologists

- Must be licensed independently as a clinical psychologist at the highest level in the state of Colorado
- Must possess a Doctoral Degree in Psychology (PhD, EdD, PsyD) from an accredited college or university

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Social Workers

- Must possess a Master's Degree in Social Work from a graduate school of social work accredited by the Council on Social Work Education
- Must be licensed by the state of Colorado or certified to practice at the highest level of independent practice in the state of Colorado

Psychiatric Nurses/Clinical Specialists (APN/NP/CS/CNS/RXN)

- Must possess a Master's degree in psychiatric nursing from an accredited college or university
- Must be licensed by the state of Colorado to practice at the highest level of independent practice in the state of Colorado
- If RXN, must be licensed by the state of Colorado with prescriptive authority privileges

Other Clinicians (Licensed Marriage and Family Therapist, Licensed Professional Counselors)

- Must possess a Master's degree in field of practice from an accredited college or university
- Must be licensed by the state of Colorado or certified at the highest level of independent practice in the state of Colorado

Clinical Experience

All eligible practitioners must have a minimum of five (5) years post licensure experience in a mental health/substance abuse setting providing direct patient care.

Professional Liability Coverage

- Psychiatrists: \$1,000,000 per individual episode; \$3,000,000 aggregate
- All other clinicians: \$1,000,000 per individual episode; \$3,000,000 aggregate

General Office Liability

Comprehensive general or Umbrella Liability: \$1,000,000 per individual episode; \$1,000,000 aggregate

Availability

All practitioners must be accessible 24 hours a day, seven days a week or make appropriate arrangements for consumer care. In addition, each practitioner must agree to make every effort to be available for appointments as follows:

- Emergency evaluation/face to face within 1 hour
- Urgent needs met within 48 hours
- Routine evaluations within seven (7) days

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Providers who serve high-risk populations

BHI does not discriminate against providers who serve high-risk populations. BHI has determined that 75% of its population meets the HCFA definition of Special Health Care Needs. As such this population requires intensive treatments such as home based services, intensive case management services, residential treatments and inpatient treatments and recruits these providers intentionally.

Providers excluded from participation

In conjunction with policies and procedures developed and administered by the Human Resources and Provider Relations Departments, all current and new employees and all subcontracted clinical providers are screened to determine whether they have been (1) convicted of a criminal offense related to health care; or (2) listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation, as required by current federal and state laws. The latter is verified through the Office of Inspector General Exclusions Database at the HHS website.

CR1 A3. Credentialing Process

See Attachment "BHI Credentialing Process Flow Chart"

- Provider requests participation in the BHI External Provider Network
- Provider completes the BHI application, and release of information to BHI to request CBI background check and Child Abuse Registry check.
- BHI notifies its NCQA Accredited Credential Verification Organization to conduct Primary Source Verification.
- The completed report is reviewed against BHI Credentialing Criteria
- If criteria are met, the application and report is presented to the BHI Risk and Resource Committee
- Based on the decision from the Risk and Resource committee, the practitioner will receive an acceptance or denial letter within seven (7) days. The denial letter will include the appeal process.

CR1 A4. Process for Managing Credentialing Files

A current file is maintained on-site for each provider contracted with or employed by BHI. The information contained in the file includes but is not limited to the following:

- A current application and CV, which includes a five (5) year work history
- Current State Professional License to practice
- Current DEA license, as applicable
- Current Professional Liability Policy face sheet
- Hospital Staff Privileges, as applicable
- Evidence of professional medical education including ECFMG, as applicable

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- Evidence of Board Certification, as applicable
- NPDB (National Practitioners Data Bank) query, which includes Medicare and Medicaid sanction activity, as applicable
- FSMB (Federation of State Medical Boards) query, as applicable
- Evidence of site review, as applicable
- Child Abuse Registry Query (youth providers only)
- Colorado Bureau of Investigation (CBI) Query
- Sanctions List

CR1 A5. Medical Director Participation

BHI's Medical Director and Associate Medical Director are members of the Risk and Resource committee and as such participate in all credentialing decisions. Only the BHI Medical Director or BHI Associate Medical Director have the authority to determine that the file meets the BHI credentialing criteria and to sign off on it as complete, clean and approved by the Risk and Resource Committee. Only the BHI Medical Director and the BHI Associate Medical Director have the authority to sign off on all credentialing decisions.

CR1 A6. Procedures to Maintain Confidentiality

- BHI credentialing files are stored in double locked files
- BHI credentialing database has restricted access to credentialing staff only
- Documents distributed for review at the Risk and Resource Committee meeting are collected and destroyed
- Risk and Resource Committee members each sign a confidentiality agreement

CR1 B. Practitioners Rights

- Practitioners maintain the right to review the information submitted in the support of their credentialing application.
- Practitioners will be notified of any information obtained during the organization's credentialing process that varies substantially from the information provided to the organization by the practitioner.
- The practitioner maintains the right to correct erroneous information.
- The information collected during the credentialing process will be kept confidential, except as otherwise required by the law.
- Practitioners maintain the right, upon request, to be informed of the status of their credentialing or recredentialing application.

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Notification to Providers of their Rights

Providers will be notified of their rights in the credentialing applicant information letter which is sent to practitioners after requesting participation in the BHI network, as well as the recredentialing notification letters.

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CR2. Risk and Resource (Credentialing) Committee

BHI utilizes a multidisciplinary Risk and Resource Committee appointed by the Executive Management of BHI as the credentialing committee for BHI. Members of the Risk and Resource Committee will represent the following disciplines: Psychiatry, Psychology, Social Work, Nursing, and Professional Counseling. The Risk and Resource Committee meets at least bi-weekly, to review and discuss documentation delineating the result of primary source verifications and other pertinent information. The committee then approves or declines the provider's request, and the provider is advised of the result. The Risk and Resource Committee has the opportunity to review the credentials of all practitioners who do not meet the organization's established criteria and to offer advice, which the organization considers. Applications are distributed to all practitioners requesting participation in the BHI network. The application is reviewed against BHI criteria.

Credentialing policies and procedures are reviewed annually to insure compliance with National Committee for Quality Assurance (NCQA) Standards.

CR3. Initial Credentialing Verification

Credentialing Process: (see credentialing flow chart)

CR4. Application and Attestation

- The provider completes an application which includes a statement regarding:
 - Reasons for any inability to perform the essential functions of the position, with or without accommodation
 - Lack of present illegal drug use
 - History of loss or limitation of privileges or disciplinary activity
 - Current malpractice insurance coverage
 - Attestation of correctness and completeness of the application

CR4 A & B. Primary Source Verification

The following information is verified from primary sources, unless otherwise indicated, and is no more than 180 days old at the time of the credentialing decision.

Doctors of Medicine and Doctors of Osteopathic Medicine

- A current valid license to practice verified by the State Medical Board.
- Clinical privileges are confirmed either by oral or written form, from the practitioner's primary inpatient admitting facility or from a BHI designated participating hospital.

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- A valid DEA or CDS certificate, as applicable, verified by:
 - Copy of the DEA or CDS certificate, or
 - Visual inspection of the original certificate, or
 - Confirmation with CDS, or
 - Entry in the National Technical Information Service (NTIS) data base, or
 - Confirmation with the state pharmaceutical licensing agency.
- Verification of the highest level of credentialed education and training attained.
 - If the practitioner is board certified, verification of board certification fully meets this requirement.
- Completion of residency training:
 - Confirmation from the residency training program, or
 - Entry in the AMA Physician Master File, or
 - Entry in the AOA Physician Master File.
- Graduation from medical school:
 - Confirmation from the medical school, or
 - Entry in the AMA Physician Master file; or
 - Entry in the AOA Physician Master File; or
 - Confirmation from the Education Commission for Foreign Medical Graduates for international medical graduates licensed after 1986.
- Verification of Board Certification by:
 - Entry in the ABMS Compendium; or
 - Entry in the AMA Physician Master File; or
 - Entry in the AOA Directory of Osteopathic Physicians; or
 - Confirmation from the appropriate specialty board.
- Five years of work history should be included on the application or curriculum vitae.
- Primary source verification of work history is not required.
- A copy of providers current Malpractice Coverage indicating a minimum coverage of \$1mm per occurrence and \$3mm aggregate.
 - Verification of the last five (5) years of history of malpractice settlements from the malpractice carrier or query the National Practitioner Data Bank.

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Doctors of Psychology (PhD, PsyD, LPsy), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC) Nurse Practitioners or Clinical Nurse Specialists (NP or CNS/CS)

The following information is verified from primary sources, unless otherwise indicated, and is no more than 180 days old at the time of the credentialing decision:

- A current valid license to practice verified by the appropriate State Licensing Board.
- Clinical privileges are confirmed either by oral or written form, from the practitioner's primary in mental health consumer admitting facility as applicable.
- Verification of graduation from accredited college or university.
- Minimum possession of a Master's degree or Doctorate in field of practice from an accredited college or university.
- Be licensed by the state of Colorado or certified at the highest level of independent practice in the state of Colorado.
- Five years of work history should be included on the application or curriculum vitae.
- Primary source verification of work history is not required.
- A copy of provider's current malpractice insurance indicating a minimum coverage of \$1mm per occurrence and \$3mm aggregate.
 - Documentation of the last five (5) years of history of malpractice settlements from the malpractice carrier.
- The provider completes an application which includes a statement regarding:
 - Reasons for any inability to perform the essential functions of the position, with or without accommodation;
 - Lack of present illegal drug use;
 - History of loss or limitation of privileges or disciplinary activity;
 - Current malpractice insurance coverage; and
 - Attestation of correctness and completeness of the application.
- The following information is reviewed and included in the credentialing files:
 - NPDB query, which includes Medicare and Medicaid Sanctions;
 - Appropriate State Licensing Board query;
 - Medicare and Medicaid sanction activity via a Cumulative Sanction Report;
 - Colorado Child Abuse Registry query; and
 - Colorado Bureau of Investigation query.

CR5. Initial Sanction Information

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- The following information is reviewed and included in the credentialing files:
 - NPDB query, which includes Medicare and Medicaid Sanctions
 - State Board of Medical Examiners query
 - Federation of State Medical Boards query
 - Colorado Child Abuse Registry query
 - Colorado Bureau of Investigation query

CR6. High Volume Provider Site Visit

BHI will conduct a site visit on all high volume providers at such time as there numbers of active BHI members approach the "high volume" criteria. BHI defines high-volume practitioners as those providers who have more than ten (10) active BHI members in their practice.

If a current provider moves to a location, leaves a group practice or opens a new location within the BHI service area, the practitioner is required to notify BHI within thirty (30) days. BHI will conduct an office site visit within thirty (30) days of notification of the practitioner's move.

BHI Credentialing staff will contact the provider to schedule a site visit at a mutually agreeable time. BHI will not conduct unscheduled site visits.

The provider will be supplied with the site visit audit tool and an explanation of relevant BHI standards prior to the site visit.

The attached office site visit review form will be used in all site visits.

Providers are required to meet eighty percent (80%) compliance against the following site visit standards:

- Physical accessibility
- Physical appearance
- Adequacy of waiting – and examining –room space
- Availability of appointments
- Adequacy of treatment record keeping

The provider or office representative will receive a copy of the site visit review form at the conclusion of the site visit.

If the provider does not meet the eighty percent (80%) standard, a follow-up site visit will be conducted within ninety (90) days. The provider may be suspended from the network if the office does not meet BHI's standards after the second audit.

CR7. Recredentialing Verification

Recredentialing will take place every three years. The Recredentialing process will begin at least 90 days prior to the date at which initial Credentialing or Recredentialing will expire. BHI's credentialing verification

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organization will send a pre-populated application to the provider requesting updates or changes in the provider information.

The following information is verified from primary sources, unless otherwise indicated, and is no more than 180 days old at the time of the credentialing decision.

Doctors of Medicine and Doctors of Osteopathic Medicine

- A current valid license to practice verified by the State Medical Board.
- Clinical privileges are confirmed either by oral or written form, from the practitioner's primary mental health consumer admitting facility or a BHI designated participating hospital.
- A valid DEA or CDS certificate, as applicable, verified by:
 - Copy of the DEA or CDS certificate, or
 - Visual inspection of the original certificate, or
 - Confirmation with CDS, or
 - Entry in the National Technical Information Service (NTIS) data base, or
 - Confirmation with the state pharmaceutical licensing agency.
- Verification of Board Certification by:
 - Entry in the ABMS Compendium; or
 - Entry in the AMA Physician Master File; or
 - Entry in the AOA Directory of Osteopathic Physicians; or
 - Confirmation from the appropriate specialty board.
- A copy of the providers current Malpractice Coverage indicating a minimum coverage of \$1mm per occurrence and \$3mm aggregate.
 - Verification of the last five (5) years of history of malpractice settlements from the malpractice carrier or query the National Practitioner Data Bank.
- The provider completes an application which includes a statement regarding:
 - Reasons for any inability to perform the essential functions of the position, with or without accommodation;
 - Lack of present illegal drug use;
 - History of loss or limitation of privileges or disciplinary activity;
 - Current malpractice insurance coverage; and
 - Attestation of correctness and completeness of the application.
- The following Recredentialing Sanction Information is reviewed and included in the credentialing files:
 - NPDB query, which includes Medicare and Medicaid Sanctions;
 - State Board of Medical Examiners query;

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- Federation of State Medical Boards query;
- Colorado Child Abuse Registry query; and
- Colorado Bureau of Investigation query.

Doctors of Psychology (PhD, PsyD, LPsy), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC) Nurse Practitioners or Clinical Nurse Specialists (NP or CNS/CS)

The following information is verified from primary sources, unless otherwise indicated, and is no more than 180 days old at the time of the credentialing decision:

- A current valid license to practice verified by the appropriate State Licensing Board.
- A copy of provider's current malpractice insurance indicating a minimum coverage of \$1mm per occurrence and \$3mm aggregate.
 - Documentation of the last five (5) years of history of malpractice settlements from the malpractice carrier.
- The provider completes an application which includes a statement regarding:
 - Reasons for any inability to perform the essential functions of the position, with or without accommodation;
 - Lack of present illegal drug use;
 - History of loss or limitation of privileges or disciplinary activity;
 - Current malpractice insurance coverage; and
 - Attestation of correctness and completeness of the application,
- The following Recredentialing Sanction information is reviewed and included in the credentialing files:
 - NPDB query, which includes Medicare and Medicaid Sanctions
 - Appropriate State Licensing Board query
 - Medicare and Medicaid sanction activity via a Cumulative Sanction Report
 - Colorado Child Abuse Registry query
 - Colorado Bureau of Investigation query

Provider information/file is summarized on the recredentialing checklist. The Credentialing Coordinator prepares the recredentialing report on provider utilization and quality information for the Risk and Resource Committee review.

The application is reviewed by Risk and Resource Committee for recredentialing approval. The Committee reviews information from the NPDB, licensure board, Medicare/Medicaid sanctions report and performance data.

Based on the decision from the Risk and Resource committee, the practitioner will receive an acceptance or denial letter within seven (7) days. The denial letter will include the appeal process.

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The recredentialing process is identical to the credentialing process except:

- Primary source verification does not re-collect educational verification; and
- Provider utilization data, and any complaints and quality information is presented for consideration in the decision making process.

CR8. Procedures for Change In Practitioner Status

All decisions about altering the practitioner's relationship with BHI include, but are not limited to, issues of quality of care and service, information submitted by the practitioner, as well as objective evidence. Decisions are guided by mental health consumer care considerations.

- Causes for corrective action include but are not limited to:
 - o The clinical competence of the BHI practitioner.
 - o The care or treatment of a mental health consumer.
 - o Violation of ethical standards or the policies, rules or regulations of BHI.
 - o Behavior or conduct that is considered lower than the standards of safe and prudent practice.
 - o Failure to achieve satisfactory utilization, cost and quality review results.
 - o Non-compliance with terms and agreements set forth in the contract or corporate compliance guidelines.
 - o Failure to comply with the provider policies and procedure manual.
 - o Failure to submit recredentialing materials within requested timeframes.
 - o Failure to comply with quality improvement activities.
- Corrective action may include:
 - o Suspension of all or any part of participation privileges/provider agreement. If suspension is placed into effect, the investigation will be completed within thirty (30) days of the suspension.
 - o Issuance of a written warning.
 - o Issuance of a letter of reprimand.
 - o Imposition of terms of probation.
 - o Imposition of a requirement of consultation.
 - o Termination of provider agreement.

If action is less severe than reduction of privileges or suspension or termination, the action will take effect immediately.

Immediate termination will be invoked for loss of any state license, indictment or conviction of a felony or any criminal charge related to his/her practice; loss of staff privileges at a participating hospital; failure to

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take such action that would result in the imminent danger to the health and/or safety of any individual; and, where reasonable circumstances are deemed appropriate by BHI.

Any behavior deemed inappropriate and/or detrimental to a BHI participant is cause for immediate review by the Medical Director. The review may result in a recommendation to the Risk and Resource Committee regarding corrective action.

Corrective action that may be undertaken without the Risk and Resource Committees recommendation includes:

- Temporary suspension which may be initiated only upon agreement between the Medical Director, Director of Managed Care and the COO.
- Probationary status which may be initiated by the Medical Director, Director of Managed Care or the COO.

Notification to Practitioner

The practitioner will be notified in writing within seven (7) days of the action taken.

Appeal Process

The practitioner will be notified of the right to appeal the decision to the Director of Managed Care Services within seven (7) days of receipt of the decision.

Corrective actions, which will be reviewed by the Risk and Resource Committee, with a recommendation for approval or disapproval include:

- Termination - the practitioner will be notified in writing of BHI's decision to terminate within seven (7) days of the decision. The BHI Provider Termination Letter Template advises the provider to contact the Director of Utilization Management within thirty (30) days of notification to initiate an appeal. Appropriate tracking systems will be updated to reflect the decision.
- The practitioner has the right to appeal the decision to the committee within thirty (30) days of the decision. Not more than one appellate review will be considered.

The board of directors will make the final decision. BHI will notify the appropriate authorities for behaviors violating the law or ethical standards or practice.

Reporting Requirements to External Authorities

All physicians and licensed clinicians are subject to reporting of adverse actions to the appropriate State Board and the National Practitioner Data Bank.

Forms will be completed in accordance with the procedure outlined in the Adverse Actions Reporting Form and Instructions.

CR9. Organization Provider (Facility) Credentialing

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“Facility” in this policy indicates Community Mental Health Centers, Child Placement Agencies, Group Practices, hospitals, Home Health Organizations, and Nursing Homes, Residential Facilities, and Rehabilitation Facilities.

The applicant must complete the BHI Organizational Provider Credentialing application. The application must contain the original signature of the Chief Operating Officer, Administrator or other appropriate designated health care facility representative. The signature of the facility representative serves as an attestation of the credentials, operational, financial, and quality performance information summarized on and included with the application. The signature also serves as a release to verify credentials externally.

Procedure

Participation request or network need is determined. The Credentialing Coordinator sends the BHI Organizational Application by mail or email to the facility. The Facility provider applicants will submit, with their completed applications:

- Copy of all current facility licenses including, but not limited to:
 - o Mental Health Day Program (including day treatment and partial hospitalization)
 - o Outpatient Mental Health Services
 - o Mental Health Residential Treatment Facilities
 - o Mental Health Crisis Stabilization Units
 - o Psychosocial Rehabilitation
 - o Mental Health Case Management
 - o Mental Health Hospital Facilities
 - o All general surgical hospitals operating a unit or program to provide mental health services.
- Current accreditation by an acceptable accreditation body including but not limited to JCAHO, CARF, CHAP, or COA. Completed site review reports from CMS, DMH, or ADAD as well as any other requested documentation to ensure the organization complies with BHI standards. If a site visit has not been conducted by the above listed, BHI will conduct its own site visit and include a copy of the organization’s credentialing or Human Resources policies for screening and verification of staff training.
- Copy of last HCFA, Health Facilities Division survey report (Hospitals only).
- Copy of Mental Health Services Designation Certificate.
- Status of certification for Medicaid and Medicare participation and numbers if participating.
- State and federal regulatory status - In good standing. A screen print displaying the query results from the Office of Inspector General (OIG) Federal Program Exclusions Database (Medicaid and Medicare status). www.oig.hhs.gov
- Copy of declaration page proving current Professional and General liability coverage demonstrating the following BHI requirements:

Facility

Malpractice

General Liability

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Facility	\$3,000,000	\$3,000,000	per occurrence
Hospital	\$5,000,000	\$5,000,000	in aggregate

- Malpractice history from the insurance carrier covering the last five (5) years.
- Attestation/Release signed by a Director.
- Attestation that their organization conducts background investigations on all employees, interns, volunteers and contract agents having contact with members, consisting of at least the following, prior to hire:
 - A name search through the Colorado Bureau of Investigation;
 - A reference from the licensing board for licensed persons;
 - A check of the Central Registry of Child Abuse for persons having unsupervised contact with members under age 18; and
 - A check of references of former employees for clinical staff.

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Accreditation or Site Visit by CMS, DMH, ADAD or BHI

The following accreditation organizations are recognized and accepted by BHI:

- Joint Commission of Accreditation of Healthcare Organizations JCAHO
- The Rehabilitation Accreditation Commission CARF
- Council on Accreditation of Services for Families and Children, Inc. COA
- Community Health Accreditation Program CHAP

Non-accredited organizational provider(s) are subject to an on-site assessment by BHI to confirm that they meet BHI quality standards. BHI will review policies and procedures related to the credentialing of direct care providers and supervisory practices, leadership interactions, evidence of criminal background checks and Child Abuse Registry checks, and licensure verifications via the Colorado Department of Regulatory Affairs if applicable.

As detailed in the table below, BHI will utilize the CMS site survey conducted by the Colorado Department of Public Health and Environment (CDHPE), the DMH site review conducted on behalf of the Department of Human Services (DHS) or the Alcohol and Drug Abuse Division (ADAD) Site Inspection in lieu of conducting a site visit. In these instances, BHI will require a copy of the reports from the state agency to verify that the assessment complies with BHI standards and to ensure that the organizations credentialing and personnel policies and procedures were reviewed. If the organizational provider has not undergone a site visit by one of the above, or the documentation does not support BHI standards, BHI will perform a site visit.

Following are the organizational providers and their associated accrediting bodies or in lieu of accreditation, the applicable CMS, DMH or ADAD site review. The organizational provider must provide evidence of one of the following or have a site visit performed by BHI to be considered for participation or ongoing participation.

Organizational Provider Type	Accrediting Body or CMS, DMH or ADA Site Review
Hospital	<ul style="list-style-type: none"> ○ JCAHO (general, psychiatric, children's and rehabilitation) ○ CARF ○ CMS Site Review ○ DMH Survey of psychiatric hospitals
Community Mental Health Center/Clinic	<ul style="list-style-type: none"> ○ JCAHO ○ COA ○ CARF ○ CMS Site Review ○ DMH Site Review
Psychiatric Residential Treatment Facility	<ul style="list-style-type: none"> ○ JCAHO ○ COA

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	<ul style="list-style-type: none"> ○ CARF ○ DMH Site Review
Therapeutic Residential Child Care Facility	<ul style="list-style-type: none"> ○ JCAHO ○ COA ○ CARF ○ DMH Site Review
Alcohol & Drug Treatment Center	<ul style="list-style-type: none"> ○ JCAHO ○ COA ○ CARF ○ ADAD Site Inspection ○ DMH Site Review

The Credentialing Coordinator reviews all information and when the application is complete, presents the credentials to the Risk and Resource Committee. The Risk and Resource Committee does the following:

- Reviews documents.
- Makes determination regarding participation.
- Chairperson documents determination in committee minutes.

Organizational Provider Notification

BHI supplies the facility with the written decision by the committee to accept or deny participation within seven (7) days.

Organizational Provider Quality Site Visit Standards

If the organizational provider is not accredited by an entity recognized by BHI or not subject to site reviews conducted by CMS, DMH or ADAD, BHI will perform a site visit. If the organizational provider is not accredited or is accredited by an entity not recognized by BHI, BHI will require:

- 1) a copy of the report or letter sent from CMS, DMH or ADAD that shows that the facility was reviewed, and,
- 2) findings of the review, and
- 3) the organization's credentialing or Human Resources policies for screening and verification of staff training,

If any of the above reports indicate corrective action plans were imposed within the last three (3) years, the Credentialing Coordinator will obtain the written documentation of corrective action plan implementation and results for review and approval by the Risk and Resource Committee.

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If BHI becomes aware of conditions at a site at any time that suggest compromised safety or other concerns related to the delivery of care, BHI may perform a site visit as soon as possible to assess the facility and identify corrective actions.

If the non-accredited organization has not had a site visit performed by one of the entities noted above, BHI will contact the organization and perform a site visit. The facility site visit will include, but is not limited to:

Availability

Review of appointment availability for emergency, routine, urgent, life threatening and non-life threatening appointments and the ability to assess the waiting time for an evaluation once the member arrives. Ensure compliance with the Americans with Disabilities Act.

Credentialing/Privileging

Review Policies and Procedures for credentialing or privileging, recredentialing/reappointment and primary source verification for staff licensing. Review 3 personnel files to verify credentialing documentation including staff education, training, licensure and experience. Ensure policies are in place to review Medicare/Medicaid or state regulated sanctions as well as disciplinary actions of staff members.

Clinical Operations

Review evaluation and reporting of Patient Satisfaction and Patient Complaints and Grievances. Review Clinical Standards of Care development and implementation procedures as well as clinical policy and procedure education to staff. Examine program specific criteria for admissions, continuing stay and discharge. Review staffing plan including number and types of disciplines employed and documentation of staff training and education. Review staffing ratio vs. facility's policies and procedures and jurisdictional statues.

Safety

Ensure the organization has policies and procedures for emergency coverage, and use of seclusion and/or restraints. Proper training provided for staff in the use of seclusion and restraints. Does the facility provide a safe place for patients to be seen free from physical furnishings or equipment that could pose a safety hazard?

Appearance

Ensure that the offices are neat, clean and professional.

Treatment Record Practices and Record Keeping

Review the area where patient files are kept to ensure they are maintained in a locked and secure area. Examine member records to verify that they are kept in individual folders and identified appropriately, professional standards for documentation are met and current CCAR and Encounter Data is included. Ensure record availability to other staff onsite as necessary. Review if treatment plans are completed within an appropriate time frame for level of care

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Confidentiality

Review patient confidentiality standards with organization including keeping computer screens from being seen in open view, fax machines and mail that may hold patient identification information and verbal communication that is not audible to unauthorized personnel.

Medication Safety

Ensure all medications are stored in a safe location that is not accessible to patients and records of how medication samples are kept and distributed.

Organizational Provider Quality Site Visit Standards will be completed at the time of the office site visit and reviewed with the Office Manager or designee. The Office Manager or designee will sign the form, indicating that the results of the review were shared with the facility. A copy of the signed evaluation form will be given to the Office Manager or designee.

Acceptable performance is a score of eighty percent (80%) or higher and the practitioner is in compliance with the secured treatment records section of the site visit evaluation form.

If BHI becomes aware of conditions at a site that suggest compromised safety or other concerns related to the delivery of care, BHI may perform a site visit as soon as possible to assess the facility and identify corrective actions.

Follow-up will be as follows:

If the score for the site visit is less than eighty percent (80%) or if the practitioner is not in compliance with secured treatment records, a corrective action plan will be developed and shared with the Office Manager or designee.

- A return office site visit will be scheduled at least every six (6) months until the performance standard(s) is met. Progress reports will be submitted to the appropriate Risk and Resource Committee for review and recommendations, as necessary.
- Copies of the completed site visit evaluation, corrective action plan, and follow-up site visits, as applicable, will be incorporated into the facility's file for consideration by the Risk and Resource Committee at the time of the credentialing or recredentialing decision.

Organization Provider (Facility) Recredentialing

Recredentialing will take place every three years. The recredentialing process will begin at least ninety (90) days prior to the date at which initial credentialing or recredentialing will expire.

Follow procedures for Organizational Provider Credentialing.

All requirements and documents listed for Organization Credentialing will be current at the time of credentialing and recredentialing.

Organizational Monitoring

It is the expectation of BHI that all contracted organizations providing specialty support services to consumers will:

- Remain in good standing with all regulatory bodies and report to BHI any issues as they arise;

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- Maintain current insurance and licensure as required by the contract and provide evidence of the same to BHI;
- Respond promptly and effectively to any quality of care concern findings, grievances or other complaints, or service delivery concerns;
- Participate as appropriate in ongoing administrative and clinical/service delivery monitoring and continuous quality improvement efforts;
- Address any deficiencies found during monitoring activities in a timely manner by submitting a plan of correction within the timeframe required by BHI; and
- Maintain active accreditation by JCAHO, CARF, CHAP, or COA.
- In instances in which the organization is not accredited, they must maintain passing performance on the BHI Organizational Provider Quality Site Visit.

CR10. Delegation of Credentialing

Delegated Activities

BHI has delegated the following activities to Med Advantage, Inc.:

- Application mail out;
- Application follow up;
- Application review for completeness; and
- Application review for signature and attestation date.
- Verification of licensure in the state where the provider has an office. The practitioner holds a valid, current license to practice which is verified directly from the state licensing agency to include sanction information where available.
- Obtain copy of DEA and when appropriate a CDS certificate for practitioners and facilities that can prescribe or dispense controlled substances. The 180 day limit does not apply, however, the practitioner's certificate must be effective at the time of the credentialing decision or verified from the NTIS as current.
- Verification of education when not board certified. The 180 day time limit does not apply to verification of education and training, but must be verified in accordance with NCQA and URAC standards.
- Verification of board certification for practitioner's from the state they are board certified.
- Document a minimum of five (5) years work history. This can be collected on the application or curriculum vitae with dates which include the month and year. The Delegated Agency will identify any gaps in work history of six (6) months or greater. Verification of work history is not required from primary sources.
- Verification of malpractice claims history. Can be completed by collecting five (5) years of history of malpractice settlements from the National Practitioner's Data Bank (NPDB) or the insurance carrier when available.

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- Verification of Medicare and Medicaid sanctions. Need to verify the status of the practitioner in regard to Medicare and Medicaid sanctions which can be done by completing a query of the NPDB.

Delegation Oversight

BHI requires all Credentialing Verifications Organizations with whom it contracts for primary source verification functions to maintain active accreditation with the National Committee for Quality Assurance (NCQA). BHI will maintain a copy of current accreditation status on file for review by providers and regulatory agencies. Per NCQA credentialing standards, 2000: "where an entity is NCQA Certified or NCQA accredited, the MBHO can assume that the delegate is carrying out responsibilities in accordance with NCQA standards. In those cases, the MBHO does not need to conduct an annual audit or evaluation and the reports required may contain only the information necessary for the MBHO to ensure that the delegate is meeting the MBHO's needs."

Expedited Credentialing

See BHI's Single Case Agreement Policy

Review of Respite Providers

The purpose of Respite Care at BHI is to provide a safe haven for children who are at risk for out of home placement or hospitalization. Respite workers do not; therefore provide a "mental health" service. BHI does, however, conduct a thorough background check including Child Abuse Registry, Colorado Bureau of Investigation, references, and work history. Any clinical issues that arise during a respite episode are handled by the child's primary therapist or mental health emergency services.

Notification to the Department of Health Care Policy and Financing

BHI will notify the Department by e-mail of any additions or deletions of individual, organizational, facility or CPA providers to the BHI Provider Network within ten (10) business days of the provider addition or deletion.

The process for ensuring those listings in provider directories and other materials for members are consistent with credentialing data, including education, training certification and specialty.

The BHI Provider directory is generated from the credentialing database for both individual and organizational providers. The credentialing coordinator updates the database on an ongoing basis based on changes in the network secondary to credentialing activities and reviews the database quarterly to ensure accuracy and completeness.

Attachments

- BHI Credentialing Flow Sheet

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- BHI Recredentialing Flow Sheet
- BHI Provider Application
- CVO Application
- BHI Organizational Provider (Facility) Credentialing Application
- BHI Organizational Provider Quality Site Visit Standards
- BHI Initial Site Visit
- Provider Termination Letter Template
- Application Discrepancy Letter