County of Marin **Behavioral Health and Recovery Services (BHRS)**	POLICY NO. BHRS-28
	Next Review Date: October 2026
POLICY: **PROVIDER CREDENTIALING AND RE-CREDENTIALING** **SUPERSEDES – BHRS-SUS-22 AND MHSUS 211-04**	Date Approved: October 24, 2023
	By: Todd Schirmer, PhD Director of Behavioral Health and Recovery Services

POLICY: PROVIDER CREDENTIALING AND RE-CREDENTIALING

I. PURPOSE:

This policy establishes the procedures for credentialing and re-credentialing of the workforce who provide services under the Marin Mental Health Plan (MHP) or Marin Drug Medi-Cal Organized Delivery System (DMC-ODS) in Marin County (Plan). This policy and procedure will ensure compliance with federal and state regulations regarding employment of excluded and/or suspended individuals in the capacity where they will be billing for federal funds.

II. REFERENCES:

Title 42 Code of Federal Regulations, Subpart F §438.214
Title 9, California Code of Regulations, Chapter 11, §1810.240
& 2540 DMC-ODS Intergovernmental Agreement, Exhibit A, Attachment I
MHSUDS Information Notice 18-019

III. POLICY:

It is the policy of Marin County Behavioral Health and Recovery Services (BHRS) that all licensed, waivered, registered and/or certified rendering providers who provide services within the MHP and/or DMC-ODS complete credentialing procedures, comply with BHRS contract conditions, and with State and Federal Regulations. In accordance with these regulations, BHRS may not employ or contract with any individual or entity excluded from participation in Federal Health Care programs and will verify that new and current providers and contractors are not present on any of the Federal or State Exclusion lists. Furthe1more, BHRS will review quality assurance, billing, and licensure information during the re-credentialing process. The Plan will re-credential all rendering providers no less than every three years.

IV. AUTHORITY/RESPONSIBILITY:

Quality Management
Compliance Officer
Program Managers/ Supervisors

V. DEFINITIONS:

Network: The Network is made up of the Marin Mental Health Plan and the Marin County DMC-ODS waiver services. It includes all services rendered to Marin County Medi-Cal Beneficiaries by Marin County staff, independent contractors or contracted agencies.

Network Provider: A rendering provider who has completed the credentialing process and is approved to render services within the Plan.

Workforce: Includes rendering providers who are licensed, registered, waivered and/or certified mental health providers, licensed practitioners of healing arts, and registered or certified alcohol or other drug counselors. (Department of Health Care Services 'DHCS' Info1mation Notice 18- 019 and Title 22 of the California Code of Regulations, Section 51051).

Sanction Lists: The federal and state governments maintain lists of individuals and entities that have been excluded, suspended, debarred, or otherwise made ineligible to participate in federally funded health care programs including, but not limited to, Medicare and Medi-Cal. These lists must be used to screen future and current workforce members to ensure Marin County MHP or DMC-ODS does not employ, in the capacity where they will be billing for federal funds, individuals excluded from participating in federal health care programs.

Excluded: A determination made by the Health and Human Services Office, Office of Inspector General (OIG), or other federal agencies, that payment may not be made by a federally funded health care program for items or services furnished, ordered, or prescribed by individuals who have been debarred. This determination continues to apply to an individual even if they change from one health care profession to another while excluded. There is no automatic reinstatement for an excluded individual. An individual who is excluded remains excluded until all specified reinstatement procedures are completed regardless of whether or not the period of exclusion has been completed. Completion of the reinstatement process is subject to the sanctioning agency's approval.

Suspended: A determination made by DHCS that payment may not be made by a federally funded health care program for items and services furnished, ordered, or prescribed by suspended or ineligible individuals. This determination continues to apply to an individual even if they change from one health care profession to another while suspended. ***An individual that is suspended or ineligible remains suspended or ineligible until the individual has been formally reinstated for participation in federally funded health care programs.***

VI. PROCEDURE:

The following procedure describes the necessary steps for a provider to become authorized to provide and claim for specialty mental health services (SMHS) as part of the Marin County MHP and substance use treatment services as part of the DMC-ODS waiver. Authorized providers are given a unique staff identifier for use in Medi-Cal claiming as well as access to electronic health records. These procedures apply to both Marin County BHRS staff as well as providers from BHRS contracted agencies ***after*** provider hire/onboarding. These procedures do not include hire/onboarding requirements.

For all licensed, waivered, registered and/or certified providers, the Plan will verify and document the following items through a primary source unless the required information has been previously verified by the applicable licensing, certification and/or registration board.

1. The appropriate license and/or board certification or registration, as required for the particular provider type;
2. Evidence of graduation or completion of any required education, as required for the particular provider type;
3. Proof of completion of any relevant medical residency and/ or specialty training, as required for the particular provider type; and
4. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

In addition, the Plan will verify and document the following infolmation from each network provider, as applicable[1].

1. Work History;
2. Hospital and clinic privileges in good standing;

[1] These do not need to be verified via a primary source.

3. History of any suspension or curtailment of hospital and clinic privileges;
4. Current Drug Enforcement Administration identification number;
5. National provider identifier number;
6. Current malpractice insurance in an adequate amount, as required for the particular provider type;
7. History of liability claims against the provider;
8. Provider Information, if any, entered in the National Practitioner Data Bank, when applicable.
9. History of sanctions from participating in Medicare and/or Medicaid; Providers te1minated from either Medicare or Medicaid, or on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network.
10. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

Provider Attestation:

In addition, for all providers who deliver covered services the Plan will require a signed and dated statement attesting to the following:

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodations;
2. A history of loss of license or felony conviction;
3. A history of loss or limitation of privileges or disciplinary activity;
4. A lack of present illegal drug use; and
5. The application's accuracy and completeness.

Provider Re-Credentialing:

The Plan will verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements listed above. The plan will require each provider to submit any updated information needed to complete the re-credentialing process, as well as a new signed attestation. In addition, the Plan will review and include documentation that the Plan has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, beneficiary grievances, and medical records review.

The Medi-Cal Provider Credentialing procedure must be followed when:

1. A new provider requests to provide services as part of the Plan;
2. A current provider no longer meets the requirements for their credentialing category;
3. Upon request from the BHRS Credentialing Committee

Credentialing Procedure

BHRS INTERNAL PROVIDERS, TBH PROVIDERS & INDIVIDUAL CONTRACTED PROVIDERS

A. LICENSED, REGISTERED, WAIVERED, AND/OR CERTIFIED PROVIDERS

1. BHRS will utilize a National Committee for Quality Assurance (NCQA) accredited credentialing contractor that performs primary source verification whenever possible. This includes credentialing for BHRS internal providers, TBH providers and individual contracted providers.

2. The credentialing process for new providers will start in conjunction with the hiring process. HR will include in the hiring packet the "BHRS Credentialing Application" for specific job classifications/provider types and the BHRS Network Provider Attestation and send it to prospective employee. The HR job offer letter will state that hiring is contingent upon any HR requirements and being credentialed as per BHRS policy.

3. Upon receipt of the credentialing application, BHRS credentialing staff will forward the application to the contracted credentialing agency.

4. BHRS will perform an interim credentialing of the provider which includes verifying current license status, verification of NPI, and excluded provider databases. Upon review and approval of interim credentialing requirements from BHRS credentialing staff, a provider may render services while primary source credentialing is performed by the credentialing contractor.

5. When the credentialing report has been received from the credentialing agency, BHRS credentialing staff will issue a determination of credentialing. Upon review of the report, if BHRS credentialing staff identify unsatisfactory credentialing requirements, the provider may be asked to stop rendering services. Any services deemed disallowed will be brought to the attention of the BHRS Compliance Officer and shall be returned to payors as specified in the BHRS Policy on Voluntary Reporting of Overpayments & Disclosure of Material Deficiencies.

6. Providers with a denied credentialing determination may appeal the decision by contacting the Credentialing Committee to request a review of their application and determination. They may provide additional supporting information to assist their case. The application determination, supporting documentation and additional

information will be reviewed by the BHRS Compliance Officer, BHRS Quality Management Director, or their designee within two weeks of receipt of appeal.

7. Providers must notify Quality Management ***immediately*** if their provider status changes in any way. This may include an expired license/registration, name change, or a change in educational or new licensure/registration status. Providers **<u>may not</u>** provide and claim for Plan Services if they do not meet the requirements of their credentialing category.

   Change in Status:
   a. Intern > Staff
   b. Waiver> License
   c. Registered > License
   d. Expiration of license or certification

B. CONTRACTED AGENCY PROVIDERS

1. BHRS contracted agencies must have a procedure in place and are responsible for ensuring that all their providers are credentialed and re-credentialed as per the policy of BHRS and MHSUS Information Notice No. 18-019. Contracted agencies must ensure that each provider is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, registered, waivered, and/or certified.

2. Contracted agencies are responsible for ensuring that all their providers complete a credentialing process that meets DHCS requirements. For all licensed, waivered, registered and/or certified providers, the contracted agency must verify and document the following items through a primary source, as applicable: (Note: the listed requirements below are not applicable for all provider types).

   a. Appropriate license and/or board certification or registration, as required for the particular provider type;
   b. Evidence of graduation or completion of any required education, as required for the particular provider type;
   c. Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
   d. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

3. Moreover, contracted agencies must verify and document the following information for all providers, as applicable, but do not need to verify this information through a primary source:

a. Work history;
b. Hospital and clinic privileges in good standing;
c. History of any suspension or curtailment of hospital and clinic privileges;
d. Current Drug Enforcement Administration (DEA) identification number;
e. National Provider Identifier (NPI) number;
f. Current malpractice insurance in an adequate amount, as required for the particular provider type;
g. Provider information, if any, entered in the National Practitioner Data Bank, when applicable;
h. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal such as providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List, whom may not participate in the Plan's provider network; and
i. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

4. Additionally, the contracted agencies will need to provide a signed "BHRS Contractor Annual Attestation" statement, provided by BHRS at the beginning of each contract year, in which the contracted agency must sign and date attesting to the following for all of their rendering providers:

    a. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
    b. A history of loss of license or felony conviction;
    c. A history of loss or limitation of privileges or disciplinary activity;
    d. A lack of present illegal drug use; and
    e. The application's accuracy and completeness.

5. If any issues with credentialing arise, QM will work with the contracted agency to determine necessary next steps.

C. UNLICENSED WORKERS

1. Unlicensed workers which include Unlicensed Interns, Mental Health Rehabilitation Specialists (MHRS), Certified Peer Support Specialists, Peer Providers, and Other Provider Types (non-MHRS), do not require formal credentialing to be credentialed. However, BHRS credentialing will still require the hiring manager to collect BHRS Network Provider Attestation, education and experience information, NPI numbers

and any applicable information needed to confirm their rendering provider status before they begin to render services to beneficiaries.

2. Unlicensed workers will receive a credentialing determination prior to rendering services for the Network and before they are given access to SmartCare.

3. Providers with a denied credentialing determination may appeal the decision by contacting the Credentialing Committee to request a review of their application and dete1mination. They may provide additional supporting information to assist their case. The application determination, supporting documentation and additional information will be reviewed by BHRS Compliance or its designee within two weeks of receipt of appeal.

D. INTERNS & STUDENTS

1. Interns and students do not require formal credentialing. However, BHRS credentialing will still require a BHRS Network Provider Attestation, education and experience information, NPI numbers and any applicable information needed to confirm their provider status before they begin to render services to beneficiaries. Interns and students will continue to be subject to the requirements of the BHRS intern program.

2. Interns and students will receive a credentialing determination prior to rendering services for the Plan and before they are given access to SmartCare electronic health record system.

3. Providers with a denied credentialing determination may appeal the decision by contacting the Credentialing Committee to request a review of their application and determination. They may provide additional supporting information to assist their case. The application determination, supporting documentation and additional information will be reviewed by BHRS Compliance or its designee within two weeks of receipt of appeal.

Re-Credentialing Procedure

1. Re-credentialing must occur for all network providers including internal BHRS providers, individual contracted providers, TBH providers, contracted agency providers, and interns/students at a minimum <u>every three years</u> to ensure that they continue to possess valid credentials. The re-credentialing process will follow the same guidelines/steps as described under the "Credentialing Procedure" section above.

2. In addition to the initial credentialing requirements, re-credentialing will include documentation stating the quality improvement activities, beneficiary grievances, and medical records reviews have been taken into consideration while completing the re- credentialing process.

3. The re-credentialing process can be triggered at any time during a rendering provider's career by events including but not limited to a request by compliance staff, a program manager, contract manager, or billing or quality management staff as a result of concerns, grievances or unusual findings during the course of their duties. Concerns and requests must be sent in writing to the Credentialing Committee and must include the reason for an out of cycle review.

Reporting Serious Quality Deficiencies:
The Plan will report serious quality deficiencies that result in suspension or termination of a provider to DHCS and other authorities as appropriate. In addition, the plan will follow policies and procedures for disciplinary action, including reducing, suspending or terminating a provider's privileges.

Process for Appeals:
Providers may appeal a credentialing or re-credentialing decision such as a denial of aprovider's credentialing application, or suspension, or termination of a previously approved credentialing approval by submitting a written appeal to the Credentialing Committee within two weeks of notification of denial. The Credentialing Committee will review the appeal and make a decision within 30 days of receiving the appeal. The provider will be notified by mail of the decision. If an appeal of the denial of a credentialing application is upheld, the appropriate parties will be notified and county policies and procedures will be followed, which may result in employee suspension and/or termination.

Required Documents

ALL STAFF

1. National Provider Number (NPI)
2. NPI taxonomy that reflects appropriate licensure level
3. BHRS Network Provider Attestation

LICENSED STAFF

1. **Physician**

a. Copy of current Drug Enforcement Administration (DEA) license.
b. Copy of current Physician license from the Medical Board of California, or Copy of current Physician license from the Osteopathic Medical Board of California
c. Evidence of completing an accredited psychiatry residency program (i.e. certificate, letter OR Board certification in psychiatry)
d. Verification of enrollment in Cures 2.0.
e. Doctorate degree certificate
f. Master's degree certificate

2. **Psychologist**
    a. Copy of current license from the California Board of Psychology
    b. Doctorate degree certificate
    c. Master's degree certificate

3. **LCSW, LMFT and LPCC**
    a. Copy of current license from the California Board of Behavioral Sciences
    b. LPCC's must provide a letter from the Board of Behavioral Sciences confirming that they meet the necessary educational/experiential requirements prior to working with couples and families.
    c. Master's degree certificate

4. **Registered Nurse**
    a. Copy of license from the California Board of Registered Nursing (Note: RN's do longer get a copy of their license and therefore a copy from the DCA website should suffice).
    b. Evidence of experience/training in psychiatric nursing
    c. Master's degree certificate, or
    d. Bachelor's degree certificate

5. **Licensed Vocational Nurse and Psychiatric Technician**
    a. Copy of license from the California Board of Registered Nursing and Psychiatric Technicians
    b. Evidence of experience/training in psychiatric nursing

6. **Other Medical Professionals**
    Other medical professionals such as Nurse Practitioners (NP) and Physician Assistants (PA) may become enrolled as network providers. Scope of practice is per Standardized Procedure or Delegated Service Agreement.
    - NP must be registered with the Board of Registered Nursing as Nurse

Practitioner, be licensed as an RN, and have a furnishing number to prescribe medications. A DEA license may also be required.

WAIVERED PROFESSIONALS

1. **Pre-Doctoral Psychology Interns/Post-Graduate Psychologist Candidates/Registered Psychological Assistants**
   a. The Department of Health Care Services (DHCS) Professional Licensing Waiver (PLW) will issue the waiver (requested by BHRS Quality Management).
   b. Diploma or official copy of transcript(s) showing successful completion of at least 48 semester/trimester or 72 quarter units of graduate coursework, not including thesis, internship or dissertation
   c. Current Curriculum Vitae(CV)/Resume
   d. Employment start date (in the position requiring the waiver; PLW is non- renewable)
   e. If registered, copy of current registration from the California Board of Psychology (not required if practicing under PLW in an approved program)
   f. Doctorate degree certificate
   g. Master's degree certificate

2. **Out of State Licensees**
   a. DHCS will issue PLW (requested by BHRS Quality Management)
   b. Letter from the appropriate California licensing board stating that the licensee has sufficient experience to gain admission to the licensing examination
   c. Employment start date (in the position requiring the waiver; PLW is non- renewable)
   d. Copy of license/registration with their respective state licensing board

REGISTERED PROFESSIONALS

1. **AMFT, ASW, APCC**
   a. Copy of current registration from the California Board of Behavioral Sciences
   b. Master's degree certificate
   c. Bachelor's degree certificate

2. **Registered Psychologist and Registered Psychological Assistant**
   a. Copy of Current registration from the California Board of

Psychology

b. Primary supervisor must be a designated psychologist (for Psych Asst.)
c. For SMHS provision, requires a PLW (see *WAIVERED PROFESSJONALS)*

CERTIFIED SUBSTANCE USE SERVICE PROVIDERS

Registered Certified Substance Use Counselor

Copy of current registration from a state approved ce1iifying organization such as CAADE, CCAPP, or CADTP

GRADUATE STUDENTS

1. **Master's and Doctoral Degree Candidates**
   a. Attestation by intern program that intern has met internship requirements.

UNLICENSED WORKERS

1. **Mental Health Rehabilitation Specialist:**
   a. Education and Experience form
   b. Master's degree certificate, or
   c. Bachelor's degree certificate, or
   d. Associate's degree certificate

2. **Non-Mental Health Rehabilitation Specialist:**
   a. Education and Experience form
   b. Bachelor's degree certificate, or
   c. Associate's degree certificate