Alameda County **Behavioral Health Care Services Date**	Date Approved: 10/17/07 By: _____ Mental Health Director
POLICY: **CREDENTIALS AND RE-CREDENTIALING**	Date Revised: 2/17/10 Policy No.: _____

POLICY: **Credentials and Re-Credentialing**

Policy Statement: Alameda County Behavioral Health Care Service, Behavioral Health Plan (ACBHCS-BHP) will ensure that all of its licensed behavioral health care practitioners have the required licensure, education, board certification, training, clinical experience, and malpractice coverage to provide care that meets the organization's standards by initially credentialing all practitioners /agencies and re-credentialing biannually. ACBHCS-BHP Credentialing Committee will abide by all California and federal peer review reporting laws. The staff credentialing function is delegated to county Human Resources and contract organizations for their respective staff.

Definitions:

Credentialing: The process by which the behavioral care organization authorizes, contracts with, or employs practitioners who are licensed to practice independently, to provide services to its clients. Eligibility is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability and accessibility, and conformance with managed care organization utilization and quality management requirements. (The Behavioral Health Plan's decision to contract may also be influenced by such non-re-credentialing factors as the need for services in the geographic area.)

Re-Credentialing: An evaluation process for behavioral health care practitioners/agencies that includes an appraisal of practitioner's professional performance, judgment and clinical competence. This includes a review of information collected since the previous re-credentialing cycle; an example is the client satisfaction reports along with the review of licensure standing and malpractice coverage.

Reporting Laws
Reporting laws are meant to assist licensing agencies in identifying incompetent practitioners and to alert medical staffs and other peer review bodies during the credentialing process to disciplinary action at other hospitals and to liability settlements or judgments that exceed a certain threshold. There are both California and federal reporting laws.

California Law
State law imposes ten reporting obligations, some of which are:

Malpractice. Settlements or judgments over $30, 000 for doctors and $3,000 for other health care practitioners. [B&P §801, 802].

Peer Review. Denial of Privileges, Membership, Employment for Cause. A peer review body shall file a report to the relevant agency whenever the following actions are taken as a result of a determination of a peer review body: [B&P §805].

A licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.
A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.

Restrictions are imposed or voluntarily accepted on staff privileges, membership or employment for cumulative total of 30 days or more for any 12-month period, for medical disciplinary cause or reason.

A licentiate's resignation or leave of absence from membership, staff, or employment following notice of an impending investigation based on information indicating medical disciplinary cause or reason.

The reporting is not a waiver of confidentiality of medical records and committee reports. The information reported will be kept confidential except as for that portion that can be shared with the accused licentiate (or counsel or representative) and except as to disclosure to law enforcement or regulatory agency when required, per Section 800 (c).

Removal of privileges whether voluntary or involuntary, for a non-medical disciplinary cause or reason or for an institutional policy reason unrelated to discipline does not require an 805 Report.

Criminal Convictions. Court Clerk reports criminal convictions. [B&P §803]

Criminal Filings. Prosecutor must report any felony filings against a doctor. [B&P §803.5]

Insurance Fraud. Bureau of Fraudulent Claims reports name of licensed provider suspected or convicted of insurance fraud. [Ins. Code. §1872.85]

Child & Spousal Support. Department of Social Services reports names of providers who have failed to comply with child and spousal support obligations. [W&I §11350.6]

Federal Health Care Quality Improvement Act.
Federal law imposes additional obligations. The National Practitioner Data Bank was created in 1990. There are three mandatory reporting obligations.

Malpractice. Any amount paid on behalf of a physician or other provider in full or partial settlement or judgment must be reported.

Peer Review. Certain adverse peer review determinations involving physicians and dentists must be reported. Reporting of other practitioners is voluntary, but cannot be reported if the conduct is something other than that which would require reporting if the practitioner were either a physician or dentist, and if there is no HCQIA immunity covering the underlying peer review activity.

Licensure. Licensing agencies must report in the event of action taken to revoke or suspend a physician's license or in another manner censures, reprimands, or places on probation a physician for reasons relating to professional competence or conduct.

Standards for Credentialing and Re-Credentialing

The Credentialing Committee consists of a multi-disciplinary team that may include a psychiatrist, registered nurse, social worker, psychologist and marriage and family therapist will have the responsibility for credentialing, re-credentialing, evaluating and selecting individual practitioners or groups of practitioners that participate within the ACBHCS-BHP provider network. The ACBHCS Medical Director must be a Committee member and must provide input into decision-making. It is this committee's responsibility to choose practitioners who will work well within the network of providers. The Quality Assurance Administrator is responsible to establish written procedures for credentialing and re-credentialing decisions.

The policies developed define the licensed independent practitioners who are subject to these policies and the criteria required to reach a decision. The criteria are designed to assess a practitioner's ability to deliver care. They include licensure, relevant training and/or experience and disclosure of any health issue that may affect care delivered within the ACBHCS-BHP care system.

The kinds of practitioners included, but not limited to:

- Psychiatrists who are board eligible or board certified;
- Master's level Marriage and Family Therapist who are licensed by the State of California;
- Psychiatrists and/or physicians who are certified in addiction medicine;
- Doctoral Psychologists who are licensed by the state of California ;
- Master's level clinical social workers who are licensed by the state of California;
- Master's level clinical nurse specialists who are nationally certified and/or licensed by the State of California to practice independently; and
- Behavioral Health Care clinicians who practice within the local hospital inpatient setting are required to be credentialed or re-credentialed by the accredited hospital.
- Behavioral Health Care clinicians who practice outside of local area hospital, in-patient settings are required to be credentialed or re-credentialed by that accredited hospital.

At the time of credentialing, the ACBHCS-BHP Credentialing Committee will verify at least the following information from primary sources:

CREDENTIALING

1. A current valid license to practice in good standing as an independent behavioral health care practitioner approved by the State of California; information about sanctions or limitations or licensure from the State agency; review of previous sanction activity by regional Medicare and Medicaid offices.

Verification: Documentation directly from the State Licensing Agency.

2. Clinical privileges in good standing at the institution designated by the behavioral health care practitioner as the primary admitting facility, as applicable.

Verification: Documentation directly from the primary admitting institution that confirms current privileges in good standing. The documentation may be a letter from the institution, or documentation of oral confirmation that includes the date received, and name of person receiving the information.

3. A valid DEA certificate, as applicable;

Verification: Copy of the DEA certificate. Primary source verification is not required. DEA certificates are not applicable to non-physician behavioral health care practitioners who do not prescribe medications, such as clinical social workers, professional counselors, marriage and family therapist, and addiction counselors.

4. Graduation from an accredited professional school or university and/or highest training program applicable to the academic degree, discipline, and licensure of the behavioral health care practitioner;

Verification: If the practitioner is a board-certified physician, medical school graduate and completed residency program verification through one of the following will occur:
Entry in the American Board of Medical Specialties Compendium;
Confirmation from the appropriate specialty board;
Entry in the American Medical Association Physician Master File; or
Confirmation from the state licensing agency.

If the physician is board eligible, graduation from medical school and the completion of an APA approved residency program, will be verified through one of the following:
Confirmation of completion from the appropriate physician's residency program;
Confirmation from the National Physician Data Bank;
Confirmation from the appropriate medical school;
Entry in the American Medical Association Physician Master File;

Confirmation from the State licensing agency;
Confirmation from the Educational Commission for Foreign Medical Graduates for International medical graduates licensed after 1986.

For non-physician behavioral health care clinicians, graduation from an accredited university or professional school can be verified by one of the following:
Confirmation from the university or professional school;
Confirmation from the State licensing agency for verification of university or professional school training;
Confirmation from the National Reporting for Psychologists Credential Verification Service.

5. Board certification if the practitioner states that he/she is board certified on the application.

Verification:
Entry in American Board of Medical Specialties Compendium;
Confirmation from the appropriate specialty boards;
Confirmation from the State licensing agency.

6. Work History/Experience

Verification: Complete work history for the past five years is stated on the application, curriculum vitae, or other documentation. Primary source verification is not required.

7. Current, adequate malpractice insurance according to the ACBHCS-BHP policy.

Verification: Current, adequate malpractice insurance for each incident at $1 million dollars.

8. History of professional liability claims which resulted in settlements or judgments paid by or on behalf of the practitioner.

Verification: Written documentation of five years claims history from the malpractice carrier or National Practitioner Data Bank or documented explicit refusal by the carrier to provide the requested information.

9. Specialized training for non-traditional behavioral health care practitioners.

Verification: Confirmation from the specialized school or training program.

10. Letters of Reference

Verification: Two reference letters from local practitioners that reflect the most relevant information about the practitioner.

11. A complete practitioner application must be submitted for consideration.

12. The provider is not listed on the Federal, State or County ineligible provider lists for Medi-Cal, Medicare or any other payer source. The provider has no history of disciplinary action by County or agency. The provider is not excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

Verification: Documentation of the provider's name not appearing on the Federal, State or County ineligible provider lists. The provider has no record of disciplinary action by the County or agency.

RE-CREDENTIALING

At a minimum, re-credentialing of practitioner is conducted every three years by the ACBHCS-BHP Credentialing Committee. The Committee verifies at least the following information from primary sources:

1. A valid license to practice in the State of California.

Verification: Documentation directly from the State of California Licensing Agency.

2. A valid DEA certification (a copy is sufficient)

Verification: Copy of the DEA Certification

3. Board certification, only if the practitioner was due to be re-certified, or states that he/she has become board certified since the last time he/she was credentialed or re-credentialed.

Verification: Confirmation from the appropriate specialty board.

4. Current, adequate malpractice insurance for each incident in the aggregate at $1 million.

Verification: A copy of the current malpractice coverage that shows dates and amount of coverage. Primary source verification of malpractice coverage occurs during the initial credentialing and re-credentialing process.

5. Updated history of professional liability claims resulting in settlements or judgments paid by or on behalf of the practitioner.

Verification: Documentation of claims history from the malpractice carrier or National Practitioners Data Bank or documented explicit refusal by the carrier to provide the requested information.

6. The provider is not listed on the Federal, State or County ineligible provider lists for Medi-Cal, Medicare or any other payer source. The provider is not excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

Verification: Documentation of the provider's name not appearing on the Federal, State or County ineligible provider lists.

7. The provider has scored 90% or higher on any and all quality and claim audits conducted by ACBHCS. If the provider scored under 90% on a single audit outcome, they must have demonstrated a score of 90% or higher on the first follow-up audit.

Verification: Documentation of the provider plan of correction audit outcomes in the ACBHCS Quality Assurance Office.

8. The provider has no history of adverse decisions or disciplinary action by County or ACBHCS.

Verification: Documentation of the provider's clear record in the ACBHCS Quality Assurance Office.

Response by Alameda County Behavioral Health Care Services

Within ninety (90) days after request of the completed application, the ACBHCS-BHP Credentialing/Re-Credentialing Committee will notify the applicant regarding approval or denial, of the application and if additional information is needed for the initial credentialing.

When problems arise with an application, the applicant shall be included in the process with written notification. Upon confirmation of continued compliance with all requirements, ACBHCS-BHP Credentialing/Re-Credentialing Committee will conduct a re-credentialing review biannually and notify the practitioner if they are approved or denied continuance within our network.

All decisions of the Credentialing Committee are based on known facts, delineated criteria and standards.

The Credentialing Committee does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

Confidentiality

Strict confidentiality shall be maintained within all Credentialing Committee meetings. No discussion of the application or applicant shall take place outside of Administration and the committee meetings. Tape recorders shall not be used during the committee meeting.

Restricting, Suspending, and Revoking Privileges

The Credentialing Committee shall have the Authority to restrict, suspended and revoke privileges within the ACBHCS network of practitioners. Actions of the Committee will be consistent to the policy, "RESTRICTION OF PRIVILEGES FOR PRACTITIONERS".

Practitioner Appeals

If a practitioner is denied admission to the ACBHCS-BHP practitioner network, he/she can file a written appeal request. The Credentialing Committee will review all appeal requests and forward them to the Administrative Team for review. The Administrative Team will respond with a written decision to the practitioner within thirty (30) days.

An appeal of adverse decision or discipline of the provider will be consistent with the policy, "RESTRICTION OF PRIVILEGES FOR PRACTITIONERS".

CREDENTIALING COMMITTEE PROCEDURAL STANDARDS

The ACBHCS-BHP's Credentialing Committee or designee will review the practitioner's application, the primary source verification documentation and recommendation, information about ethical violations, and any past Medi-Cal, licensing board, professional associations, hospital or HMO staff, or other professional privileges restrictions.

Malpractice history will be examined and evaluated taking into consideration the number, severity, extent, disposition and nature of all lawsuits past, present, and future.

The practitioner's resume will be compared with the application to determine whether there is sufficient and accurate data on the resume that substantiates the areas of proficiency identified on the application. For example, practitioners with specialties in mental health should have the appropriate education, training, and experience in that specialty reflected on their resume.

After reviewing the information from the applicant and source verification agent, the credentialing committee or designee will determine the practitioner's eligibility to become a member of the ACBHCS-BHP's provider network. Any and all negative findings are sufficient justification for denial or termination of membership.

When the Credentialing Committee approves the applicant, a recommendation will be submitted to the Fiscal Contract Office for a contract to be offered to the practitioner.

The Credentialing Committee will comply with any additional requirements established by the State regarding provider selection, credentialing, and re-credentialing.