PerformCARE®	Policy and Procedure
Name of Policy:	Credentialing and Re-credentialing Criteria - Facilities
Policy Number:	QI-CR-001
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Quality Improvement Department
Related Stakeholder(s):	All Departments
Applies to:	PerformCare Associates and Providers
Original Effective Date:	10/01/01
Last Revision Date:	02/01/24
Last Review Date:	01/22/25
OMHSAS Approval Date:	N/A
Next Review Date:	01/01/26

Policy: PerformCare has a relationship with a National Committee for Quality Assurance (NCQA) approved Credentials Verification Organization (CVO), which will complete the primary source verification needed to credential and re-credential facilities within the PerformCare Network. PerformCare has a standard credentialing procedure for admitting providers into the network. PerformCare's Credentialing Committee, chaired by the Medical Director or designee, reviews all applicants to verify license and specialty. In addition, PerformCare will assure that providers adhere to credentialing requirements under the *PA Department of Health regulations, Title 28, Chapter 9, Managed Care Organizations, Subchapter L, Sections 9.761, 9.762 and 9.763.*

Purpose: To establish procedures for the credentialing and re-credentialing of licensed facilities within the PerformCare Provider network.

Definitions: **Clinician:** This term is used in reference to an individual practicing under the license of a facility.
Facility: This term is used in reference to an institution, or organization that provides services for enrollees. Examples include hospitals, licensed outpatient clinics, licensed partial hospitalization programs, etc.
Provider: This term may be used interchangeably to represent an individual practitioner or a facility.

Acronyms: **ABA:** Applied Behavioral Analysis
AE: Account Executive
BA: Behavior Analytic
BC: Behavior Consultant
BCM: Blended Case Management

BH-MCO: Behavioral Health Managed Care Organization
BHT: Behavioral Health Technician
CARF: Commission on Accreditation of Rehabilitation Facilities
CCM: Clinical Care Manager
CMS: Centers for Medicare & Medicaid Services
COA: Council on Accreditation
CRR-HH: Community Residential Rehabilitative Host Home
CVO: Credentials Verification Organization
DEA/CDS: Drug Enforcement Administration/Controlled Dangerous Substance
DOS: Department of State
EPLS: Excluded Parties List System
FBMHS: Family Based Mental Health Services
HHS-OIG: U.S. Department of Health & Human Services-Office of Inspector General
HMO: Health Maintenance Organization
IBHS: Intensive Behavioral Health Services
ICM/RC: Intensive Case Management and Resource Coordination
IP: Inpatient
JCAHO: Joint Commission on Accreditation of Healthcare Organizations
MA: Medical Assistance
MH: Mental Health
NCQA: National Committee for Quality Assurance
NH: Non-Hospital
NPDB: National Provider Data Bank
NPI: National Provider Identifier
NPPES: National Plan and Provider Enumeration System
OP: Outpatient
PHI: Protected Health Information
PHP: Partial Hospitalization Program
QPS: Quality Performance Specialist
RTF: Residential Treatment Facility
SAM: System for Award Management
SU: Substance Use
WM: Withdrawal Management

Procedure:

1. Credentialing and Re-credentialing of Facilities
   1.1. In establishing and maintaining the provider network, PerformCare considers the number of network facilities and their capacity to meet the needs of new and existing Members. A Facility is defined as an institution, or organization that holds licensure or is MA enrolled as such to perform one or all of the following services:
      1.1.1. SU and/or MH OP/crisis intervention;
      1.1.2. SU and/or MH IP;
      1.1.3. SU and/or MH PHP;
      1.1.4. SU and/or MH ICM/RC or BCM;

1.1.5. Peer support services;
1.1.6. IBHS;
1.1.7. RTF;
1.1.8. FBMHS;
1.1.9. CRR-HH;
1.1.10. SU Medically Monitored Inpatient WM, Clinically Managed, High-Intensity Residential Services or Clinically Managed Low-Intensity Residential Services;
1.1.11. SU Medically Managed Intensive Inpatient WM or Medically Managed Intensive Inpatient Services.

1.2. Recruitment efforts for in-plan service providers are directed toward facilities in accordance with the following general guidelines:
1.2.1. It offers a full continuum of care or offers a distinct specialized service.
1.2.2. It is a primary admitting inpatient facility for physician providers who have been contracted for the individual provider network.
1.2.3. It would be an asset to the network as reported by PerformCare CCMs or other PerformCare personnel.
1.2.4. It has the appropriate license and/or certificate of compliance from the appropriate government agency(ies).
1.2.5. It is a participant in the Pennsylvania MA Program and has been assigned a Provider Number with the appropriate types and specialties.
1.2.6. It is identified by the Counties as a resource.
1.2.7. Inclusion in the network is supported by HealthChoices Primary Contractor(s).

1.3. According to NCQA guidelines, behavioral health facilities include organizations providing MH or SU services in an IP, residential, or ambulatory setting including OP WM and community MH centers.

1.4. When selecting network facilities, PerformCare solicits the experience and opinions of their senior clinical staff, CCMs, HealthChoices Primary Contractors, and other staff who have knowledge of facilities in a specific area. All applications are reviewed by PerformCare Credentialing staff and presented to the Credentialing Committee. Final authority to approve or deny a facility rests with the Credentialing Committee as outlined in *QI-CR-005-Credentialing Committee*.

1.5. The following items will be submitted with the facility Credentialing Application for review:
1.5.1. Copy of current state license(s).
1.5.2. Copy of current Joint Commission (formerly JCAHO), CARF, or COA accreditation certificate. If a facility is not accredited, network acceptance is subject to a site visit.

1.5.3. Copy of current professional liability insurance in the amount of $1,000,000 per occurrence / $3,000,000 aggregate.
1.5.4. Current or pending malpractice claims; professional liability claims history; past, current, or pending legal actions to include settlements/lawsuits; any voluntary, involuntary revocation, suspension, limitation, or restriction of state license/certification/registration; censures or sanctions by a national, state or county medical or professional association.
1.5.5. Copy of independent auditor report of facility solvency and the self-insurance fund amount if the facility is self-insured.
1.5.6. List of current professional staff and their credentials including all Board Certifications and Subspecialty Board Certifications privileged to admit and/or treat patients. The facility must sign an attestation form indicating they have completed all relevant checks for all professional staff that treat PerformCare Members.
1.5.7. Prior to presentation to Credentialing Committee, PerformCare confirms that the facility remains in good standing with State and Federal regulatory bodies.

1.6. In addition, all facilities must complete and submit an application, which requires disclosure to PerformCare if Prior expulsion from participation in any insurance and/or HMO program has occurred.

1.7. The facility must also have the following:
1.7.1. Willingness to contractually commit to meeting requirements of the PerformCare HealthChoices program.
1.7.2. Have an admissions policy free from restrictions based on an individual's race, religion, color, creed, sexual orientation, gender identity, or national origin.
1.7.3. Multi-disciplinary treatment staff.
1.7.4. Facility appropriately credentials practitioners working for the facility. The facility's policy for credentialing practitioners will be reviewed by PerformCare and must include but is not limited to:
1.7.4.1. Verification of licenses directly with DOS.
1.7.4.2. Documentation of disciplinary actions identified by DOS.
1.7.4.3. Primary source verification of education is conducted for all clinical staff.
1.7.4.4. For physicians, the DEA/CDS is confirmed to be current.
1.7.4.5. The resume reflects continuous work experience – breaks are explained.
1.7.4.6. Medicheck is referenced to assure all owners, board members, employees and contractors/sub-contractors

are not precluded or excluded from Pennsylvania MA with on-going review required.

1.7.4.7. HHS-OIG is referenced to assure all owners, board members, employees and contractors/sub-contractors are not excluded from participation in any federal health care program.

1.7.4.8. SAM formerly known as EPLS is referenced to assure that all owners, board members, employees and contractors/sub-contractors are not excluded from receiving Federal contracts, certain subcontracts and certain Federal financial and/or financial benefits.

1.7.4.9. All three lists (Medicheck, HHS-OIG and SAM) are checked prior to hiring/instating all owners, board members, employees, and contractors/sub-contractors.

1.7.4.10. All three lists are checked ***monthly*** for all owners, board members, employees, and contractors/sub-contractors.

1.7.4.11. If any adverse issues are discovered through these checks, the information must be submitted as part of the facility's credentialing packet including any actions the facility has taken as a result of this information. This information will then be presented to the Credentialing Committee for consideration to allow this clinician to continue to treat PerformCare Members at the agency considering the adverse actions. Although PerformCare does not individually credential clinicians working within a facility, PerformCare reserves the right to ask for review of a facility's credentialing files for anyone at any time. If adverse issues are found during the review, PerformCare reserves the right to request that the clinician undergo the PerformCare credentialing process where any adverse issues the clinician may have will be presented to the Credentialing Committee for review. The Credentialing Committee will determine if the clinician should be permitted to provide services to Members in the network based on the adverse issue. The facility will be notified of this decision and the committee's recommendations.

1.7.4.12. PerformCare expects members under the age of thirteen (13) to be treated by a Board-Certified Psychiatrist with a subspecialty certification in Child & Adolescent Psychiatry. If the facility provides child/adolescent RTF and/or child/adolescent IP services and does not employ the above qualified staff, the facility will be required to submit a statement with

the credentialing application which informs PerformCare of the provisions the facility will make to meet this expectation.

2. Site Visit Requirements
   2.1. Site visits will be required for any potential high-volume facility.
      2.1.1. Outpatient services (individual, family and group therapy, medication management and psychiatric evaluations) are considered to be high volume services. Outpatient is typically the gateway to higher levels of care and captures the largest segment of unique Members served.
      2.1.2. To be identified as a potential high-volume provider that would require a site visit, the facility will indicate that they have existing capacity to serve more than 200 unique Members.
      2.1.3. For re-credentialing, high volume providers are determined through claims statistics.
   2.2. The site visit is conducted by an AE to the office of potential high-volume behavioral healthcare facilities prior to the credentialing or re-credentialing decision.
   2.3. For re-credentialing, the AE will conduct the site visit in-person for the first re-credentialing cycle. Subsequent re-credentialing site visits will be conducted in the following manor based on upon the score of the first re-credentialing site visit:
      2.3.1. 95-100%: The PerformCare site visit will be replaced by the most recent state licensure inspection report;
      2.3.2. 80-94%: The site visit will be conducted by the AE in-person, via self-audit tools, or a combination of both;
      2.3.3. 79% or lower: The AE will follow the process as outlined in Section 2.7.
   2.4. The office site visit includes evaluation of the facility for accessibility, appearance, adequacy of waiting and treatment rooms, appointment availability, and appropriate treatment record storage practices.
   2.5. The minimum score for initial and re-credentialing visits is 80%. The site visit tool is included as an attachment, *Attachment 1 PerformCare Site Visit Tool.*
   2.6. Site visits will be required for any non-accredited facility using the same criteria as indicated above with the following exception.
      2.6.1. CMS or State review or certification does not serve as accreditation of a facility however in the case of a non-accredited organization; NCQA permits that PerformCare may substitute a CMS or State review in lieu of the required site visit.

2.6.2. State licensing tools have been reviewed and are acceptable to meet PerformCare's standards. PerformCare will obtain the report directly from the facility.

2.6.3. Should the facility have not obtained full licensure, PerformCare will conduct a site visit.

2.7. If the facility does not meet PerformCare thresholds for acceptable performance, the AE will notify the site of deficiencies and re-evaluate the site within six (6) months. If the facility does not meet the threshold after six (6) months, PerformCare has the option to discontinue efforts. In such a case, the facility may reapply when corrections have been made.

2.8. AEs are responsible to complete all credentialing and re-credentialing site visits.

2.8.1. Every effort will be made to coordinate the AE site visit with the treatment record review as outlined in section 6.2.1.2 of this policy.

2.8.2. The Director of Operations is responsible to assure that each AE has initial training in the survey process as well as the survey tool. New employees are trained on the survey process and tool as part of new employee training. Ongoing training is provided through staff meetings and individual supervision meetings. Detailed instruction is also available in the Provider Relations Handbook for reference.

3. Alternative, Non-Traditional Provider Credentialing (Applicable to HealthChoices)

3.1. PerformCare will utilize alternative and non-traditional therapeutic services in each community. Such services include licensed Substance Use Clinically Managed, High-Intensity Residential Services, Medically Monitoried Inpatient WM and Clinically Managed Low-Intensity Residential Services programs as well as IBHS for children and adolescents under the age of 21 including but not limited to BHT, Mobile Therapy, and BC.

3.2. Alternative and non-traditional providers not only increase flexibility in providing services to Members, but they also represent local networks of care. PerformCare understands the importance of the inclusion of existing community-based providers, be they traditional or non-traditional.

3.3. PerformCare understands that Members served by the network deserve high quality services that will effectively and efficiently meet their behavioral health care needs. For this reason, it is important to establish standards to be met by every provider serving any Member.

3.4. The ability to work with alternative and non-traditional providers identified within the region enables the network to be broad and address unique needs. PerformCare and local providers have spent

many years refining skills to meet the priority needs as identified by the Counties.

3.5. Credentialing of such providers by PerformCare will be accomplished by verifying continued state licensure and adherence to Provider Relations policies.

4. Primary Source Verification – Initial and Re-credentialing Applications for Facilities

4.1. Primary Source Verification is completed by an NCQA certified CVO for each facility who is contracted with PerformCare to provide services to PerformCare's Members. The CVO uses the following verification sources:

4.1.1. Verification of licensure in the state where the facility has an office(s). This is verified directly from the state licensing agency to include sanction information.

4.1.2. Verification of accreditation directly from the accrediting agency.

4.1.3. Verification of malpractice insurance coverage by obtaining current face sheet.

4.1.4. Verification of malpractice claims history by collecting history of malpractice settlements from the NPDB or directly from the insurance carrier when available.

4.1.5. Verification of Medicare and Medicaid sanctions completed via a query of NPDB.

4.1.6. Medicheck is referenced to assure the facility is not precluded or excluded from Pennsylvania MA.

4.1.7. HHS-OIG is referenced to assure the facility is not excluded from participation in any federal health care program.

4.1.8. SAM, formerly known as EPLS, is referenced to assure the facility is not excluded from receiving Federal contracts, certain subcontracts and certain Federal financial and/or financial benefits.

4.1.9. NPPES is referenced to assure the facility has valid NPI number(s).

4.1.10. MA provider enrollment is referenced to assure the facility has valid MA enrollment with the appropriate types and specialties for the planned services.

5. Delegation Activities and Oversight

5.1. PerformCare has made a business decision to delegate primary source verification activities to a NCQA approved CVO. The CVO is contracted to request/mail initial and re-credentialing applications and complete the primary source verification needed to credential and re-credentialing facilities in the PerformCare network.

5.2. A specific description of the activities performed by the CVO is located in section 4 of this policy. *Facility Credentialing and*

Re-credentialing Applications are submitted to the CVO by PerformCare or the provider and returned to PerformCare with completed verifications within 45 calendar days.

5.3. The CVO provides an audit sheet with each returned file so that PerformCare can monitor quality continuously. Upon receipt of each credentialing file, the assigned QPS reviews the audit sheet to assure that timeframes and requirements are met for the file.

5.4. The CVO is required to report, monthly, facilities whose credentials were verified in the previous month. The CVO will also provide a report of facilities that should be in the process of re-credentialing monthly. PerformCare reviews the CVO's performance relative to quality of work via weekly reports and monthly monitoring meetings.

5.5. PerformCare monitors the length of time it takes the CVO to complete a file. Per the contractual agreement. The average turnaround time goal is under 30 days but not to exceed 45 days.

5.6. All CVO verifications of facility credentialing files are reviewed for quality and accuracy as they are received for processing. Upon receipt from CVO, the assigned QPS conducts a final review of each application for completeness.

6. Performance and Quality of Care Monitoring at time of Re-credentialing of Facilities

6.1. PerformCare's review of network facilities performance is an ongoing process; however, all facilities are formally re-credentialed at least every three (3) years. PerformCare reviews the facility's licensure, malpractice insurance, accessibility to Members, clinical and administrative outcomes, accreditation status, the results of satisfaction surveys mailed to all treated Members, when available, and compliance with PerformCare standards. The re-credentialing process also includes review of the facilities performance since the last credentialing decision.

6.2. Performance Monitoring

6.2.1. Ongoing performance monitoring is completed on the following:

6.2.1.1. Member Complaints and Grievances

6.2.1.2. Results of quality improvement initiatives, monitoring, and evaluation activities including Treatment Record Reviews as outlined in *QI-026- Provider Treatment/Service Record Reviews*.

6.2.1.3. Provider Profiles, when applicable

6.2.1.4. PerformCare Member Satisfaction Surveys, when available

6.2.1.5. Critical Incident Reports

6.2.2. In addition, PerformCare monitors provider performance relative to evaluation of clinical outcomes, administrative outcomes, and internal concerns on an ongoing basis. The

Re-Credentialing Provider Summary is attached, *Attachment 2 Re-credentialing Provider Summary*. The summary is completed for each facility as they undergo re-credentialing.

6.2.3. Problematic issues discovered through the profiling process are addressed immediately with the facility. Profiling results are also reviewed and considered during the re-credentialing process.

7. The Credentialing Committee

7.1. The completed, verified application of a facility is presented to the Credentialing Committee as defined in *QI-CR-005 Credentialing Committee*.

7.2. At least every three years, PerformCare network facilities undergo a re-credentialing process including re-verification of credentials and review of other relevant clinical and administrative information.

8. Listings in Provider Directory

8.1. PerformCare ensures that information about facilities published in the Provider Directory and shared with Members is as accurate as possible. Facilities receive a form to complete and fax to PerformCare should changes to their information be necessary. The form is provided upon request and included in the Provider Manual.

Related Policies:

PR-010 Provider Training and Orientation
QI-015 Incorporating Consumer Satisfaction Information in the Quality Improvement Process
QI-026 Provider Treatment/Service Record Reviews
QI-CR-003 Credentialing Progressive Disciplinary Actions for Providers
QI-CR-005-Credentialing Committee

Related Reports:

None

Source Documents and References:

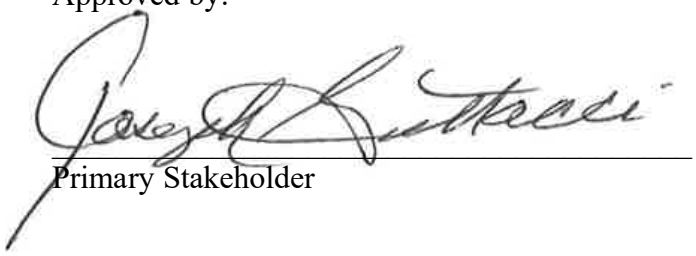
PA Department of Health regulations, Title 28, Chapter 9, Managed Care Organizations, Subchapter L, Sections 9.761, 9.762 and 9.763.

Superseded Policies and/or Procedures:

PR-004 Credentialing and Re-Credentialing Criteria

Attachments: *Attachment 1 PerformCare Site Visit Tool*
Attachment 2 Re-credentialing Provider Summary
Attachment 3 Facility Credentialing and Re-credentialing Application

Approved by:



Primary Stakeholder

Initial/Recredentialing
Credentialing Site Visit Tool

Date of Site Visit:	
Initial/Recredentialing	
Name of AE completing Site Visit:	
Provider Score:	#DIV/0!
Total Yes:	0
Total No:	0
Pass/Fail:	
Recommendations to Providers:	
Required Corrective action plan required and accepted:	
Comments:	
PROVIDER DEMOGRAPHICS:	
Provider ID:	
Name of Provider:	
Physical Address Where Credentialing Review Occurred:	
Phone Number of Facility:	
Fax Number of Facility:	
Contact Person Name:	
Title of Contact Person:	
Contact Person Email Address:	
AFTER HOURS TELEPHONE VERIFICATION:	
Date Of Call:	
Time of Call:	
Are urgent/emergent instructions provided including on-call staff/Crisis/ER/911:	
PROVIDER MANUAL REVIEW:	
Copy of or link to provider manual given:	
Member Rights:	
Access Standards:	
Freedom of Choice:	
Claims Submission Timeframes:	
Authorization Processes:	
Review of TPL requirements by provider:	
PerformCare Complaints and Grievances Brochure distributed:	
QUALITY IMPROVEMENT:	
Corporate Compliance policy and/or plan exists:	
Name of Corporate Compliance officer:	
GROUP ONLY: The group has an adequate QI plan to detect and address quality issues:	
Process to identity quality issues (i.e. routine self audits-must be quantified):	
Process identified to report quality issues:	
Process identified to analyze/track and determine action steps:	
GENERAL POLICY & PROCEDURE REVIEW:	
Protect patient confidentiality (GROUP ONLY):	
Confidentiality agreements for staff and vendors:	
Report program and licensure changes to BH-MCO and appropriate entities:	
Critical Incident Reporting to BH-MCO and appropriate entities:	
Address offering of provider choice:	
Address compliance with the Child Protective Services Law (previously Act 124 of 1975) relative to mandatory reporting. Mandated Reporter training must be done, and redone every 2 years:	

Management and disposal of data storage (paper and electronic) for current and archived files that is HIPAA compliant:	
Policy that outlines all staff trainings required per year and how individual staff plans are generated:	
Individual Staff training plan example provided:	
HR POLICY & PROCEDURE REVIEW:	
PA Code Check Policy: ***(all checked prior to hire and every 3 years)***	
Resume reflects continuous work experience and breaks are explained:	
Primary source vertification of education is conducted for all clinical staff:	
Vertification of licenses directly with Department of State (DOS):	
Documentation of disciplinary actions identified by DOS:	
Board Certification Status:	
For prescribers, DEA Certification is confirmed and current:	
Evidence of malpractice/liability insurance:	
Child Abuse Clearances (PA Act 33) Policy: ***(checked prior to hire and every 5 years)***	
PA Child Abuse History Clearances:	
PA Criminal Record Checks:	
FBI Criminal Background Checks:	
Sanction/Exclusion Check Policy: ***(checked monthly)***	
HHS-OIG is referenced to assure employee is not excluded from participation in any federal health care program:	
SAM is references to assure that employees are not excluded from receiving federal contracts, certain subcontracts and certain federal financial and non-financial benefits:	
Medicheck is referenced to assure employees are not precluded or excluded from PA MA:	
NPDB - National Practitioner Data Bank (optional):	
FACILITIES ONLY:	
Have sanction/exclusion checks been submitted to PerformCare Corporate Credentialing?	
Date Submitted:	
Verified by AE:	

EMPLOYEE FILE REVIEW (FACILITY ONLY): ***(Review of 2 licensed staff files, with one staff being an MD/DO)*** **:**	
	EMPLOYEE NAME #1 (Licensed Staff):
PA Code checks: **(all to be checked prior to hire and every 3 years)**	
Work History - Resume reflects continuous work experience. Breaks are explained:	
Education/Training - Highest level of education is verified at the primary source:	
License verified on DOS website - print out in employee chart:	
Board Certification Status:	
For Prescribers, DEA Certification is confirmed and current:	
Evidence of malpractice/liability insurance:	
Child Abuse Clearances (PA Act 33) checks: **(all to be checked prior to hire and every 5 years)**	
PA Child Abuse History Clearances:	
PA Criminal Record Checks:	
FBI Criminal Background Checks:	
	EMPLOYEE NAME #2 (MD/DO):
PA Code checks: **(all to be checked prior to hire and every 3 years)**	
Work History - Resume reflects continuous work experience. Breaks are explained:	
Education/Training - Highest level of education is verified at the primary source:	
Original license reviewed:	
License verified on DOS website - print out in employee chart:	
Board Certification Status:	
For Prescribers, DEA Certification is confirmed and current:	
Evidence of malpractice/liability insurance:	
Child Abuse Clearances (PA Act 33) checks: **(all to be checked prior to hire and every 5 years)**	
PA Child Abuse History Clearances:	
PA Criminal Record Checks:	
FBI Criminal Background Checks:	

FREEDOM OF CHOICE REVIEW:	
Documentation of freedom of choice Member #1:	
Documentation of freedom of choice Member #2:	
Documentation of freedom of choice Member #3:	
Documentation of freedom of choice Member #4:	
Documentation of freedom of choice Member #5:	
PHYSICAL SPACE INSPECTION:	
GROUP INSPECTIONS:	
Printed material is appropriate to age and developmental needs of population:	
Signs and brochures are in language based on population *(Spanish materials required for Dauphin, Franklin, Lancaster, Lebanon only)* :	
Medical records are kept in a separate area and locked:	
Medical records are stored in an organized manner and a specific member file can be easily located:	
Policy and procedure manuals are readily available:	
Appointment book indicates provider has capacity to offer a routine appointment within 7 calendar days: *(If self audit, date required)*	
Waiting area accommodates the site of the OP practice (minimum of 4 chairs or 2 chairs per practitioner on duty):	
Waiting area is well-lit:	
Waiting area has office hours posted:	
Patient's rights are posted in waiting area OR provided at intake:	
Office is handicapped accessible (i.e. bathrooms equipped with handrails / emergency exits are handicapped accessible). For offices that are not handicapped accessible, staff are willing to make special provisions to accommodate:	
Information about other services available:	
Certificate of Occupancy available:	

Re-credentialing Provider Summary

PROVIDER DEMOGRAPHICS	
PROVIDER NAME:	
LEVELS OF CARE:	
TOTAL NUMBER OF SITES:	
TOTAL NUMBER OF UNIQUE MEMBERS SERVED:	
TIME PERIOD UNDER REVIEW:	

CREDENTIALING DISCIPLINARY HISTORY	
Has this provider been referred to the Credentialing Committee during the period under review?	**□ YES □ NO**
If YES, brief description of the reason for the referral:	
Have referrals been suspended to this provider during the period under review?	**□ YES □ NO**
If YES, list the source (i.e. QOCC, Credentialing); the reason; and date range of the suspension:	

ACCOUNT EXECUTIVE REVIEW	
High Volume – AE Site Visit Required?	**□ YES □ NO**
Date of Site Visit:	
Score:	

LEVEL OF CARE REVIEW			
	LEVEL OF CARE:		
QI REVIEW:	**NUMBER OF REFERRALS DURING THE PERIOD UNDER REVIEW:**		
	NON-ROUTINE SITE VISIT REQUIRED?	**□ YES □ NO**	
	QUALITY REVIEW COMPLETE?	**□ YES □ NO □ N/A**	
TREATMENT RECORD REVIEW:	**CONTRACT(S):**	**□ CABHC**	**□ TMCA**
	SCORE(S):		
	QIP REQUIRED?	**□ YES □ NO**	**□ YES □ NO**
	QIP RECEIVED AND APPROVED?	**□ YES □ NO □ N/A**	**□ YES □ NO □ N/A**

STATISTICS (All Levels of Care and Contracts)	
NUMBER OF MEMBER COMPLAINTS DURING THE PERIOD UNDER REVIEW:	
OF THOSE, NUMBER OF SUBSTANTIATED COMPLAINTS:	
NUMBER OF ADMINISTRATIVE APPEALS DURING THE PERIOD UNDER REVIEW:	
OF THOSE, NUMBER OF APPEALS REJECTED/DENIED:	

SUMMARY COMPLETED BY:	
DATE OF SUMMARY:	

PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

Pennsylvania Behavioral Health Program Facility Credentialing and Re-credentialing Application

This application is used for the organization provider network of the Behavioral Health Managed Care Programs in the state of Pennsylvania. Organizational providers include: agencies, programs, hospitals, facilities, treatment centers, community mental health centers and others.

Behavioral Health Managed Care Organization:

Please select the Behavioral Health Managed Care Organization *to whom you are submitting the current application* information (hereafter listed as "BH-MCO").

☐ Community Care Behavioral Health Organization (CCBH)
339 Sixth Ave
Suite 1300
Pittsburgh, PA 15222
P: 412-454-2120

☐ Community Behavioral Health (CBH)
801 Market St
Suite 7000
Philadelphia, PA 19107
P: 215-413-3100

☐ Magellan Behavioral Health
Attn: ONS Network Services
14100 Magellan Plaza Dr
Maryland Heights, MO 63043
P: 610-814-8050

☐ PerformCare®
8040 Carlson Rd
Harrisburg, PA 17112
P: 888-700-7370

☐ Beacon Health Options of Pennsylvania
P O Box 1840
Cranberry Township, PA 16066-1840
P: 877-615-8503

To ensure timely processing of your application, please return the following:

- ☐ Completed Facility Credentialing/Re-credentialing Application
- ☐ Current copies of all applicable state licenses and letters of support/approval. (All letters are needed for initial credentialing but only time-limited letters need to be re-submitted at the time of re-credentialing.)
- ☐ Copy of the most recent state licensing site visit report for each license (i.e. the state performed a site visit or site survey as a part of the licensure and/or certification process)
- ☐ Copy of current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates that identify the limits of liability and the policy effective dates (documents must include "Professional Liability").
- ☐ Copy of a completed W9 form or IRS letter
- ☐ NPI Enumerator Documentation
- ☐ Staff Roster for each site and program
- ☐ Accreditation Certificate(s):
    - ☐ JC – The Joint Commission (formerly JCAHO)
    - ☐ CARF – Council on Accreditation of Rehabilitation Facilities
    - ☐ COA – Council on Accreditation
    - ☐ HFAP – The AOA's Healthcare Facilities Accreditation Program
    - ☐ Other _____
- ☐ Copies of evidence of completion of the required Monitoring of Sanctions checks at the time of hire and monthly thereafter for ALL owners, board members, and employees affiliated with the agency.

Parent Company Information:

A "Parent Company" is an entity that controls, owns, or overseas organization(s) and retains the Federal Tax Identification number for all of those organizations. The Parent Company is always the contract holder and is always the receiver of payment. A Parent is a single entity at one location.

In this section, enter Name, Administrative Address, Accounts Payable Address, IRS Address, Taxpayer Identification, and Executive Contact information pertaining to the Parent Company.

CONTRACTS	☐ CABHC (Cumberland/Dauphin/Lancaster/Lebanon/Perry) ☐ TMCA (Franklin/Fulton)	
Parent Company Name:		
Doing Business As: *(if applicable)*		
Tax ID: EIN: FIN:		
Chief Executive Officer:	Name and Title:	
	Telephone:	
	Email:	
Medical Director:	Name and Title:	
	Telephone:	
	Email:	
Managed Care/Clinical Director:	Name and Title:	
	Telephone:	
	Email:	
Credentialing Contact:	Name and Title:	
	Telephone:	
	Email:	
Billing/Claims Contact:	Name and Title:	
	Telephone:	
	Email:	
Corporate Compliance Officer:	Name and Title:	
	Telephone:	
	Email:	
Contracting Contact:	Name and Title:	
	Telephone:	
	Email:	

Administrative Address: (Address where contract correspondence of mail occurs)

Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**ZIP Code:**
Telephone Number:		**Fax Number:**	

Accounts Payable Address: (Finance Address; where checks are mailed)

Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**Zip Code:**
Telephone Number:		**Fax Number:**	

IRS Address: (Address for tax reporting purposes – must match W9 or IRS documentation)

Tax Id Number (EIN/FEIN):			
Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**Zip Code:**
Telephone Number:		**Fax Number:**	

Business Classification:							
Ownership:		Private		Public			
Status:		For Profit		Non-Profit			
Medicaid:		Single County Authority		Base Service Unit		N/A	
Demographic Data:		Women-Owned		Minority-Owned		Disabled-Owned		N/A

Accreditation Information:

Active Accreditation Agency: (Check all that apply)	**Accredited Date:**	**Expiration Date:**
☐ **Joint Commission**		
☐ **CARF**		
☐ **COA**		
☐ **Other _____**		

LIABILITY/MALPRACTICE COVERAGE INFORMATION

Note: If you have different Liability/Malpractice coverage for different programs/sites, you must complete this section for each policy/insurer. For Initial Credentialing Application, please include any occurrences within the last 5 years. For Re-credentialing Applications, please include any occurrences since the last credentialing date (withing the last 3 years).	**YES**	**NO**
Has your agency/program files a claim under general or professional liability insurance?		
Are there any new claims pending against your agency?		
Has your agency's liability/malpractice coverage been denied, cancelled, or non-renewed?		

MALPRACTICE CLAIM INFORMATION

Please attach information on what the organization's response was to the allegations and what steps were taken to prevent any future incidents for each claim listed below. This page can be copied to accommodate additional claim information.

Date of Occurrence:		**Date Claim Filed:**		**Date of Settlement:**	
Allegations and Actions Taken:					
Case Settled:	☐	In Court	☐	Out-of-Court	
	☐	With Prejudice	☐	Without Prejudice	
Total Amount Paid to Claimant on Behalf of Facilty/Program:					
Date of Occurrence:		**Date Claim Filed:**		**Date of Settlement:**	
Allegations and Actions Taken:					
Case Settled:	☐	In Court	☐	Out-of-Court	
	☐	With Prejudice	☐	Without Prejudice	
Total Amount Paid to Claimant on Behalf of Facilty/Program:					

Date of Occurrence:		**Date Claim Filed:**		**Date of Settlement:**	
Allegations and Actions Taken:					
Case Settled:		In Court		Out-of-Court	
		With Prejudice		Without Prejudice	
Total Amount Paid to Claimant on Behalf of Facilty/Program:					

General Liability Coverage:

General Liability Carrier:		**Policy Number:**	**Policy Holder:**
Effective Date:	**Expiration Date:**	**Per Occurrence Amount $:**	**Aggregate Amount $:**

Professional Liability Coverage:

Professional Liability Carrier:		**Policy Number:**	**Policy Holder:**
Effective Date:	**Expiration Date:**	**Per Occurrence Amount $:**	**Aggregate Amount $:**

Excess/Umbrella Liability Coverage:

Excess Umbrella Liability Carrier:		**Policy Number:**	**Policy Holder:**
Effective Date:	**Expiration Date:**	**Per Occurrence Amount $:**	**Aggregate Amount $:**

Automobile Insurance Information:

Automobile Liability Carrier:	**Policy Holder:**	**Combined Single Limit Amount $:**
Policy Number:	**Effective Date:**	**Expiration Date:**

Workman's Compensation Information:

Workman's Compensation Insurance Carrier:	**Policy Holder:**	**Per Accident Amount $:**	**Per Employee Amount $:**
Policy Number:	**Policy Limit $:**	**Effective Date:**	**Expiration Date:**

SANCTIONS/LICENSURE INFORMATION

For Initial Credentialing Applications, please include any occurrences within the last 5 years. For Re-credentialing Applications, please include any occurrences since the last credentialing date (within the last 3 years).

- Have there been any disciplinary actions (denied, revoked, suspended or otherwise limited) taken against the facility/program by a state licensing body or voluntarily given up by the facility/program or are any actions now underway which may lead to such sanctions? ☐ Yes ☐ No

- Have any memberships in professional organizations and/or accreditations been revoked, reduced, denied or suspended by others or voluntarily given up by the facility/program or are any actions now underway which may lead to such sanctions? ☐ Yes ☐ No

*** If you answered yes to any of the above, please attach a written explanation providing detail about the sanction or probationary status.**

OPERATIONS

	YES	**NO**
Confirm that you have an appointed a Corporate Compliance Officer?		
Confirm that you have adopted a Code of Conduct (REQUIRED)?		
Confirm that you have adopted a Corporate Compliance Plan (REQUIRED)?		
Confirm that you have a Quality Improvement (QI) plan (REQUIRED)?		
Confirm that you have a staff credentialing processing place which includes (REQUIRED):	**YES**	**NO**
Verification of licenses directly with Department of State (DOS)		
Documentation of disciplinary actions identified by DOS		
Primary source verification of education is conducted for all clinical staff		
For physicians, the DEA Certification is confirmed to be current		
The resume reflects continuous work experience – breaks are explained		
*Medicheck is referenced to assure employees are not precluded or excluded from PA Medical Assistance (**ongoing review required**)*		
U.S. Department of Health & Human Services Office of Inspector General (HHS-OIG) is referenced to assure employee are not excluded from Participation in any federal health care program		
System for Award Management (SAM formerly known as Excluded Parties List System) is referenced to assure that employees are not excluded from receiving Federal contracts, certain subcontracts and certain Federal financial and non-financial benefits		
All three lists (Medicheck, HSS-OIG and SAM) are checked prior to hiring an employee or contractor		
*All three lists are checked **monthly** for every employee or contractor*		
Agency policy supports recovery and resiliency principles? (Required For HealthChoices)		
Members are asked if they have a Wellness Recovery Action Plan (WRAP) or Advanced Directive? (Required For HealthChoices)		

PARTICIPATION STATEMENT

Please select the Behavioral Health Managed Care Organization to whom you are attesting and submitting the application information (hereafter listed as "BHMCO"):

☐ Community Care Behavioral Health Organization (CCBHO)	Date of Last Credentialing: _____
☐ Community Behavioral Health (CBH)	Date of Last Credentialing: _____
☐ Magellan Behavioral Health	Date of Last Credentialing: _____
☐ PerformCare	Date of Last Credentialing: _____
☐ Value Behavioral Health of Pennsylvania (VBH)	Date of Last Credentialing: _____

For purposes of making this application for participation in the BHMCO provider network, the Facility/Program certifies that all information provided to the BHMCO is complete and correct to the best of the Facility/Program's knowledge. The Facility/Program agrees to notify the BHMCO promptly if there are any material changes in the information provided, whether prior to or after the Facility/Program's acceptance as a the BHMCO participating provider. The Facility/Program understands and agrees that if the BHMCO discovers that this application contains any significant misstatement, misrepresentations or omissions, the BHMCO may void, in its sole discretion, its application and any related participating provider agreements.

The Facility/Program authorizes the BHMCO and its Credentialing Verification Organization (CVO) to consult with State licensing agencies, accreditation bodies, malpractice insurance carriers, and, upon notification to Facility/Program of additional specific entities or organizations, any other entity from which information may be needed to complete the credentialing process, and the Facility/Program authorizes the release of such information to the BHMCO and its CVO. The Facility/Program releases the BHMCO and its CVO and its employees and agents and all those whom the BHMCO contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating the Facility/Program's application.

The Facility/Program further understands and agrees that; (a) the Facility/Program is responsible for producing all information required or re quested by the BHMCO and its CVO in connection with this application; (b) the BHMCO is under no obligation to complete the processing of this application until such information is provided by the Facility/Program; (c) in the event that the BHMCO decides not to accept the Facility/Program as a participating provider and the Facility/Program desires to have this decision reviewed, the Facility/Program will appeal such determination via the BHMCO's appeal process.

_____

Facility Name

_____ Dated (mm/dd/yy)_____/_____/_____

Authorized Signature

_____

Name (Please Print)

_____

Title

For Internal Use Only:

Date application received from Provider:

Monitoring of Sanctions Attestation

The Pennsylvania Medicheck (Precluded Providers) List; the Office of Inspector General U.S. Department of Health & Human Services (HHS-OIG) Exclusions Database; and the System for Award Management (SAM – formerly EPLS) Exclusion Records MUST be checked at the time of hire and monthly thereafter for ALL owners, board members, and employees affiliated with the agency. PerformCare is required to complete a desk audit as part of each re-credentialing application in order to ensure compliance. *Please include copies to document evidence of completion of the checks each of the bolded categories below for time of hire/placement/election and one other month during the lookback period (different months for each category).* **Failure to submit this attestation or comply with the desk audits may result in suspension of referrals to the program.**

I, _____ assure that _____ is in compliance with the on-going Monitoring of Sanctions as required for participation in the PerformCare network.

I affirm that:	**INITIAL HERE**
1) I (or a designee) have completed Medicheck, HHS-OIG, and SAM verifications for all **OWNERS** at the time of hire/start of ownership.	
2) I (or a designee) have completed and will continue to complete Medicheck, HHS-OIG, and SAM verifications for all **OWNERS** monthly.	
3) I (or a designee) have completed Medicheck, HHS-OIG, and SAM verifications for all **BOARD MEMBERS** at the beginning of his/her position on the board.	
4) I (or a designee) have completed and will continue to complete Medicheck, HHS-OIG, and SAM verifications for all **BOARD MEMBERS** monthly.	
5) I (or a designee) have completed Medicheck, HHS-OIG, and SAM verifications for all **EMPLOYEES** at the time of hire.	
6) I (or a designee) have completed and will continue to complete Medicheck, HHS-OIG, and SAM verifications for all **EMPLOYEES** monthly.	
7) I (or a designee) have completed Medicheck, HHS-OIG, and SAM verifications for all **CONTRACTORS and SUB-CONTRACTORS** at the start of the contract.	
8) I (or a designee) have completed and will continue to complete Medicheck, HHS-OIG, and SAM verifications for all **CONTRACTORS and SUB-CONTRACTORS** monthly.	

_____ _____ _____

Agency Director Signature **Agency License Number & Type** **Date**

PerformCare Use:

Verified by: _____ Date: _____

PERFORMCARE ADDENDUM (Part II)

Please complete a copy of this section for each Site or Program that is currently seeking credentialing with PerformCare.
Be sure to complete levels of care associated with each site and treatment modalities, diagnosis focus, and population information specific to each site. Please make additional copies as needed.

Provider Name:		**License Type:**	
		License Number:	
CONTRACTS	☐ CABHC (Cumberland/Dauphin/Lancaster/Lebanon/Perry) ☐ TMCA (Franklin/Fulton)		

MENTAL HEALTH LEVELS OF CARE

√	**Level of Care Description**	**Medical Assistance Provider Number and Location Code**
	Acute Care Hospital	
	Best Practice Evaluation	
	Clozapine/Clozaril Support Services	
	FQHC or Rural Health Center	
	IBHS - Applied Behavior Analysis (ABA)	
	IBHS Group - After School Program	
	IBHS Group - Stepping Stones	
	IBHS Group – Intensive Day Treatment	
	IBHS/ABA Group	
	IBHS – Functional Family Therapy (FFT)	
	IBHS – Multisystemic Therapy (MST)	
	IBHS – YFACTS	
	IBHS – Individual	
	MH Art Therapy	
	MH Assertive Community Treatment (ACT/CTT)	
	MH Crisis Intervention	
	MH CRR Host Home	
	MH Electroconvulsive Therapy (ECT)	
	MH Family Based Mental Health	
	MH Inpatient – Extended Acute Psych Inpatient Unit	

	MH Inpatient – Private Psych Hospital	
	MH Inpatient – Private Psych Unit	
	MH Mobile MH/ID	
	MH Music Therapy	
	MH Outpatient – Medication Management	
	MH Outpatient – Psychiatric Evaluation	
	MH Outpatient – Psychological Testing	
	MH Outpatient – Therapy	
	MH Partial Hospitalization – Adult	
	MH Partial Hospitalization – Child/Adolescent	
	MH Residential Treatment – Accredited	
	MH Residential Treatment – Non-Accredited	
	MH TCM (ICM, RC, BC)	
	Mobile Mental Health Treatment	
	Neuropsychological Evaluation/Testing	
	Peer Support Services (DHS Approved) - Adult	
	Peer Support Services (DHS Approved) - Youth	
	Psychiatric Rehab	
	Psychiatric Rehab - Clubhouse	
	School-Based Outpatient Site	
	Specialized In-Home Treatment Program (SPIN)	
	Telepsychiatry	
SUBSTANCE USE LEVELS OF CARE		
√	**Level of Care Description (PCPC-ASAM)**	**Medical Assistance Provider Number and Location Code**
	SU Outpatient (1)	
	SU Intensive Outpatient (2.1)	
	SU Partial Hospitalization (2.5)	
	SU Clinically Managed Low-Intensity Residential Services (3.1)	

	SU Clinically Managed, High-Intensity Residential Services (3.5)	
	SU Medically Monitored Intensive Inpatient Services (3.7)	
	SU Medically Monitored Inpatient WM (3.7 WM)	
	SU Medically Managed Intensive Inpatient Services (4)	
	SU Medically Managed Intensive Inpatient WM (4 WM)	
	SU D&A Level of Care Assessment	
	SU Certified Recovery Specialist (CRS)	
	SU TCM (ICM, RC)	
	SU Buprenorphine/Suboxone Services	
	SU Methadone Maintenance	
	SU Vivitrol/Naltrexone Services	
	Tobacco Cessation Treatment	
MISCELLANEOUS LEVELS OF CARE		
√	**Level of Care Description**	**Medical Assistance Provider Number and Location Code**
	Administrative Site Only	N/A
	LAB	
	Mobile Psych Nursing	

Practice Site Address: (Address where services will be rendered)

Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**ZIP Code:**

Telephone Number:	**Fax Number:**	**After Hours Telephone Number:**

Administrative Address: (Address where contract correspondence of mail occurs)

Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**ZIP Code:**
Telephone Number:		**Fax Number:**	

Accounts Payable Address: (Finance Address; where checks are mailed)

Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**ZIP Code:**
Telephone Number:		**Fax Number:**	

IRS Address: (Address for tax reporting purposes – must match W9 or IRS documentation)

Tax Id Number:			
Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**ZIP Code:**
Telephone Number:		**Fax Number:**	

Contact Person for this Site:	Name and Title:	
	Telephone:	
	Email:	

POPULATION AND SPECIALTY INFORMATION AT THIS SITE

Please identify your clinical interests and populations served by check marking applicable items. Perform Care will put this information in your provider profile and referrals will be made based on your responses.

√	**TREATMENT MODALITIES (Checking any of the boxes below requires that the provider is certified and must provide evidence of certification including copies of certifications or other evidence of certification.)** ☐ **Check here if this section is N/A**
	Cognitive Behavioral Therapy (CBT)
	Dialectical Behavioral Therapy (DBT)
	Eye Movement Desensitization and Reprocessing (EMDR)
	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
√	**TREATMENT MODALITIES/SPECIALIZED POPULATIONS (Checking any of the boxes below requires that the provider has specialized training in the area identified and provider must list the training completed and provide evidence of completed training.)** ☐ **Check here if this section is N/A**
	Biofeedback
	Eating Disorders
	Faith-based Counseling
	Family/Couples Therapy
	Geriatrics/Older Adults (65+)
	Lesbian/Gay/Bi-sexual/Transgender/Questioning (LGBTQ+)
	Pain Management
	Play Therapy
	Problem Sexual Behavior
	SUD – Contingency Management
	SU Co-occurring Enhanced
√	**DIAGNOSIS FOCUS** ☐ **Check here if this section is N/A**
	Anxiety Disorders/Phobias/Panic Disorders
	Attention Deficit Disorders / Oppositional Disorders (ADD/OD)
	Autism/Developmental Disorders
	Co-Occurring (MH/SUD)
	Co-Occurring (MH/ID)
	Depression/Mood Disorder
	Obsessive Compulsive Disorders (OCD)

	Personality Disorders		
	Reactive Attachment Disorder (RAD)/Attachment Issues		
	Sexual Disorders/Dysfunction		
	Trauma/Physical/Sexual Abuse Issues (PTSD)		
√	**ACCESSIBILITY** ☐ **Check here if this section is N/A**		
	Handicap Accessible		
	Wheelchair Accessible		
	Restrooms Accessible to Physically Disabled		
	Deaf/Hard of Hearing Accommodations		
	Blind/Visually Impaired Accommodations		
	Tobacco-Free Facility		
√	**POPULATIONS** ☐ **Check here if this section is N/A**		
	Children (preschool 0-4)		
	Children (5-12)		
	Children (13-17)		
	Adults (18-64)		
	Geriatric (65+)		
√	**LANGUAGES**		
	Spanish		Nepali
	English		Polish
	American Sign Language		Portuguese
	Amharic		Punjabi
	Arabic		Romanian
	Chinese		Russian
	Farsi		Swahili
	French		Syrian
	German		Tagalog
	Hawaiian		Telugu
	Hebrew		Thai

	Hindi		Ukrainian
	Italian		Urdu
	Japanese		Vietnamese
	Korean		Yiddish
	Latin		Yoruba

GEOGRAPHIC COVERAGE/ACCESS

County(ies) in which this Program is located	
County(ies) Served	

Do you believe that you are meeting PA Health Choices access standards as listed below?	**YES**	**NO**
Routine – offered an appointment within 7 days		
Urgent – offered an appointment within 24 hours		
Emergent – offered an appointment within 1 hour		
Accessibility Questions	**YES**	**NO**
Is this site accessible to public transportation?		
Is this site handicapped accessible?		
If this site is an Inpatient or Residential Program, please include the number of beds:		

What are your normal business hours for seeing clients?

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

CULTURAL COMPETENCY SURVEY

Question	**YES**	**NO**
Does the agency have Policies and Procedures or provide training opportunities that cover areas of cultural diversity and cultural competence to all applicable staff members?		

Corporate Compliance Responsibilities

Question	**YES**	**NO**
Is a Corporate Compliance Officer appointed? (REQUIRED)		
Has the Agency (Practice) adopted a Code of Conduct? (REQUIRED)		
Does the Agency (Practice) have a Corporate Compliance Plan? (REQUIRED)		

Corporate Compliance Officer:	Name and Title:	
	Telephone:	
	Email:	

Quality Contact for this Site/Level of Care:

Quality Contact Information:	Name and Title:	
	Telephone:	
	Email:	

Clinical Staff Overview:

LANGUAGES SPOKEN FLUENTLY BY CLINICAL STAFF **Fluently is defined as able to speak with ease or express effortlessly and correctly.**			
# of Each	**Descriptor**	**Language(s)**	**Service(s)**
	Physician(s)		
	Therapist(s)		
	Behavioral Health Technician (BHT)		
	Behavioral Consultant (BC)		
	Mobile Therapist(s) (MT)		
	Other (list):		

NUMBER OF EACH OF THE FOLLOWING: (Specify the number of clinical staff only – include names on the rosters attached)					
#	**Descriptor**	**#**	**Descriptor**	**#**	**Descriptor**
	Psychiatrist – Board Certified		Psychiatrist – Board Eligible		Psychologist – Doctoral Level
	Psychologist – Masters Level		LCSW or LSW		Lic Professional Counselor (LPC)
	LMFT		Cert Addictions Counselor		MH Counselor – Masters Level

STAFF ROSTERS

(Licensed and Non-Licensed Clinicians at this Service Site)

Providers must have Policy and Procedure in place to assure that employees have appropriate credentials. Per Perform Care policy, members under the age of thirteen (13) must be treated by a Board Certified Psychiatrist with a subspecialty certification in Child & Adolescent Psychiatry. If a facility provides child/adolescent RTF and/or child/adolescent IP services and does not employ the above qualified staff, the facility will be required to submit a statement with the credentialing application which informs Perform Care of the provisions the facility will make to meet this expectation. You may submit this information in an alternate format.

Clinician's Name	Clinician's Highest Level of Education (i.e. BS, MS, PhD)	Clinician's License Number	Clinician's Specialties/Areas of Interest

PROGRAM EXCEPTION ATTESTATION

Submit an updated signed attestation form to the attention of your Provider Relations Representative by January 1 of each year for each Program Exception Service. Failure to submit this attestation may result in suspension of referrals to the program. Program exception services must comply with Federal rules and requirements for Medicaid. DHS/OMHSAS staff approve service descriptions that comply with those requirements. Providers must assure that service delivery is consistent with the DPW/OMHSAS approved service description. Perform Care Quality Improvement Staff will audit records against the service description. Payment made for services not delivered in accordance with the approved service description is subject to repayment.

I, _____ assure that _____ (Program Name) was approved by OMHSAS and deemed compensable using Medical Assistance Identification Number / Service Location Code _____ for _____ County(ies).

I affirm that:		**Initial Here:**
1	I have reviewed the current approved service description against operations and attest that service delivery is occurring in accordance with the DHS/OMHSAS approved service description.	
2	I understand that any change to the service description requires approval by Perform Care, the County(ies) and DHS/OMHSAS. Approval must be in writing.	
3	I certify that documentation of services delivered is in accordance with the service description or, in the absence of such detail, in accordance with 1101.51 of the Medical Assistance Manual.	
4	I certify that clinical staff is receiving appropriate supervision.	
5	I have attached a staff roster reflecting current staff complement in the program and confirm that ratios remain consistent with that defined in the approved service description.	

_____ _____ _____

Agency Director Signature **Agency License Number & Type** **Date**

ATTESTATION OF COMPLIANCE
RELATING TO REQUIRED TELEHEALTH POLICIES

The Office of Mental Health and Substance Abuse Services (OMHSAS) first issued guidance in March 2020 on the temporary use of telehealth for behavioral health providers in response to the COVID-19 public health emergency. In order to allow for continued flexibility and increased access to services, OMHSAS issued updated *Guidelines for the Delivery of Behavioral Health Services Through Telehealth* (Bulletin OMHSAS-21-09) allowing for the continuation of behavioral health services via telehealth. OMHSAS 21-09 was then superseded by the issuance of Bulletin OMHSAS-22-02 - Revised Guidelines for Delivery of BH Services Through Telehealth 7.1.22

Per OMHSAS-22-02, any provider seeking to utilize telehealth for delivering behavioral health services must comply with the following procedures:

- Provider agencies should offer telehealth using equipment that meets all state and federal requirements for the transmission or security of health information and comply with the Health Insurance Portability and Accountability Act (HIPAA).

- Effective 1/1/2024 Provider agencies must obtain the individual's or legal guardian's consent for telehealth and service verification consistent with Act 69 of 1999 Electronic Transactions Act, including having systems in place to ensure that there is an audit trail that validates the signer's identity, and the consent and/or service verification must be included in the medical record.

- Provider agencies should establish and enforce policies for assessing when it is clinically appropriate to deliver services through telehealth.

- Licensed practitioners and provider agencies delivering services through telehealth must have policies that ensure that services are delivered using telehealth only when it is clinically appropriate to do so and that licensed practitioners are complying with standards of practice set by their licensing board for telehealth where applicable.

- Providers using telehealth must maintain written policies for the operation and use of telehealth equipment. Policies must include the provision of periodic staff training to ensure telehealth is provided in accordance with the guidance in this bulletin as well as the provider's established patient care standards.

- Providers must maintain a written policy detailing a contingency plan for transmission failure or other technical difficulties that render the behavioral health service undeliverable. Contingency plans should describe how the plan will be communicated to individuals receiving services.

- The licensed practitioner or provider agency must have policies in place to address emergency situations, such as a risk of harm to self or others.

- Providers who elect to deliver services through telehealth must have a policy that makes available interpretation services, including sign language interpretation, for individuals being served through telehealth.

By signing below, Provider hereby agrees that any behavioral health telehealth services being offered are done so in compliance with OMHSAS-21-09. Provider understands that failure to comply with any of the outlined requirements of OMHSAS-21-09 could result in the denial or recoupment of payment for services.

PROVIDER NAME & ADDRESS

_____

_____

_____

_____

PROVIDER SIGNATURE:

_____ DATE:_____