PerformCARE®	Policy and Procedure
Name of Policy:	Credentialing and Re-credentialing Criteria - Practitioners
Policy Number:	QI-CR-002
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:	10/18/24
Last Review Date:	08/11/25
OMHSAS Approval Date:	08/11/25
Next Review Date:	08/01/26

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 independent practitioners in 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, level of training experience, and specialty. In addition, PerformCare will assure that providers adhere to credentialing requirements under the *PA Department of Health regulations, Chapter 9, Managed Care Regulations, Subchapter L, Section 9.761 through 9.763.*

Purpose: To establish procedures for the credentialing and re-credentialing of professional clinicians and physicians within the PerformCare Provider network.

Definitions: **Certified in Addiction Medicine:** Refers to clinicians who have completed the course/examination requirements to receive a Certified Alcohol and Drug Counselor (CADC), Certified Advanced Alcohol and Drug Counselor (CAADC), board certifications from the Pennsylvania Certification Board (PCB) or other equivalent boards.
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 programs, etc.
Practitioner: This term is used to define an independent individual and/or group practice of similarly licensed practitioners (e.g., MD, Psychologist) contracted to provide services to PerformCare Members.
Provider: This term may be used interchangeably to represent an individual practitioner or a facility.

Acronyms:
ABMS: American Board of Medical Specialties
ACGME: American Council on Graduate Medical Education
AE: Account Executive
ASD: Autism Spectrum Disorder
BH MCO: Behavioral Health Managed Care Organization
CAQH: Council for Affordable Quality Healthcare Universal Provider Datasource
CP: Licensed Psychologist
CRNP: Certified Registered Nurse Practitioner
CVO: Credentials Verification Organization
DEA/CDS: Drug Enforcement Administration/Controlled Dangerous Substance
DMF: Social Security Death Master File
EPLS: Excluded Parties List System
HHS-OIG: U.S. Department of Health & Human Services-Office of Inspector General
IBHS: Intensive Behavioral Health Services
LCSW: Licensed Clinical Social Worker
LMFT: Licensed Marriage and Family Therapist
LPC: Licensed Professional Counselor
MA: Medical Assistance
NCQA: National Committee for Quality Assurance
NPDB: National Practitioner Data Bank
NPI: National Provider Identifier
NPPES: National Plan and Provider Enumeration System
NTIS: National Technical Information Service
PHI: Protected Health Information
SAM: System for Award Management

Procedure:
1. Physician practitioners include Psychiatrists or Physicians who are certified in addiction medicine. Such practitioners must comply with the following criteria:
   1.1. Graduation from an accredited medical school or school of osteopathy.
   1.2. Current unrestricted medical license in the state in which practice is to occur.

1.3. Professional liability insurance coverage in the amount of $1,000,000 per occurrence / $3,000,000 aggregate for physicians if not participating in the PA MCare Fund or $500,000 per occurrence / $1,500,000 aggregate if participating in the MCare Fund.
1.4. Board certification or eligibility in psychiatry or completion of a residency in psychiatry approved by the ACGME. A psychiatrist is board eligible if the psychiatrist has successfully completed all the requirements of an ACGME certified (or equivalent) residency program.
1.5. Current controlled substances registration, DEA/CDS certificate.
1.6. Current resume or curriculum vitae that details a minimum five (5) year work history and clinical training; any gap in work history of six (6) months or more must be accompanied by explanation.
1.7. Be eligible and willing to become an enrolled Medical Assistance practitioner to participate in the HealthChoices Program.
1.8. Provision of 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 for review.

2. Non-Physician practitioners include doctoral or master's level CP, LCSW, LPC, LMFT, CRNP with Mental Health Specialty, and other licensed, certified practitioners. Such practitioners must comply with the following selection criteria:
2.1. Current, unrestricted license in the state where practice is to occur.
2.2. Professional liability insurance in the amount of $1,000,000 per occurrence/$3,000,000 aggregate; lower limits may be allowed, based upon approval by the Credentialing Committee as being consistent with current community standards.
2.3. Current resume or curriculum vitae that details a minimum five (5) year work history and clinical training; any gap in work experience of six (6) months or more must be accompanied by explanation.
2.4. If the practitioner has prescriptive authority for controlled substances, then they must have a current DEA/CDS certificate.

2.5. Be eligible and willing to be an enrolled Medical Assistance provider to participate in the HealthChoices Program.
2.6. Provision of 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 for review.

3. The following items apply to both Physician and Non-Physician Practitioners:
   3.1. A practitioner cannot have any current disciplinary investigations or restrictions, including probation or any other disciplinary conditions imposed by the state-licensing agency.
   3.2. The location where services are to be delivered (and Medical Assistance enrollment is active) cannot be a home office.
   3.3. All independent physician and non-physician practitioners or members of a group practice not eligible for State licensure as a mental health outpatient clinic who have a direct contractual relationship with PerformCare and /or practitioners who bill using their own Medical Assistance Identification Number must complete and submit an individual credentialing application, which requires disclosure to PerformCare if any of the following have occurred:
      3.3.1. A felony conviction or misdemeanor conviction.
      3.3.2. A pending felony or misdemeanor allegation.
      3.3.3. Sanctions by a federal or state payment program (Medicare, Medicaid).
      3.3.4. Adverse professional review actions reported by any professional review board.
      3.3.5. Loss, suspension or limitation of medical license or narcotics license.
      3.3.6. Denial, loss, or limitation of hospital privileges (or action pending).
      3.3.7. Malpractice claim, investigation or lawsuit filed.
      3.3.8. Cancellation or notification of impending cancellation of professional liability insurance.
      3.3.9. Physical or mental condition or substance abuse problem that would impair ability to practice.
   3.4. For HealthChoices, LCSWs, LPCs and LMFTs are considered supplemental services and require the BH MCO to request Medical Assistance enrollment.

3.4.1. PerformCare will only provide Medical Assistance enrollment assistance to practitioners who:
3.4.1.1. Meet a geographic access need; or
3.4.1.2. Meet a need for a certain specialty; or
3.4.1.3. Is serving a Member(s) who became a HealthChoices Member during treatment; and
3.4.1.4. Receives approval of County HealthChoices Primary Contractor.

4. Primary Source Verification – Initial and Re-credentialing Applications for Practitioners.
   4.1. Primary source verification is completed by an NCQA certified CVO for each practitioner who is determined to have an independent relationship with PerformCare. An independent relationship exists if PerformCare intends to refer Members directly to a practitioner rather than to a facility. The CVO uses the following verification sources:
      4.1.1. Verification of licensure in the state where the practitioner has an office. This is verified directly from the state licensing agency to include sanction information.
      4.1.2. Verification of clinical privileges is obtained through oral or written confirmation from the institution(s) designated on the application.
      4.1.3. DEA / CDS certificate is verified by obtaining a copy or verified by the NTIS as current.
      4.1.4. Verification of education when not board certified. Verification is obtained directly from the school or from the Pennsylvania state licensing agency. The education verification is required at initial credentialing only.
      4.1.5. Verification of board certification. The CVO is a data warehouse and information is provided directly to CVO from the ABMS. Verification is completed by review of data provided directly to the CVO from Medical Boards.
      4.1.6. Documentation of minimum five (5) years' work history per review of the resume or vitae.
      4.1.7. Verification of malpractice insurance coverage by obtaining current face sheet.
      4.1.8. Verification of malpractice claims history by collecting history of malpractice settlements from the NPDB or directly from the insurance carrier when available.

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

4.1.10. Verification of the following checks via the Streamline Verify system:

4.1.10.1. Medicheck is referenced to assure practitioners are not precluded or excluded from PA Medical Assistance.

4.1.10.2. HHS-OIG is referenced to assure practitioners are not excluded from participation in any federal health care program.

4.1.10.3. SAM formerly known as EPLS is referenced to assure that practitioners are not excluded from receiving Federal contracts, certain subcontracts and certain Federal financial and/or financial benefits.

4.1.10.4. NPPES is referenced to assure that practitioners have a valid NPI number.

4.1.10.5. DMF is referenced to assure that the social security number reported on the practitioner's application has not been reported to the Social Security Administration as belonging to a deceased person.

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 mail initial and re-credentialing applications and complete the primary source verification needed to credential and re-credential practitioners in the PerformCare network. PerformCare credentials and re-credentials the following types of practitioners:

5.1.1. All practitioners who have an independent relationship with PerformCare.

5.1.2. Practitioners who see enrollees outside an inpatient hospital setting or outside provider-based settings.

5.1.3. Practitioners who are provider-based but see PerformCare's enrollees as a result of their independent relationship with PerformCare.

5.1.4. Non-physician practitioners who have an independent relationship with PerformCare and who provide care under PerformCare benefits.

5.2. A specific description of the activities performed by the CVO is located in section 3 and 4 of this policy. PA Standard Applications or CAQH numbers are submitted

to the CVO by PerformCare and returned with completed verifications within 30 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 Quality Performance Specialist assigned to Credentialing reviews the audit sheet to assure that timeframes and requirements are met for the file.

5.4. The CVO is required to report on a monthly basis practitioners whose credentials were verified in the previous month. The CVO will also provide a report of practitioners that should be in the process of re-credentialing on a monthly basis. 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 must be under 30 days.

5.6. All CVO verifications of practitioner credentialing files are reviewed for quality and accuracy as they are received for processing. Upon receipt from CVO, PerformCare Quality Performance Specialist assigned to Credentialing conducts a final review of each application for completeness.

6. Credentialing Decision Notification and Practitioner Right to Correct Erroneous Information

6.1. A practitioner may request information about the status of their application at any time upon request. Such requests will be made to the Quality Performance Specialist assigned to Credentialing who is free to provide all information about the status of the application such as that it was received, sent to the CVO for primary source verification, that it is scheduled to be presented to credentialing committee, etc.

6.2. The practitioner will be notified of the decision of the Credentialing Committee within 20 business days of the decision. Except for NPDB information and peer references, the practitioner has the right to review information received by PerformCare and to be notified if information received from the CVO is substantially different than was reported by the provider. The practitioner will be notified of the right to review information in the request for application forms; the decision notification letter; and the provider manual. Applications will be processed, and credentialing

activities will be completed within 180 days of the attestation date.

6.3. The practitioner has the right to correct erroneous information submitted by another party. Corrections will be submitted in writing to the Director of Quality Improvement within 10 business days of notification. Corrections or information received will be reviewed and documented in the practitioner's file. The practitioner will be notified of this right in the credentialing decision notification letter as described above. During the process of correcting the erroneous information, the provider status will be pended if the error impacts the credentialing decision.

6.4. The credentialing program described above applies to any behavioral health provider. Provider rights information is distributed to all providers in the PerformCare Provider Manual.

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

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

8. Performance Monitoring

8.1. Ongoing performance monitoring for independent practitioners is completed on the following:

8.1.1. Member Complaints and Grievances

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

8.1.3. Practitioner Profiles, when applicable

8.1.4. PerformCare Member Satisfaction Surveys, when available

8.1.5. Critical Incident Reports

8.2. In addition, PerformCare monitors independent practitioner 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 independent Practitioner as they undergo re-credentialing.

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

9. The Credentialing Committee
   9.1. The completed, verified application of a practitioner is presented to the Credentialing Committee as defined in *QI-CR-005 Credentialing Committee*.
   9.2. At least every three years, PerformCare network practitioners undergo a re-credentialing process including re-verification of credentials and review of other relevant clinical and administrative information.
10. Listings in Provider Directory
   10.1. PerformCare ensures that Practitioner information that is published in the Provider Directory and shared with Members is as accurate as possible. Practitioners 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

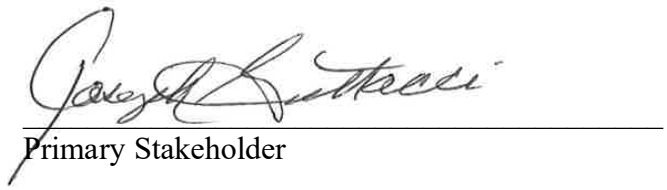
Related Reports: None

Source Documents and References: *PA Department of Health regulations, Chapter 9, Managed Care Regulations, Subchapter L, Section 9.761 through 9.763*.

Superseded Policies and/or Procedures: *PR-004 Credentialing and Re-Credentialing Criteria*

Attachments: *Attachment 1 Re-Credentialing Provider Summary*

Approved by:



Primary Stakeholder

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:	