950 - CREDENTIALING AND RECREDENTIALING PROCESSES

EFFECTIVE DATES: 10/01/94, 01/25/19, 09/01/20

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I. PURPOSE

This Policy applies to ACC, ALTCS E/PD, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors. This Policy establishes requirements for initial and temporary provider credentialing and recredentialing. The requirements specified apply to individual or organizational providers as listed.

II. DEFINITIONS

None

III. POLICY

This Policy applies to Contractors and covers temporary/provisional credentialing, initial credentialing, and recredentialing policies for both individual and organizational providers. The credentialing and recredentialing policies shall address all providers, including but not limited to physical health, behavioral, substance use disorders, and Long-Term Services and Supports (LTSS) [42 CFR 457.1208, 42 CFR 457.1233(a), 42 CFR 438.214(b)(1)]. The Contractor is required to process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing a Contractor shall follow the guidelines located in their Contract with AHCCCS. Contractors shall submit Credentialing Reports, as specified in Contract and using Attachment A.

A. CREDENTIALING INDIVIDUAL PROVIDERS

The Contractor shall have a written process and a system in place for credentialing and recredentialing providers included in its contracted provider network [42 CFR 457.1208, 42 CFR 457.1233(a), 42 CFR 438.12(a)(2), 42 CFR 438.206(b)(7), 42 CFR 438.214(b)(2)].

1. Credentialing and recredentialing shall be conducted and documented for providers delivering care and services to AHCCCS members. Credentialing and recredentialing shall be completed for at least the following provider types:
   a. Physicians (Medical Doctor (MD),
   b. Doctor of Osteopathic Medicine (DO),
   c. Doctor of Podiatric Medicine (DPM),
   d. Naturopaths (ND or NMD)
   e. Nurse practitioners (NP),
   f. Physician Assistants (PA),

g. Certified Nurse Midwives acting as Primary Care Providers(PCP), including prenatal care/delivering providers,
h. Dentists (Doctor of Dental Surgery [DDS] and Doctor of Medical Dentistry [DMD]),
i. Affiliated Practice Dental Hygienists,
j. Psychologists,
k. Optometrists,
l. Certified Registered Nurse Anesthetists,
m. Occupational Therapists,
n. Speech and Language Pathologists,
o. Physical Therapists,
p. Independent behavioral health professionals who contract directly with the Contractor including:
    i. Licensed Clinical Social Worker (LCSW),
    ii. Licensed Professional Counselor (LPC),
    iii. Licensed Marriage/Family Therapist (LMFT), and
    iv. Licensed Independent Substance Abuse Counselor (LISAC).
q. Board Certified Behavioral Analysts (BCBAs),
r. Any non-contracted certified or licensed provider that is rendering services and sees 50 or more of the Contractor's members per contract year, and
s. Covering or substitute oral health providers that provide care and services to Contractor's members while providing coverage or acting as a substitute during an absence of the contracted provider. Covering or substitute oral health providers shall indicate on the claim form that they are the rendering provider of the care or service.

2. The Contractor shall ensure:
    a. The credentialing and recredentialing processes do not discriminate against Providers who serves high-risk populations or who specializes in the treatment of costly conditions [42 CFR 457.1208, 42 CFR 457.1233(a), 42 CFR 438.12(a)(2), 42 CFR 438.214(c)], and
    b. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid or that employ individuals or entities that are excluded from participation [42 CFR 457.1233(a), 42 CFR 438.214(d)].

3. If the Contractor delegates to another entity any of the responsibilities of credentialing/recredentialing that are required by this Policy, it shall retain the right to approve, suspend, or terminate any provider selected by that entity and meet the requirements of this Chapter regarding delegation.

4. Written policies shall reflect the scope, criteria, timeliness, and process for credentialing and recredentialing providers. The policies and procedures shall be reviewed and approved by the Contractor's executive management and shall:
    a. Reflect the direct responsibility of the local Medical Director or in the absence of the local Medical Director, other local designated physician to:

i. Act as the Chair of the Credentialing Committee,
ii. Implement the decisions made by the Credentialing Committee, and
iii. Oversee the credentialing process.

b. Indicate the use of participating Arizona Medicaid network providers in making credentialing decisions, and
c. Describe the methodology to be used by Contractor staff and the local Contractor Medical Director to provide documentation that each credentialing or recredentialing file was completed and reviewed, as per section B, prior to presentation to the Credentialing Committee for evaluation.

5. Contractors shall maintain an individual electronic or hard copy credentialing/ recredentialing file for each credentialed provider. Each file shall include:
   a. The initial credentialing and all subsequent recredentialing applications, including attestation by the applicant of the correctness and completeness of the application as demonstrated by the signature on the application,
   b. Information gained through credentialing and recredentialing queries,
   c. Any other pertinent information used in determining whether or not the provider met the Contractor's credentialing and recredentialing standards, and
   d. Specific to recredentialing, utilization data, quality of care concerns, grievances, performance measure rates, value based purchasing results, and level of member satisfaction.

6. Providers may be credentialed concurrently with their AHCCCS registration process; AHCCCS registration shall be confirmed prior to finalizing a contract for Medicaid services.

7. Credentialed providers shall be entered/loaded into the Contractor's claims payment system within 30 calendar days of Credentialing Committee approval.

8. Credentialed providers shall be entered/loaded into the Contractor's claims payment system with an effective date no later than the date the provider was approved by the Credentialing Committee or the Contract Effective date, whichever is later.

9. For Locum Tenens, it is each Contractor's responsibility to verify the status of the physician with the Arizona Medical Board and national databases.

B. INITIAL CREDENTIALING

Contractors are required to utilize the Arizona Health Plan Association's Credential Verification Organization (CVO) as part of the credentialing process. At a minimum, policies and procedures for the initial credentialing of providers as required by B-1 of this Policy shall include:

1. A written application to be completed, signed and dated by the provider that attests to the following elements:

a. Reasons for any inability to perform the essential functions of the position, with or without accommodation,
b. Lack of present illegal drug use,
c. History of loss of license and/or felony convictions,
d. History of loss or limitation of privileges or disciplinary action,
e. Current malpractice insurance coverage,
f. Attestation by the applicant of the correctness and completeness of the application (a copy of the signed attestation shall be included in the provider's credentialing file), and
g. Minimum five year work history or total work history if less than five years.

2. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification, if a prescriber.

3. Verification from primary sources of:
   a. Licensure or certification,
   b. Board certification, if applicable, or highest level of credentials attained,
   c. For credentialing of Independent Masters Level Behavioral Health Licensed Professionals, including:
      i. LCSW,
      ii. LPC,
      iii. LMFT, and
      iv. LISAC.
   d. Primary source verification of:
      i. Licensure by Arizona Board of Behavioral Health Examiners (AZBBHE), and
      ii. A review of complaints received and disciplinary status through AZBBHE.
   e. For credentialing of Licensed Board Certified Behavioral Health Analysts, primary source verification of:
      i. Licensure by the Arizona Board of Psychologist Examiners,
      ii. A review of complaints received, board and disciplinary status through the Arizona Board of Psychologist Examiners,
      iii. Continuing Education requirements:
         1) BCBA's credentialed under a three-Year Cycle: 36 hours every three years (three hours in ethics and professional behavior), and
         2) BCBA's credentialed under a two-Year Cycle: 32 hours every two years (four hours in ethics for all certificates; three hours in supervision for supervisors).
      iv. Continuing Education Courses
         1) BCBAs providing supervision of individuals pursuing Behavior Analyst Certification Board (BACB) certification or the ongoing practice of Board Certified Assistant Behavior Analysts (BCABAs) or Registered Behavior Technicians (RBTs) will be required to obtain specific training in order to do so. These individuals will also be required to obtain three CEUs on supervision in every certification cycle, and
         2) Acceptable supervision content is behavior-analytic in nature and covers effective supervision as defined in the BACB's Experience Standards

(in particular, the "Nature of Supervision" section) and the BACB Supervisor Training Curriculum Outline.

TYPE	DESCRIPTION	LIMIT	CEUS
1	College or university coursework	None – all CE can come from this type	1 hour of instruction = 1 CEU
2	CE issued by approved continuing education (ACE) providers	None – all CE can come from this type	50 minutes of instruction = 1 CEU
3	Instruction of Type 1 or Type 2	50% can come from this type*	1 hour of instruction = 1 CEU
4	CE issued by the BACB directly	25% can come from this type*	Determined by BACB
5	Take and pass the certification exam again	All CE will be fulfilled by this activity	Passing the exam equals 100% of your required CEUs, except for supervision
6	Scholarly Activities	25% can come from this type*	One publication = 8 CEUs One review = 1 CEU

**A maximum of 75% of the total required CE may come from categories 3, 4, 5 and 7. At least 25% shall come from Type 1 or Type 2. Passing the examination (Type 6) meets all CE requirements except for supervision.*

4. BCBAs providing supervision of individuals pursuing BACB certification or the ongoing practice of BCBAs or RBTs will be required to obtain specific training in order to supervise. These individuals will also be required to obtain three CEUs on supervision in every certification cycle. Acceptable supervision content is behavior-analytic in nature and covers effective supervision as defined in the BACB's Experience Standards (in particular, the "Nature of Supervision" section) and the BACB Supervisor Training Curriculum Outline.
   a. Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training. A print out of license from the applicable Board's official website denoting that the license is active with no restrictions is acceptable,
   b. National Practitioner Databank (NPDB),
   c. Verification of the following:
      i. Minimum five year history of professional liability claims resulting in a judgment or settlement,
      ii. Disciplinary status with regulatory Board or Agency,

iii. Medicare/Medicaid sanctions, and exclusions, and terminations for cause, and
iv. State sanctions or limitations of licensure.

d. Documentation that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated and the identity of the provider shall be disclosed to AHCCCS/Office of the Inspector General (OIG) immediately in accordance with ACOM Policy 103.
   i. Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) http://oig.hhs.gov/fraud/exclusions.asp, and
   ii. The System of Award Management (SAM) www.sam.gov formerly known as the General Services Administration (GSA).

5. Affiliated practice dental hygienists shall provide documentation of the affiliation agreement with an AHCCCS registered dentist.

6. Initial site visits for PCP and Obstetrics/Gynecology (OB/GYN) applicants shall include but are not limited to verification of compliance with the following:
   a. Vaccine and drug storage regulations,
   b. Emergency and resuscitation equipment policy, and
   c. Americans with Disabilities Act (ADA) requirements [42 CFR 457.1201(f), 42 CFR 457.1220, 42 CFR 438.3(f)(1), 42 CFR 438.100(d)].

7. Contractors shall ensure that network providers have capabilities to ensure physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities [42 CFR 457.1230(a), 42 CFR 438.206(c)(2)(3)]. Contractors shall also ensure that providers deliver services in a culturally competent manner, including to those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity [42 CFR 457.1230(a), 42 CFR 438.206(c)(2)].

8. Contractors shall conduct timely verification of information, as evidenced by approval (or denial) of a provider within 75days of a receipt of complete application.

9. The Contractors shall have an established process to notify providers of their credentialing decision (approved or denied) within 10 days of Credentialing Committee decision.

10. Contractors shall have written policies and procedures for notifying practitioners of their right to review information it has obtained to evaluate their credentialing application, attestation, or Curriculum Vitae (CV).
11. Contracted providers including licensed or certified behavioral health providers may be subject to an initial site visit as part of the credentialing process.

C. TEMPORARY/PROVISIONAL CREDENTIALING

Contractors shall have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.

Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-Alike Center, as well as hospital employed physicians (when appropriate), shall be credentialed using the temporary or provisional credentialing process even if the provider does not specifically request their application be processed as temporary or provisional. Provisional credentialing shall also be utilized during federal and/or state-declared emergencies where delivery systems are or have the potential to be disrupted.

Contractors shall follow the "Initial Credentialing" guidelines when granting temporary or provisional credentialing to:

1. Providers in a FQHC.

2. Providers in a FQHC Look-Alike organization.

3. Hospital employed physicians (when appropriate).

4. Providers needed in medically underserved areas.

5. Providers joining an existing and contracted oral health provider group.

6. Covering or substitute providers providing services to the Contractor's members during a provider's absence from the practice.

7. Providers eligible under the Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Opioid Treatment Programs (OTPs) per 42 CFR 8.11. SAMHSA Certified OTPs shall be credentialed using the temporary/provisional credentialing process even if the provider does not specifically request their application be processed as temporary or provisional.

8. Providers as directed by AHCCCS during federal and/or state-declared emergencies.

   The Contractor shall have 14 calendar days from receipt of a complete application, accompanied by the minimum documents specified in the section, in which to render a decision regarding temporary or provisional credentialing. Once provisional/temporary credentialing is approved, provider information shall be entered into the Contractor's information system to allow payment to the provider effective the date the provisional credentialing is approved.

In situations where a covering or substitute provider shall be utilized by a contracted provider and is approved through the temporary/provisional credentialing process, Contractors shall ensure that its system allows payments to the covering/substitute provider effective when the date notification was received from the provider of the need for a covering or substitute provider. Covering or substitute providers shall also meet the following requirements:

a. Licensure: Provider and employees rendering services to Members shall be appropriately licensed in Arizona to render such services as required by state or federal law or regulatory agencies, and such licenses shall be maintained in good standing,
b. Restriction of Licensure: Provider shall notify the Contractor within two business days of the loss or restriction of his/her DEA permit or license or any other action that limits or restricts the Provider's ability to practice or provide services,
c. Professional Training: Provider and all employees rendering services to Members shall possess the education, skills, training, physical, and mental health status, and other qualifications necessary to provide quality care and services to Members,
d. Professional Standards: Provider and employees rendering services to Members shall provide care and services which meets or exceeds the standard of care and shall comply with all standards of care established by state or federal law,
e. Continuing education: Provider and employees rendering care or services to Members shall comply with continuing education standards as required by state or federal law or regulatory agencies, and
f. Regulatory compliance: Provider shall meet the minimum requirements for participating in the Medicaid program as specified by the State.

9. For consideration of temporary or provisional credentialing, at a minimum, a provider shall complete a signed application that shall include the following items:
   a. Reasons for any inability to perform the essential functions of the position, with or without accommodation,
   b. Lack of present illegal drug use,
   c. History of loss of license and/or felony convictions,
   d. History of loss or limitation of privileges or disciplinary action,
   e. Current malpractice insurance coverage, and
   f. Attestation by the applicant of the correctness and completeness of the application (a copy of the most current signed attestation shall be included in the provider's credentialing file).

10. In addition, the applicant shall furnish the following information:
    a. Work history for the past five years or total work history if less than five years, and

    b. Current Drug Enforcement Agency (DEA) or Controlled Drug System (CDS) certificate.

11. Contractor shall conduct primary verification of the following:
    a. Licensure or certification; A print out of license from the applicable Boards' official website denoting that the license is active with no restrictions is acceptable,

b. Board certification, if applicable, or the highest level of credential attained, and
c. NPDB query including the following:
   i. Minimum five year history of professional liability claims resulting in a judgment or settlement,
   ii. Disciplinary status with regulatory board or agency,
   iii. State sanctions or limitations of licenses, and
   iv. Medicare/Medicaid sanctions, exclusions, and terminations for cause.

The local Contractor's Medical Director shall review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and Credential Committee review, as specified in this Section, shall be completed.

D. RECREDENTIALING INDIVIDUAL PROVIDERS

Contractors are required to utilize the Arizona Health Plan Association's CVO as part of its credentialing process. At a minimum, the recredentialing policies for physicians and other licensed or certified health care providers shall identify procedures that address the recredentialing process and include requirements for:

1. Recredentialing at least every three years.

2. An update of information obtained during the initial credentialing process, as specified in this Policy.

3. Verification of continuing education requirements being met.

4. A process for monitoring health care providers specific information such as, but not limited to, the following:
   a. Member concerns which include grievances (complaints),
   b. Utilization management information (such as: emergency room utilization, hospital length of stay, disease prevention, pharmacy utilization),
   c. Performance improvement and monitoring (such as performance measure rates),
   d. Results of medical record review audits, if applicable,
   e. Quality of care issues (including trend data). If an adverse action is taken with a provider, including non-renewal of a contract Contractors shall report the adverse action and include the reason for the adverse action to the AHCCCS Clinical Quality Management Unit within one business day,
   f. Pay for performance and value driven health care data/outcomes, if applicable,
   g. Evidence that the provider's policies and procedures meet AHCCCS requirements.

5. Timely approval (or denial) by the Contractor's Credentialing Committee within three years from the previous credentialing approval date. Primary Source Verification shall also be current, within 180 days, for the Committee's decision.

E. INITIAL CREDENTIALING OF ORGANIZATIONAL PROVIDERS

As a prerequisite to contracting with an organizational provider, Contractors shall ensure that the organizational provider has established policies and procedures that meet AHCCCS requirements including policies and procedures for credentialing and recredentialing if those functions are delegated to the organizational provider. The requirements specified in this section shall be met for all organizational providers included in its network including, but not limited to:

1. Hospitals.
2. Home health agencies.
3. Attendant care agencies.
4. Habilitation Providers.
5. Group homes.
6. Child/Adult Developmental Homes.
7. Nursing Supported Group Homes.
8. Nursing facilities.
9. Dialysis centers.
10. Dental and medical schools.
11. Freestanding surgical centers.
12. Intermediate Care Facilities.
13. State or local public health clinics.
14. Community/Rural Health Clinics (or Centers).
15. Air Transportation.
16. Non-emergency transportation vendor.
17. Laboratories.
18. Pharmacies.
19. Respite Homes/Providers.

20. Behavioral health facilities, including but not limited to:
    a. Independent Clinics,
    b. FQHCs,
    c. Community Mental Health Centers,
    d. Level 1 Sub-Acute Facility (IMD and non-IMD),
    e. Intermediate Care Facility/Individuals with Intellectual Disabilities,
    f. Level 1 Residential Treatment Center (IMD),
    g. Level 1 Residential Treatment Center Non-Secure (non-IMD),
    h. Level 1 Residential Treatment Center Non-Secure (IMD),
    i. Community Service Agency,
    j. Crisis Services Provider/Agency,
    k. Behavioral Health Residential Facility,
    l. Behavioral Health Outpatient Clinic,
    m. Integrated Clinic,
    n. Rural Substance Abuse Transitional Agency,
    o. Behavioral Health Therapeutic Home,
    p. Respite Homes/Providers,
    q. Specialized Assisted Living Centers, and
    r. Specialized Assisted Living Homes.

21. Prior to contracting with an organization provider, each Contractor shall:
    a. Confirm that the provider has met all the state and federal licensing and regulatory requirements (a copy of the license or letter from the regulatory agency will meet this requirement),
    b. Confirm that the provider is reviewed and approved by an appropriate accrediting body as specified by the Centers for Medicare and Medicaid Services (CMS) (a copy of the accreditation report or letter from the accrediting body will meet this requirement). Contractors shall state in policy which accrediting bodies it accepts that is in compliance with federal requirements,
    c. Conduct an onsite quality assessment if the provider is not accredited. Contractors shall develop a process and utilize assessment criteria for each type of unaccredited organizational provider for which it contracts that shall include, but is not limited to, confirmation that the organizational provider has the following:
        i. A process for ensuring that the organizational provider credentials its providers for all employed and contracted providers as specified in policy,
        ii. Liability insurance, and
        iii. Business license, or
        iv. (CMS) certification or state licensure review/audit may be substituted for the required site visit as long as the site visit was within the past three years prior to the credentialing date. In this circumstance, Contractors shall obtain the review/audit documentation from CMS or the state licensing agency and verify that the review/audit was conducted and that the provider meets the Contractor's standards. A letter from CMS that states the organizational provider was reviewed/ audited and passed inspection is sufficient documentation when the Contractor has documented that they have reviewed and approved the CMS criteria and they meet the Contractor's standards.

d. In addition, Community Service Agencies shall also have a:
   i. Signed relationship agreement with the Contractor whose members they are serving,
   ii. Approved application with the Contractor,
   iii. Signed contract with a RBHA contracted network provider or with the Contractor directly as applicable,
   iv. Description of the services provided that matches the services approved on the Title XIX Certificate,
   v. Fire inspection reports,
   vi. Occupancy permits,
   vii. Tuberculosis testing,
   viii. CPR certification,
   ix. First Aid certification, and
   x. Respite providers shall provide and maintain consistently a signed agreement with an Outpatient Treatment Center.

22. Review and approve the organizational provider through the Contractor's Credentialing Committee.

23. For transportation vendors, a maintenance schedule for vehicles used to transport AHCCCS members and the availability of age appropriate car seats when transporting children.

F. THERAPEUTIC FOSTER CARE PROVIDERS

Therapeutic Foster Care Providers for children, submission of a Foster Home License, as specified in A.A.C. 21, Article 1 through Article 4, will be accepted as meeting the requirements for credentialing as an AHCCCS provider.

Therapeutic Foster Care Providers serving adults shall operate under the governing authority A.A.C. R9-10-1803 and according to licensure requirements as specified in A.A.C. R9-10, Article 18.

For information regarding AHCCCS responsibilities related to Therapeutic Foster Care settings, refer to AMPM Policy 320-W.

G. REASSESSMENT OF ORGANIZATIONAL PROVIDERS

Contractors shall reassess organizational providers at least every three years. The reassessment shall include the following components and all information utilized by Contractors shall be current.

1. Confirmation that the organizational providers remain in good standing with State and Federal bodies, and, if applicable, are reviewed and approved by an accrediting body. To meet this component Contractor shall validate that the organization provider meets the conditions listed below:

a. Is licensed to operate in the State, and is in compliance with any other State or Federal requirements as applicable, and
b. Is reviewed and approved by an appropriate accrediting body. If an organization provider is not accredited or surveyed and licensed by the State an on-site review shall be conducted.

2. Review of the following:
   a. The most current review conducted by the Arizona Department of Health Services (ADHS) and/or summary of findings (date of ADHS review shall be documented). If applicable, review the online hospital/nursing home compare,
   b. Record of on-site inspection of non-licensed organizational providers to ensure compliance with service specifications,
   c. Supervision of staff and required documentation of direct supervision/clinical oversight as required in A.A.C. R9-10-114. This process shall include a review of a valid sample of clinical charts,
   d. Most recent audit results of the organizational provider,
   e. Confirmation that the service delivery address is verified as correct, and
   f. Review of staff to verify credentials, and that the staff person meets the credentialing requirements.

3. Evaluate organizational provider specific information such as, but not limited to, the following:
   a. Member concerns which include grievances (complaints),
   b. Utilization management information,
   c. Performance improvement and monitoring,
   d. Quality of care issues,
   e. Onsite assessment, and
   f. If an adverse credentialing, recredentialing or organizational credentialing decision is made on the basis of quality concerns; Contractors shall report the adverse action to the AHCCCS Clinical Quality Management Unit within one business day.

4. Review and approval by the Contractor's Credentialing Committee with formal documentation that includes discussion, review of thresholds, and complaints or grievances.

5. In addition to the requirements in this Policy, ALTCS Contractors shall review and monitor other types of organizational providers in accordance with their contract.

H. NOTIFICATION REQUIREMENTS

1. Contractors shall have procedures for prompt reporting in writing to appropriate authorities including the AHCCCS Clinical Quality Management Unit, the provider's regulatory Board or Agency, the Arizona Department of Health Services Licensure Division, and the Office of the Attorney General. Contractors shall report within one business day to the AHCCCS Clinical Quality Management Unit issues/quality deficiencies that result in a provider's suspension or termination from the Contractor's

network. If the issue is determined to have criminal implications, including allegations of abuse or neglect, a law enforcement agency shall also be promptly notified as well as Adult Protective Services or the Department of Child Safety. Contractors shall have an implemented process to report providers to licensing and other regulatory entities, all allegations of inappropriate or misuse of prescribing practices. This shall include allegations of adverse outcomes that may have been avoided if the provider had reviewed the Controlled Substance Prescription Monitoring Program (CSPMP) and coordinated care with other prescribers.

2. Contractors shall report to the AHCCCS Clinical Quality Management Unit all credentialing, provisional credentialing, recredentialing and organizational credentialing denial decisions that are made on the basis of quality-related issues or concerns.

3. The Contractor shall indicate in its notification to AHCCCS the reason or cause of the adverse/denial decision and when restrictions are placed on the provider's contract, including, but not limited to denials or restrictions which are the result of, licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste, or abuse. The AHCCCS Clinical Quality Management Unit shall refer cases, as appropriate, to the AHCCCS Office of the Inspector General (AHCCCS-OIG), in accordance with 42 CFR 455.14. The AHCCCS-OIG shall conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation [42 CFR 455.14] [42 CFR 455.17][42 CFR 455.1(a) (1)]. Contractors shall:
   a. Maintain documentation of implementation of the procedures,
   b. Have an appeal process for instances in which the Contractor places restrictions on the provider's contract based on issues of quality of care and/or service,
   c. Inform the provider of the Quality Management (QM) dispute process through the QM Department,
   d. Notify the AHCCCS Clinical Quality Management (CQM) within one business day for all reported events,
   e. Have procedures for reporting to the AHCCCS Clinical Quality Management Unit in writing any final adverse action for any quality-related reason, taken against a health care provider, supplier/vendor, or practitioner. A "final adverse action" does not include an action with respect to a malpractice notice or settlements in which no findings or liability has been made,
   f. Submit to the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB):
      i. Within 30 calendar days from the date the final adverse action was taken or the date when the Contractor became aware of the final adverse action, or
      ii. By the close of the Contractor's next monthly reporting cycle, whichever is later.

4. A "final adverse action" includes:
   a. Civil judgments in Federal or State court related to the delivery of a health care item or service,

b. Federal or State criminal convictions related to the delivery of a health care item or service,
c. Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including:
   i. Formal or official actions, such as restriction, revocation or suspension of license (and the length of any such suspension), reprimand, censure or probation,
   ii. Any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or
   iii. Any other negative action or finding by such Federal or State agency that is publicly available information,
   iv. Exclusion from participation in Federal or State health care programs (as defined in 42 CFR 455 Subpart B. and
   v. Any other adjudicated actions or decisions that the Secretary shall establish by regulation.
d. Any adverse credentialing, provisional credentialing, recredentialing or organizational credentialing decision made on the basis of quality-related issues/concerns or any adverse action from a quality or peer review process, that results in denial of a provider to participate in the Contractor's network, provider termination, provider suspension or an action that limits or restricts a provider.

5. Notice of a Contractor's final adverse action should be sent to CQM within one business day of the notice.

6. In accordance with A.R.S. §36-2918.01 §36-2905.04, §36-2932, and ACOM Policy 103, the Contractor, its subcontractors and providers are required to immediately notify the AHCCCS Office of Inspector General (AHCCCS-OIG) regarding any allegation of fraud, waste or abuse of the AHCCCS Program. Notification to AHCCCS-OIG shall be in accordance with ACOM Policy 103 and as specified in Contract. This shall include allegations of fraud, waste, or abuse that were resolved internally but involved AHCCCS funds. Contractors shall also report to AHCCCS, as specified in any credentialing denials issued by the CVO including, but not limited to, those which are the result of licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste, or abuse. Contractors shall provide notification regarding credentialing denials and approvals to the applicable provider(s) within 10 days of committee decisions. In accordance with 42 CFR 455.14, AHCCCS-OIG will then conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation [42 CFR 455.17][42 CFR 455.1(a)(1)].

7. The Contractor shall report, within one business day, the following information:
   a. The name and Tax Identification Number (TIN) (as defined in section 7701(A)(41) of the Internal Revenue Code of 1986[1121]),
   b. The name (if known) of any heath care entity with which the health care provider, supplier, or practitioner is affiliated or associated,
   c. The nature of the final adverse action and whether such action is on appeal,

d. A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section,
e. The date the final adverse action was taken, its effective date and duration of the action,
f. Corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner,
g. Documentation that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated and the identity of the provider shall be disclosed to AHCCCS-OIG immediately in accordance with the AHCCCS ACOM Policy 103:
    i. The SAM formerly known as the Excluded Parties List System (EPLS),
    ii. The Social Security Administration's Death Master File,
    iii. The National Plan and Provider Enumeration System (NPPES),
    iv. The LEIE, and
    v. Any other databases directed by AHCCCS or CMS.

I. TEACHING PHYSICIANS AND TEACHING DENTISTS

1. AHCCCS permits services to be provided by medical students or medical residents and dental students or dental residents under the direct supervision of a teaching physician or a teaching dentist. In limited circumstances when specific criteria are met, medical residents may provide low-level evaluation and management services to members in designated settings without the presence of the teaching physician.

2. The teaching physicians and teaching dentists shall be an AHCCCS registered provider and shall be credentialed by the AHCCCS Contractors in accordance with AHCCCS policy as specified in this Policy.

J. CREDENTIALING TIMELINESS

The Contractor is required to process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing a Contractor shall divide the number of complete applications processed (approved/denied) during the time period per category by the number of complete applications that were received during the time period per category, reference Attachment A.

An example for processing timelines is listed by category below:

CREDENTIALING ACTIVITY	TIME FRAME	COMPLETION REQUIREMENTS
Provisional	14 Days	100%
Initial	75 Days	100%
Organizational Credentialing	75 Days	100%
Recredentialing (Professional and Organizational)	Every three years	100%
Load Times (Time between Credentialing Committee Approval and loading into Claims System)	30 Days	90%