Section 10

NETWORK CREDENTIALING

The Network Credentialing Department is responsible for monitoring all administrative aspects of the provider network. This includes, but is not limited to, provider credentialing and recredentialing, provider status changes and updates, geographic and specialty access, training, and provider relation activities.

ValueOptions' program for credentialing and re-credentialing providers is designed to comply with the National Committee for Quality Assurance (NCQA) standards for the credentialing of behavioral health providers. This program will be described below as it applies to Colorado Medicaid participating providers.

If you are interested in becoming a provider for the Behavioral Health Organization that administers the Colorado Community Mental Health Services Program, please send a letter of intent along with a copy of your resume by fax or email. Please review the remainder of this section for information about our credentialing criteria.

Provider Relations:	**1-800-804-5040**
Fax:	**719-538-1433**
Email:	COProviderRelations@valueoptions.com

CREDENTIALING

All providers who participate in the ValueOptions Colorado Medicaid Network must be credentialed according to ValueOptions' standards. Among these requirements is Primary Source Verification (see Glossary) of the following information:

- Current valid license to practice as an independent behavioral healthcare practitioner at the highest level certified or approved by the state.
- Clinical privileges in good standing at the institution designated by the practitioner as the primary admitting facility, as applicable.
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline, or licensure.
- Board certification, if designated on the application.
- Current, adequate malpractice insurance.
- History of professional liability claims which result in settlements or judgments paid by or on behalf of the practitioner.
- Specialized training for non-traditional practitioners.
- Three years post-licensure experience.

ValueOptions also requires:

- A copy of a current DEA Certificate, as applicable
- Work history

- Information from the State Board of Licensure and the National Practitioner Data Bank
- Information about sanctions or limitations on licensure from the appropriate state
- Medicare and/or Medicaid sanctions.

ValueOptions performs verification of the following elements to meet the State of Colorado Medicaid requirements for providers:

- Background investigation through the Colorado Bureau of Investigation; and
- Background investigation through the Background Investigation Unit Colorado Department of Human Services.

As part of the credentialing process, ValueOptions conducts a structured site visit of high volume provider offices. This site visit includes an evaluation using ValueOptions' standards and includes evaluation of the provider's clinical record-keeping practices to ensure conformity with ValueOptions' standards.

It is the responsibility of the provider to give current information to our Network Credentialing Department within the timeline defined below for the provider to maintain network status. When Network Credentialing receives the new information, they will update the data system and add the documentation to the provider's file. Failure to submit current copies of expired items will result in suspension or termination from the network.

PROVIDER CONTRACT REQUIREMENTS

1. **Providers must notify the BHO within 24 hours upon the occurrence of any of the following:**
   - Adverse incidents regarding members, i.e. attempted suicide requiring medical care, suicide, homicide, suspected neglect or abuse of members, incidents that may attract media attention. (See Section 14 Quality Management for more information.)
   - Revocation, suspension, restriction, termination, or relinquishment of any of the licenses, authorizations, or accreditation's whether voluntary or involuntary.
   - Any legal action pending for professional negligence or alleged malpractice.
   - Any indictment, arrest, or conviction for felony charges or for any criminal charge.
   - Any lapse or material change in professional liability insurance coverage.
   - Revocation, suspension, restriction, termination or relinquishment of medical staff membership or clinical privileges at any healthcare facility.
   - Any alleged professional misconduct or ethical violations reported to state licensing boards, professional organizations or the National Practitioners Data Bank.

Failure to report any of the above within the specified time frame will result in immediate suspension from the network with possible termination.

2. **APPOINTMENT AVAILABILITY AND ACCESS STANDARDS**

ValueOptions contracted providers are required to meet all access standards as stated in the Medicaid regulations. Specific information for routine access will be gathered during the initial

authorization process for outpatient care. ValueOptions conducts quarterly quality activities to assure compliance with these standards. These activities may include random contacts to providers to measure timeframes for Routine and Emergent appointment access.

The access/availability timeframes required in the Medicaid regulations are as follows:

- **Emergent Access**: Members in a crisis must be contacted by phone within 15 minutes of initial member request. A face-to-face evaluation must be conducted within 1 hour of initial contact in urban areas and within 2 hours in rural areas. Providers are required to have coverage for after-hours emergencies; it is not an acceptable practice to refer members to a Mental Health Center without a prior agreement with the Mental Health Center, or for a phone message to refer clients directly to an emergency room in a crisis. If members are referred to an emergency room or crisis center following a crisis evaluation, the provider must be available by phone 24 hours a day, 7 days a week to offer information and consultation to the emergency services provider.
- **Urgent Access**: Members must be offered an appointment that is within 24 hours of initial contact.
- **Routine Access**: Members must be offered an initial appointment that is within 7 business days of the member's request.

Inpatient and Residential Treatment post-discharge follow-up appointments: Outpatient follow-up appointments are required within seven (7) business days after discharge from an inpatient psychiatric hospitalization. Outpatient follow-up appointments or equivalent post-discharge follow-up are required, documented in the discharge care plan, within seven (7) business days after discharge from a residential treatment facility.

Waiting Room Time for Scheduled Member Appointments: A Medicaid Member who arrives on time for their scheduled appointment shall wait no longer than fifteen minutes to begin their scheduled appointment. If the appointment does not begin within 15 minutes, the Member shall be offered the option of rescheduling for the next available appointment. Members shall be notified of the option to reschedule through a posted notice in the waiting area or by reviewing the wait time policy with the Member at the initiation of treatment.

Members who were scheduled for prescriber services should be provided an appointment date that does not cause a delay or gap in their prescribed medication regimen. Members indicating urgent or emergent concerns should be provided an appointment that meets the access standards for urgent/emergency requests.

If you have questions about these timeframes, please contact the BHO Director of Quality Management.

3. RECREDENTIALING

ValueOptions requires that practitioners and organizational providers undergo recredentialing every three years. Recredentialing begins approximately six months prior to the expiration of the 3-year cycle. Providers are sent a recredentialing application that must be completed in its entirety, signed, and returned to ValueOptions as soon as possible, with all requested verifications attached.

Credentialing information that is subject to change must be re-verified from primary sources during the recredentialing process. The practitioner must attest to any limits on his/her ability to perform essential functions of the position and attest to absence of current illegal drug use (in accordance with applicable legal requirements such as the Americans with Disabilities Act).

High volume providers (as defined by ValueOptions) must undergo a structured site review to ensure conformity with ValueOptions' standards. This review includes an evaluation of clinical record keeping practices at each site.

LOCAL CREDENTIALING COMMITTEE

The Local Credentialing Committee (LCC) is comprised of representatives of all major clinical disciplines. The LCC functions as an advisory body to the National Credentialing Committee (NCC). Files for credentialing and recredentialing are first reviewed by the LCC; recommendations are forwarded to the NCC regarding the network participation in ValueOptions Colorado Medicaid Provider Network.

NATIONAL CREDENTIALING COMMITTEE

ValueOptions' National Credentialing Committee (NCC) is made up of representatives of all major clinical disciplines, participating providers, and representatives of major departments including the National Network Management and Quality Management departments. The NCC has decision-making authority for all credentialing matters including approvals and denials for network participation during initial credentialing and recredentialing. The NCC also makes decisions regarding provider sanctions. The NCC reports its activities to ValueOptions' Corporate Quality Improvement Committee (CQIC) which provides oversight.

CHANGE OF STATUS OR ADDRESS

Providers can help keep files current by notifying Network Credentialing of change of status or address. Information can be submitted by calling **1-800-804-5040,** faxing to **1-719-538-1433**, sending an email to COProviderRelations@Valueoptions.com , or by writing ValueOptions, Network Credentialing Department, 7150 Campus Drive., Ste. 300, Colorado Springs, CO 80920.

Failure to notify Network Credentialing of changes may result in delay in payment of claims or change in network status to include suspension or termination from the network.

Notify Network Credentialing of new practice affiliations, changes in address or licensure, and facility or program involvement. Remember to include all important information:

- Your name and name(s) of practice, facility, program
- Tax identification number and billing information
- Street address(es), city, state and zip
- Telephone number(s)

- Copies of new or updated licenses or authorizations
- Copies of cover sheets for updated liability coverage

A copy of the form can be obtained by visiting http://www.valueoptions.com or is attached to this handbook.

PROVIDER TERMINATIONS, SANCTIONS AND APPEALS

Voluntary: If a provider chooses to terminate from the network, a written request must be submitted to Provider Relations. Provider Relations will acknowledge receipt of the request, coordinate Member related services with the clinical department, and notify the provider of the final termination date.

Involuntary: Non-adherence to performance standards or criteria, substandard performance, unethical practices, and breaches in professional code of conduct may result in termination from the provider network. Critical areas monitored include:

- professional and ethical conduct
- adherence to contract stipulations
- professional liability claims/disposition involving direct Member care
- patterns of practice contrary to ValueOptions' procedural standards
- patterns of service delivery
- billing fraud
- due process
- violation of state/federal laws
- reporting of all sentinel events.

If performance standards are suspect, ValueOptions will contact the provider by phone, or by authorized mail to alert the provider to the issue(s) and will review the appropriate documentation in compliance with due process/fundamental fairness procedures. A full description for ValueOptions' sanctioning policies and procedures can be obtained on written request from Network Credentialing.

APPEALS

Providers who are terminated from the network or are otherwise sanctioned have the right to appeal. Such appeals are heard by the National Provider Appeals Committee (PAC), which is comprised of representatives of all major disciplines, ValueOptions participating providers, and representatives of certain ValueOptions' departments, including Network Management, Clinical Operations and Quality Management. Members of the PAC must not have participated in the National Credentialing Committee decision under review. Providers who have been sanctioned by the National Credentialing Committee, based on a peer review of a quality of care concern have the right to a fair hearing, if such a hearing is requested within 30 days. Sanctioned or terminated providers are notified about the procedure for requesting the fair hearing at the time they are notified about the adverse action. Providers sanctioned by the National Credentialing Committee for reasons other than quality of care concerns must submit their appeal in writing within 30 days. Providers eligible for written appeals will be notified of

their appeal rights at the time they are notified about the adverse action. Filing an appeal will not stay the sanctions imposed by the National Credentialing Committee.

NOTE: Providers who are convicted of crimes involving sexual misconduct or the violation of a member's civil rights, or who are the subject of malpractice judgements or settlements or licensure actions involving sexual misconduct or violations of a member's civil rights, are excluded from any further network participation. The National Credentialing Committee must approve any exceptions to this policy.