



BHD

MILWAUKEE COUNTY

Behavioral
Health
Division

Provider Network Credentialing Program

**Community Access to Recovery Services
(CARS)**

and

Wraparound Milwaukee

July 2019

Executive Summary: Credentialing Program Description
Effective: July 2019

Purpose:

The BHD Provider Network Credentialing Program is comprehensive and ensures that its practitioners meet the standards of professional licensure, training and certification. The process enables BHD to recruit and retain a quality network of practitioners to serve its members and ensure ongoing access to care.

Scope:

The scope of the Credentialing Program is comprehensive and includes credentialing, recredentialing and ongoing monitoring of all BHD Provider Network physicians, licensed clinical and counseling psychologists and advanced practice nurses. All such physicians and licensed independent practitioners with an unrestricted, current and valid Wisconsin professional license are eligible to participate.

The BHD Provider Network Credentialing Program is reviewed and updated, at least biennially, by the Credentialing Committee based upon CMS, Wisconsin DHS, NCQA requirements and recognized managed care credentialing best practices. The Credentialing Program shall be approved by the BHD Provider Network Credentialing Committee, the Wraparound and Community Access to Recovery Services Administrators, the BHD Chief Medical Officer, the BHD Administrator and the Mental Health Board.

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I. DEFINITIONS

The acronyms, phrases, words and terms used in this document shall have the following meanings unless the context specifically states otherwise:

1. **Administrator:**

BHD Administrator: The individual appointed to oversee overall operations of the Behavioral Health Division programs and services. Accountable to the Director of Health and Human Services and the Mental Health Board.

Community Access to Recovery Services (CARS) Administrator: The individual appointed to oversee operations for Behavioral Health Division non-inpatient programs and services and community-based programs and services for adults.

Wraparound Program Administrator: The individual appointed to oversee operations for Behavioral Health Division non-inpatient programs and services and community-based programs and services for children and adolescents.

2. **Board:** The Milwaukee County Mental Health Board (MHB) created by 2013 Wisconsin Act 203 and charged with jurisdiction over all inpatient and community-based mental health functions, programs, and services in Milwaukee County, including those relating to alcohol and other drug abuse.
3. **BHD:** The Milwaukee County Behavioral Health Division.
4. **CARS:** The Community Access to Recovery Services adult outpatient services and programs of the Behavioral Health Division and Provider Network.
5. **Clean Application:** A practitioner's application submission that meets the standards, guidelines, and established minimum professional threshold criteria for network participation.
6. **CMS:** Centers for Medicare and Medicaid Services.
7. **Credentialing Committee (Committee):** A peer review body chaired by a Medical Director (or equally qualified physician designee) to make recommendations to approve, deny, suspend, or terminate a practitioner's participation in the Network based on the established criteria.
8. **Credentialing Process:** Includes both the credentialing and recredentialing of licensed practitioners that may independently bill for their services.
9. **DEA:** The Drug Enforcement Administration is a United States federal law enforcement agency, under the United States Department of Justice, tasked with combating drug smuggling and distribution within the United States; and has a system in place which authorizes eligible individuals and entities to register in order to manufacture, import, export, distribute, research, prescribe, have access to and/or dispense scheduled drugs.

10. **DHS-Wisconsin:** The Wisconsin Department of Health Services oversees Medicaid and other health social service programs to ensure that the care provided to Wisconsin residents is high quality and provided in accordance with state and federal law; ensures that Wisconsin taxpayer dollars are being used effectively and efficiently by preventing and detecting waste, fraud, and abuse.
11. **Delegated Credentialing:** Occurs when the credentialing functions of a managed care organization or other organization have been outsourced or contracted out to be performed by another capable organization.
12. **Dual Credentialing:** A practitioner who is educated and trained to provide care in two (or more) specialties.
13. **Dual Contracting:** A practitioner that is contracted directly with the BHD Provider Network and also with an agency that contracts with the BHD Provider Network or works with two or more agencies that contract with the BHD Provider Network.
14. **Impaneling:** The determination of eligibility for individuals applying to become a part of the MCBHD Provider Network(s). Impaneling consists of a review of required documentation set forth by county, state and/or federal licensing and regulatory agencies, but does not encompass full credentialing, as outlined in this Program.
15. **Licensed independent practitioner (LIP):** A practitioner who does not work under the auspices or authority of another practitioner.
16. **Locum Tenens:** A Latin phrase that means "to hold the place of, to substitute for." In layman's terms, it means a temporary and/or covering practitioner.
17. **Medical Directors:** The Behavioral Health Division's staff of employed Medical Director(s).

Chief Medical Officer (CMO): The CMO is responsible for providing direction for the development and implementation of the Credentialing Program.

Service Medical Director(s): The Service Medical Director(s) is responsible for peer review activities and for collaboration with the Chief Medical Officer, Credentialing and Quality Management Staff on the development and implementation of the Credentialing Program. One Service Medical Director shall be selected to serve as Chairman of the BHD Provider Network Credentialing Committee.

Administrative Medical Director – BHD Service Medical Director(s) are not required to be credentialed by the BHD Provider Network when s/he is not contracted to provide direct care to BHD Provider Network members. The Medical Director(s)' license shall be verified to ensure it is unrestricted, current and/or valid, and shall be included in the Human Resources File. In the event the Medical Director provides hospital and/or clinic services under the Behavioral Health Division's operational licenses and authority, the BHD Medical Staff Organization will assume any further credentialing requirements.

Non-Administrative Medical Director – BHD Service Medical Director(s) who are required to be credentialed by the BHD Provider Network because s/he is contracted individually or as part of a group/agency to perform direct care to BHD Provider Network members. Care

provided falls outside of BHD licensed settings and the scope of the Medical Director(s)' BHD employment duties and schedule.

18. **Member:** An individual residing in Milwaukee County and eligible for BHD Provider Network services.
19. **Nationally Recognized Accrediting Entity/Body:** An organization that sets national standards specifically governing healthcare quality assurance processes, utilization review, practitioner credentialing, as well as other areas covered in this document and provides accreditation to hospitals, managed care organizations and managed care health insurance plans pursuant to national standards. The following entities are examples of nationally recognized accrediting entities/bodies:
 - **TJC:** The Joint Commission
 - **NCQA:** National Committee for Quality Assurance
 - **HFAP:** Healthcare Facilities Accreditation Program
 - **URAC:** Utilization Review Accreditation Commission
 - **DNV:** Det Norske Veritas Healthcare, Inc.
20. **Network:** Refers to the BHD Provider Network
21. **Network Practitioner:** A verified person who has been credentialed by the BHD Provider Network to provide healthcare services to its members and follow all established network policies and procedures.
22. **Network Provider:** An individual or agency that holds a contractual agreement with the BHD Provider Network to provide healthcare services to its members and follow all established network policies and procedures.
23. **Office of the Inspector General (OIG):** The Health and Human Services Office of Inspector General responsible for excluding individuals and maintaining a sanctions list that identifies those practitioners and providers who have participated or engaged in certain impermissible, inappropriate, or illegal conduct to include, but not limited to, fraudulent billing and misrepresentation of credentials. The OIG's List of Excluded Individuals and Entities (LEIE) provides information on all individuals and entities currently excluded from participation in the Medicare, Medicaid, and all other Federal health care programs.

If identified billing practices are suspected to be potentially fraudulent or abusive, the **OIG's National Hotline** should be contacted at **1-800-HHS-TIPS (1-800-447-8477)** to report the activity.

Contacting the HHS OIG Hotline:

By Phone: 1-800-HHS-TIPS (1-800-447-8477) By Fax: 1-800-223-8164

By E-Mail: HHSTips@oig.hhs.gov

By TTY: 1-800-377-4950

By Mail:

Office of Inspector General
Department of Health and Human Services
Attn: HOTLINE
330 Independence Ave., SW
Washington, DC 20201

Centers for Medicare & Medicaid Services (CMS): Suspicions of fraud or abuse may also be reported to Medicare's Customer Service Center at **1-800-MEDICARE (1-800-633-4227)**.

24. **Primary Source Verification (PSV):** The original source of a specific credential that can verify the accuracy of a qualification reported by an individual health care practitioner. Primary source examples include medical school, graduate medical education programs, and state medical/professional licensing boards.
25. **Recognized Equivalent to Primary Source (TJC) or Approved Sources (NCQA):** Consistent with The Joint Commission (TJC), the Centers for Medicare and Medicaid Services (CMS) and the National Center for Quality Assurance (NCQA) standards, the following are considered to be an equivalent and/or an approved source for primary source verification of education and for ongoing monitoring of certain credentials and sanctions/exclusion monitoring:
1. The American Medical Association (AMA) Physician Masterfile
 2. The American Osteopathic Association (AOA) Physician Database
 3. The Education Commission for Foreign Medical Graduates (ECFMG)
 4. American Board of Medical Specialties (ABMS) through the on-line data base (CertiFACTS)
 5. Federation of State Medical Boards (FSMB)
 6. National Student Clearinghouse
26. **Wraparound Milwaukee:** The child and adolescent outpatient services and programs of the Behavioral Health Division and Provider Network.

II. INTRODUCTION

The BHD Provider Network is committed to providing its members with high quality health care. This commitment is achieved, in part, by establishing and maintaining a credentialing system to assure the selection and maintenance of a network of highly qualified and competent professionals. Such a system includes developing specific, objective criteria intended to reflect professional competency and character and ascertaining whether or not individual health care professionals meet the criteria.

Credentials, as referred to in this document, are records of an individual's education, training, certifications, licensures, experience, character and other professional qualifications. Credentialing is defined as the administrative processes that support the collection, verification, review and evaluation of an individual's credentials.

The credentialing program incorporates the following three functions:

- (1) Initial credentialing: involves the evaluation of an individual's application for participation as a BHD Provider Network practitioner.
- (2) Recredentialing: assesses practitioners' qualifications for continued participation with the BHD Provider Network.
- (3) On-going monitoring: includes the continuous monitoring of license actions, Medicare/Medicaid and other state or local exclusions, sanctions and member complaint information.

III. AUTHORITY AND RESPONSIBILITY FOR CREDENTIALING

The Milwaukee County Mental Health Board ("Board") has ultimate authority, accountability and responsibility for the Provider Network Credentialing evaluation process ("Credentialing Program") and delegates the full oversight and administration of the Credentialing Program to the BHD Provider Network Medical Director(s) and the Credentialing Committee ("Committee"). The BHD Provider Network Medical Director(s) and Credentialing Committee accept the responsibility of administering the Credentialing Program and for the oversight of operational activities, which include making the final decision, (i.e., approve, table, or deny) for all physicians, advanced practice nurses, doctoral level licensed psychologists and any other licensed independent practitioners or allied health professionals that it deems credentialing shall be necessary for network participation.

The Credentialing Program Description shall be reviewed and amended, as necessary, but shall be reapproved at least every two years by the Credentialing Committee, Administration and the Board. Such reviews shall be documented in the minutes of the Credentialing Committee and Mental Health Board. On recommendation of the Credentialing Committee, the Credentialing Program shall be approved by the BHD Provider Network Credentialing Committee, the Wraparound and Community Access to Recovery Services Administrators, the BHD Chief Medical Officer, the BHD Administrator and the Mental Health Board.

In addition to the Credentialing Program, the Provider Network has in place written policies and procedures that support implementation of the Credentialing Program. Such policies and procedures including any modifications thereto shall first be reviewed and recommended for approval by the BHD

Provider Network Credentialing Committee and approved by the Wraparound and Community Access to Recovery Services Administrators, the BHD Chief Medical Officer and the BHD Administrator.

IV. PURPOSE

The purpose of the Credentialing Program is to support a systematic approach to credentialing within the BHD Provider Network. A Credentialing Program includes having in place a written Credentialing plan, documenting compliance with the plan, assigning specific credentialing responsibilities to administrative and professional staff, and establishing a mechanism for the periodic review and revision of the plan. The purpose of the Credentialing Program is to provide general guidance for the decision-making surrounding acceptance or continued participation of professional staff (practitioners) who are initially seeking association with the BHD Provider Network, practitioners who are seeking approval of on-going association, or practitioners for whom there is reason to conduct a special review.

The process enables the BHD Provider Network to recruit and retain a broad range of quality network practitioners to serve its members and ensure ongoing access to care. It consistently and periodically assesses and evaluates a practitioner's ability to deliver quality care between credentialing and recredentialing cycles, and it emphasizes and supports a practitioner's ability to successfully manage the health care of network members in a cost-effective manner.

Specific objectives of the Credentialing Program include:

- Setting forth the criteria to be used in assessing the qualifications of applicants seeking initial or on-going association with the BHD Provider Network;
- Establishing the processes for verification and evaluation of a practitioner's credentials;
- Establishing the processes for action, if a practitioner's credentials do not meet the established minimum criteria.

Unless there are clear and convincing reasons to depart from these guidelines, the BHD Provider Network's Credentialing Committee, Quality Management Staff and Credentialing Staff are expected to adhere to these guidelines.

Nothing contained in the Credentialing Program shall limit the BHD Provider Network's discretion in accepting, restricting, disciplining, or terminating a practitioner's association with the BHD Provider Network. The Credentialing Program may be changed at any time. Such changes shall be effective on the date of approval of the change for new applicants and existing practitioners.

V. CREDENTIALING COMMITTEE STRUCTURE & ACTIVITIES

A. Committee Composition:

The BHD Provider Network Credentialing Committee is a peer-review body comprised of not less than four (4) voting physician members including the Chief Medical Officer and the Service Medical Director(s). One Service Medical Director (CARS or Wraparound) shall be selected to serve as chair of the Committee at the first meeting of each year by volunteering and/or by appointment of the Chief

Medical Officer, in the absence of a volunteer. The Chair, in consultation with the Chief Medical Officer and Service Medical Director(s) shall select the additional physician member(s). Alternate physician committee members may be utilized when a voting committee member is unable to attend a committee meeting. Alternates are identified and appointed by one of the BHD Provider Network Medical Directors. The Chair shall select one doctoral level licensed psychologist to serve as a non-voting member. Allied health representatives shall be selected and appointed by the Chair to serve as non-voting members, on an ad-hoc basis, when applications are being considered by the Committee and the practitioner specialty is not represented. All members are asked to make a one year commitment to the Committee. Members shall be reaffirmed at the first meeting of each year with new members appointed, when needed. Members may be removed from the Committee on recommendation of two voting members of the Committee.

Additional non-voting membership may include the CARS and Wraparound Quality Director(s) and Credentialing Manager(s).

B. Committee Responsibilities/Duties:

The Credentialing Committee shall be responsible for assuring that each practitioner granted participation in the BHD Provider Network possesses the qualifications necessary to deliver quality care to members. The Credentialing Committee shall be responsible for recommendations and decisions for approval, denial, termination, or restriction of a practitioner's participation in the BHD Provider Network.

The Credentialing Committee shall be responsible for the credentialing and recredentialing of all physicians, advanced practice nurses, and doctoral level licensed psychologists.

Other behavioral health professionals and other allied health practitioners that provide an independent billable level of care shall be subject to the impaneling process, at this time. However, these practitioners may also become subject to the full credentialing process, if so determined by the BHD Provider Network at a later time.

- Allied health practitioners are defined as nurse midwives, traditional midwives, nurse practitioners, chiropractors, optometrists, physician assistants, psychologists, licensed marriage and family therapists, alcohol and chemical dependency counselors, licensed independent clinical social workers, licensed professional counselors, board certified behavioral analysts, and clinical nurse specialists.
- All other individuals applying to participate in the BHD Provider Network(s) shall be subject to the impaneling process.

The Credentialing Committee is responsible for the review and evaluation of the credentials of individuals (*physicians, advanced practice nurses and doctoral level licensed psychologists*) applying for new or on-going participation as BHD Provider Network practitioners and at any time that concerns arise regarding an individual practitioner's credentials and/or practice. The Committee shall monitor all credentialing activities and delegated credentialing arrangements, which includes but is not limited to responsibility to:

- Receive, review and evaluate the credentials of all physician, advanced practice nurse and psychologist practitioners applying for new or on-going participation as BHD Provider Network

practitioners and at any time that concerns arise regarding an individual practitioner's credentials and/or practice.

- Receive, review and evaluate the credentials of practitioners who do not meet the organization's established clean application criteria (e.g. malpractice cases, licensure issues, sanctions, quality concerns, missing documentation, etc.)
 - Review practitioner credentials and give thoughtful consideration to the credentialing elements before making recommendations about a practitioner's ability to deliver care
- Establish, implement, monitor, and revise policies and procedures for BHD Provider Network credentialing and recredentialing
- Report to BHD Administration, the Board and other appropriate authorities, as required
- Review and approve Committee minutes
- Review the Credentialing Program Description at least every two years
- Other related responsibilities

C. Committee Chair Responsibilities/Duties:

The Credentialing Committee Chair (a Medical Director or his/her physician designee) may approve a practitioner independent of the Credentialing Committee who fully meets the established criteria before, between, and after each Committee meeting. At the next scheduled Committee meeting, a list of all such approved practitioners and dates of approval shall be presented to ensure network participation decisions are recorded in the meeting minutes.

The Credentialing Committee or Chair may accept the applications of practitioners who meet all established criteria as defined in Section VII. Credentialing Committee review and discussion is required for any practitioners who have an identified variance from the minimum standards for participation criteria.

In addition, files requiring special review due to recent license or other disciplinary actions, member complaints or Medicare/Medicaid sanctions, must be reviewed by the Credentialing Committee. A special review is defined as review of a practitioner's credentials outside the initial credentialing or recredentialing cycle. Recommendations by the Credentialing Committee to deny or restrict participation are communicated, in writing, to the practitioner within 30 days of the decision.

D. Quality Manager(s) and Credentialing Manager(s) Responsibilities/Duties:

The Quality Manager(s) and Credentialing Manager(s) shall report to the Credentialing Committee. The Quality Manager(s) and Credentialing Manager(s) are responsible for ensuring network practitioners and providers are providing high quality care to network members, for ensuring the quality improvement programs comply with accreditation and state and federal regulatory requirements, and for the ongoing monitoring activities. The Quality/Credentialing Manager(s) shall report all physician, advanced practice nurse and psychologist practitioner specific quality concerns to the Credentialing Committee. The Quality/Credentialing Manager(s) may delegate continuous monitoring of license actions, Medicare/Medicaid exclusions and other state or local exclusions to credentialing staff.

E. Quorum:

A quorum (majority of voting members present) shall be satisfactory for the valid transaction of business by the Committee, which shall meet monthly and/or as deemed necessary by the Chairperson. The Committee action may be implemented in the absence of a face-to-face or other type meeting if consent in writing, setting forth the action, is obtained, i.e., telephone conference, skype meeting. A meeting may not be conducted only through e-mail. Voting members include only the Committee Physicians. Non-voting members include one psychologist member, the Quality and Credentialing Manager(s) and ad hoc allied health practitioners when asked to participate. Non-voting members are not considered part of the quorum.

F. Agenda, Minutes and Reports:

The credentialing staff shall prepare each meeting agenda and shall be responsible for the preparation and maintenance of complete and accurate minutes for each meeting and for bringing all credentialing files associated with practitioners requiring Committee review to the meeting. Minutes will reflect the name of the Committee, the date and duration of the meeting, the members present and absent, and the names of guests or other representatives. The minutes will reflect meaningful discussion, decisions and recommendations regarding practitioner files presented, the status of activities in progress, reports of practitioner approvals that occurred outside of the Committee, the implementation status of recommendations/planned actions, when appropriate, including responsible person and follow-up. Applicable reports and substantiating data will be appended for reporting purposes.

The Committee will be responsible for reviewing minutes for accuracy. Minutes shall be securely retained electronically and/or manually by credentialing staff. Copies shall not be distributed but shall be made available at each meeting and then collected at the conclusion of the meeting. Committee members not able to attend a meeting(s) may review the minutes in the credentialing staff office but shall not receive printed or electronic copies.

G. Confidentiality:

It is the policy and procedure of the BHD Provider Network to consider and treat all credentialing documents received from the practitioner and from verification sources for the purposes of credentialing, and subsequently retained as a result of the credentialing process, as confidential. The mechanisms, in effect, to ensure the confidentiality of information collected in this process are as follows:

- Access to such documents shall be restricted to:
 - (1) The practitioner being credentialed, pursuant to the requirements outlined in Section XI. A – Practitioner Right To Correct Erroneous Information,”
 - (2) BHD Provider Network Credentialing and Quality Staff,
 - (3) Credentialing Committee Members (voting and non-voting),
 - (4) the CARS Administrator, the Wraparound Administrator, the BHD Chief Medical Officer and/or the BHD Administrator, when a legitimate purpose is identified,
 - (5) Board Members, when a legitimate purpose is identified,
 - (6) Other specific individuals as designated by the BHD Credentialing Committee, when a legitimate purpose is identified.

- Limiting the number of staff with access to the credentialing files and/or credentialing databases is required to ensure that confidentiality and federal and state statutory peer review protections are met.
- Credentialing files and materials shall be secured via a passcode protected database, a shared database with access limited to only authorized credentialing staff and/or files secured within a double locked environment, i.e., in locked file cabinets within a locked room, whenever unattended.

All staff that have access to credentialing files and materials shall be required to sign confidentiality and non-disclosure statements expressly agreeing not to share information obtained or learned and to follow the established credentialing information security procedures.

H. Conflict of Interest:

In situations where a conflict of interest may exist, the Chairperson of the Credentialing Committee shall have the authority to excuse a voting member from the credentialing decision.

VI. THE CREDENTIALING PROGRAM: PRACTITIONERS

A. Practitioners Who Will Be Credentialed and Reviewed On An Ongoing Monitoring Basis Include:

The Credentialing Program applies to all individuals who are applying for initial or on-going participation as BHD Provider Network practitioners. This includes practitioners who either are parties to a BHD Provider Network contract or are employed by an organization or entity with whom the BHD Provider Network has a contract. BHD Provider Network practitioners are considered to have an independent relationship and are located in an outpatient setting. An independent relationship exists when BHD Provider Network selects and directs its members to see a specific practitioner or group of practitioners.

Practitioners that are subject to credentialing requirements are defined as licensed individuals who are legally authorized to provide independent care and treatment to patients. The practitioner types included in this definition include: physicians, doctoral level psychologists and advanced practice nurses (clinical nurse specialists, certified nurse midwives, certified nurse practitioners).

B. Practitioners Defined Above Who Do Not Need To Be Credentialed:

- Practitioners who practice exclusively within an inpatient setting and provide care or treatment to BHD Provider Network members only because members are directed to the hospital, or other inpatient setting.
- Practitioners who are not participants in the BHD Provider Network to whom limited or specialty referrals may be made on a case-by-case basis by participating practitioners or the BHD Provider Network. Such referrals are considered to be out-of-network.
- Locum Tenens practitioners, i.e., practitioners who are filling in temporarily. This exception applies only to locum tenens practitioners who are covering on a short-term basis in an urgent situation (e.g. covering for a practitioner who has an unexpected family or medical leave). Locum tenens status is limited to a cumulative lifetime total of three months work anywhere in

the BHD Provider Network. Practitioners who have exhausted their locum tenens eligibility by working more than three months may not practice in any capacity in the BHD Provider Network without first being credentialed. Verification of a valid Wisconsin professional license, a check for exclusions from state and federal programs and Wisconsin Caregiver background check must be completed prior to the practitioner seeing BHD Provider Network members regardless of service length.

Practitioners identified in any of the above categories are beyond the scope of the BHD Provider Network Credentialing Program.

VII. STANDARDS OF PARTICIPATION: PRACTITIONERS

A. Minimum Professional Criteria for Acceptance

The BHD Provider Network accepts professional practitioners into its network at its sole discretion based on the need for professional practitioners in certain specialties, geographic areas, or similar considerations.

Each network practitioner must meet the minimum standards for participation or continued participation in the BHD Provider Network. These guidelines are intended to comply with BHD Provider Network policy, NCQA, state, federal and other applicable regulatory and/or accreditation entities where applicable.

B. Minimum Standards for Participation Include:

- Unrestricted (no limitations), current and valid professional licensure to practice in Wisconsin.
- Current and valid Federal DEA Registration for practitioners with the authority to write prescriptions, as applicable, for practice.
- Board certification in a recognized practice specialty. In lieu of Board Certification, the practitioner must have completed relevant pre- or post-graduate education (residency, fellowship, practicum, preceptorship, etc.) in his/her practicing specialty.
- Documentation of a collaboration arrangement for certified nurse practitioners, clinical nurse specialists, mid-wives and physician assistants with a participating physician credentialed by the BHD Provider Network
- Acceptable, current and valid malpractice insurance in the amount \$1 Million per incident and \$3 Million per aggregate per year or as otherwise required by State Statute and/or Milwaukee County Risk Management.
- Absence of a history of denial or cancellation of professional liability insurance and has had no or minimal involvement in malpractice suits, arbitration or settlements and evidence shows that the history does not suggest any ongoing substandard professional competence or conduct.
- Absence of active disabling health problems including, but not limited to substance use disorders, which might adversely affect judgment or competence, so as to substantially impede the

professional practitioner's ability to perform the essential functions of his/her practice/profession with reasonable skill and safety.

- Absence of a history of disciplinary action resulting in suspension, repeal, or limitation by a licensing board, professional society, hospital, health care organization, managed care organization, governmental health care program; or evidence that this history does not suggest any ongoing substandard professional competence or conduct.
- Absence of a history of criminal/felony convictions or indictments or evidence that this history does not suggest an effect on current professional competence or conduct. A conviction within the meaning of this section includes a plea or verdict of guilty or a conviction following a plea of nolo contendere.

The Credentialing Committee may accept non-compliance with one or more of the participation criteria if the Committee determines that the non-compliance does not indicate a potential or existing administrative or performance issue.

If a participating practitioner becomes non-compliant with one or more of the participation criteria after initial credentialing or recredentialing, the practitioner's credentials shall be brought to the Credentials Committee for further review.

C. Clean Application Criteria

Applicants who meet all of the criteria for participation listed below may be approved for participation by the Credentialing Committee Chair (or his/her physician designee), without review by the Credentialing Committee.

Initial Credentialing:

- No history of corrective action (hospital/licensing board)
- Criminal Background Check reveals no felony convictions or criminal charges pending; and/or if history of non-felony conviction(s), matter is > than 7 years ago AND unrelated to Caregiver Law Offences AND judged by the Credentialing Committee Chair (or Medical Director designee) to have no bearing on current professional abilities or responsibilities
- No history of Operating While Intoxicated/Driving Under the Influence (OWI/DUI--alcohol or drug) offenses
- No malpractice history or minimal involvement, which is defined as not more than two (2) claim dismissals and/or not more than two (2) settlements/payments of \$30,000 or less and/or no more than one (1) open claim pending and/or matter(s) is older than 20 years
- All services practitioner is requesting to provide to members are appropriate to his/her specialty training

Recredentialing:

- If prior history of corrective action (hospital/licensing board), matter was > 7 years ago

- Criminal Background Check reveals no new non-Caregiver or other criminal (felony or misdemeanor) law offenses since last credentialed;
- First and only OWI/DUI > 7 years ago and no current cause for concern is shown following assessment of current statement by applicant and the specific event circumstances, as judged by Committee Chair (or Medical Director designee)
- Minimal or no malpractice claims history changes since last credentialed (no new claims and/or prior history of no more than 2 settlements/payments and/or no more than one open claim and/or matters are older than 20 years)
- All services practitioner is requesting to provide to members are appropriate to his/her specialty training
- No patterns or trends of member complaints/grievances or practice concerns

D. Automatic Exclusion Criteria:

The BHD Provider Network shall, upon obtaining information or receiving information from a verifiable and reliable source, exclude from participation any practitioner that may fall into one or more of the following categories (references to the Act in this section refer to the Social Security Act):

- Individuals or entities, which could be excluded under [§ 1128\(b\)\(8\)](#), as amended, of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a person who has direct or indirect ownership or controlling interest of five (5) percent or more in the entity has been convicted of any of the following crimes:
 1. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, Medicaid, or other State health care program (as provided in [§ 1128\(a\)\(1\)](#) of the Act, as amended);
 2. Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient in connection with the delivery of a health care item or service (as provided in [§ 1128\(a\)\(2\)](#) of the Act, as amended);
 3. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary duty;
- Practitioners who appear on the Office of Inspector General list of excluded individuals and entities report ([OIG-LEIE](#))
- Practitioners who appear on any ~~County~~ or State exclusions list
- Practitioners who have a suspended, revoked or terminated license to practice
- Practitioners who have a suspended, revoked or terminated drug enforcement administration registration
- Wisconsin Caregiver Law required exclusions

- Any other automatic exclusion required by law or regulation

If an automatic exclusion is discovered during the credentialing process, application processing shall immediately be halted. Furthermore, an approved practitioner shall have his or her participation terminated upon obtaining information or receiving information from a verifiable and reliable source of any of the aforementioned. The practitioner has no right to appeal under such circumstances.

E. Quality of Practice Criteria:

- Professional practitioner(s) must demonstrate acceptable office site survey and medical record keeping practices, which meet CMS, DHS, NCQA, BHD Provider Network, or any other standards adopted by the BHD Provider Network.
- Professional practitioner(s) practice patterns must reflect a general adherence to established practice standards and protocols as adopted by the BHD Provider Network.
- Professional practitioner(s) must maintain satisfactory performance in the area of practice quality indicators (i.e., clinical outcomes, performance measure outcomes, member satisfaction, etc.) established by the BHD Provider Network.
- The BHD Provider Network retains the right to approve/deny new practitioners based on quality issues, and to terminate individual practitioners for same. Termination of individual practitioners for quality of care considerations shall be supported by documented records of noncompliance with specific expectations and requirements for practitioners. The BHD Provider Network has a prescribed system of appeals available, which shall be followed.

F. Business Administrative Criteria:

The decision to contract with an individual practitioner or group practice/agency is made by the BHD Provider Network's Administrators. Considerations for making such a decision include:

- the geographic distribution of specialty care practitioners,
- the need for additional or specific specialty care practitioners based on membership numbers and demographics,
- willingness of the provider and/or individual to abide by the BHD Provider Network policies and procedures and willingness of the individual or provider group to execute a provider contract and abide by the terms of such contract,
- willingness of the individual or provider group to comply with all credentialing requirements and/or
- statutory, regulatory or related changes or requirements.

VIII. INITIAL CREDENTIALING: PRACTITIONERS

A. Process and Requirements:

Initial credentialing is performed on all practitioners *(except those specifically excluded under Section VI.B)* who are (a) beginning a relationship with the BHD Provider Network or (b) have an existing

relationship at the time that this plan is adopted but have not previously been required to complete the credentialing process; and (c) are practitioners who meet the minimum requirements to apply for participation with the BHD Provider Network, as outlined in Section VII.

The BHD Provider Network credentials all physician, advanced practice nurses and licensed psychologist practitioners prior to being admitted into the BHD Provider Network. The intent of the process is to validate and/or confirm credentials related to a prospective or participating practitioner by contacting the primary source of the issuing credential directly. All attestations and verification time limits, applicable in this Credentialing Program and referenced in this document, shall not exceed 180 calendar days of the Committee Decision or in the matter of applications deemed as clean, the decision of the Medical Director when Committee review is not required.

Each practitioner must submit a legible and complete application, signed and dated consent and release of information form, and all other required documentation as specified by the BHD Provider Network. The following information is obtained and verified according to NCQA standards as described herein and utilizes sources listed under Initial Credentialing:

- Completed BHD Provider Network application (Universal Application or equivalent), which includes a current signed and dated release of information, attestation, and disclosure statement.

Each practitioner applying for participation shall attest to the following:

1. Reasons for inability to perform the essential functions of the position, with or without accommodation
 2. Lack of present illegal drug use
 3. History of restriction or loss of license
 4. History of criminal conviction(s)
 5. History of loss or limitation of privileges or disciplinary actions
 6. Current malpractice insurance coverage
 7. The correctness and completeness of the application
- Copy of the unrestricted (no limitations), current and valid Wisconsin license for the participating practitioner
 - Copy of the current and valid DEA Registration, if applicable
 - Copy of the medical malpractice policy face sheet, or completed liability information section on the application inclusive of policy number, effective dates of coverage, and coverage amounts.
 - Copy of the Board certificate or highest level of education in specialty for which practitioner is seeking participation status in the BHD Provider Network.
 - Copy of the current Curriculum Vitae (CV) or detailed work history which must include month/year. All gaps or interruptions in work history of greater than 30 days must be explained. CV or work history must cover not less than the previous five years.
 - Completed Wisconsin Caregiver Background Information Disclosure (BID) form

- Name and contact information for at least two (2) professional peers (reference) with whom practitioner has worked within the last 24 months
- Practitioner written explanation to any “yes” response to disclosure questions that reveal an adverse action or require special consideration including, but not limited to:
 - 1) Any limitation in ability to perform the functions of the position, with or without accommodation;
 - 2) History of restriction or loss of license;
 - 3) History of any misdemeanor and/or felony convictions;
 - 4) History of any abuse of controlled substances or alcohol, including non-criminal first offense OWI/DUI;
 - 5) History of loss or limitation of privileges, memberships or disciplinary activity;
 - 6) Any malpractice history, either reported or non-reported to the NPDB or other regulatory bodies.

Applications deemed as incomplete cannot be considered. Applicants have the burden of producing accurate and adequate information for proper evaluation of professional, ethical and other qualifications for network participation and for resolving any doubts about such qualifications to the satisfaction of the Chair. Applications are not considered complete until so deemed by the Credentialing Committee and/or Chair. The credentialing staff, on behalf of the Committee, shall notify the practitioner of any areas of incompleteness, question, discrepancy and/or failure of others to respond to such information collection or verification efforts. It will then be the applicant’s obligation to correct, explain or obtain all required information within the next thirty (30) days. Applicants who do not make reasonable and timely attempts to resolve misstatements or omissions from the application or resolve doubts about qualifications, current abilities or credentials within thirty (30) days, when additional information is requested, may, in the sole discretion of the credentialing staff, be deemed a voluntary withdrawal of the application due to incompleteness. Practitioners shall have no appeal rights for failing to complete application requirements.

B. Primary Source Verification:

The BHD Provider Network credentialing staff shall conduct primary source verification (PSV) as required by the most current and applicable CMS, NCQA, and any other BHD Provider Network adopted guidelines. The BHD Provider Network accepts letters, telephone calls, faxes, computer printouts, and/or online viewing of information as acceptable sources of verification, with appropriate reference documentation (i.e., the name of the person who provided the verification, the date of the call and the verification source). The credentialing staff shall authenticate all required PSVs by signature/initials and date. The information must be accurate and current.

Verbal verifications documented in credentialing files are dated and signed by the credentialing staff member who receives the information, noting source and date. Written verifications are received in the form of letters or documented review of latest cumulative reports released by primary sources. Internet verifications may be obtained from any CMS, DHS, NCQA, and/or BHD Provider Network-approved web-site source, as applicable, and signed/initialed and dated by the verifier.

To meet verification standards, all credentials must be valid at the time of the Credentialing Committee's decision, and PSVs must be within the specific time limits as set forth by CMS, DHS, NCQA, BHD Provider Network and any other applicable regulatory and/or accreditation entities:

Table VIII-B:

Primary Source Information:	Acceptable Verification Sources:
Credential: License ○ Verification Time Limit: 180 calendar days* Must confirm that practitioner holds a valid, current Wisconsin license or certification, which must be in effect at the time of the Committee's decision; verification must come directly from the state licensing or certification agency. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	○ Wisconsin Department of Safety and Professional Services [State Licensing Board(s)]
Credential: DEA Certificate ○ Verification Time Limit: 180 calendar days * Must be effective at the time of the credentialing decision; registration must display a Wisconsin address. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	○ A copy of the DEA certificate ○ Documented visual inspection of the original certificate ○ Confirmation with the DEA Agency Approved Equivalent to Primary Source ○ Entry in the National Technical Information Service (NTIS) database https://www.ntis.gov/ ○ Entry in the American Medical Association (AMA) Physician Master File
Credential: Education and Training ○ Verification Time Limit: None for graduation from medical or professional school and/or completion of residency The organization must verify the highest of the three levels of education and training completed by the practitioner. 1. Graduation from medical or professional School 2. Residency program completion, if appropriate 3. Board certification, if appropriate Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable) Note: If a practitioner's education has not changed during the recredentialing cycle, the previous education verification will stand and need not be re-verified.	Graduation from medical school (MD, DO): ○ Medical School Residency Completion ○ Residency Training Program Approved Equivalent to Primary Source ○ AMA Physician Master File ○ American Osteopathic Association (AOA) (Official Osteopathic Physician Profile Report or AOA) ○ Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986 ○ Association of schools of the health professional, if the association performs primary source verification. At least annually, the organization must obtain written confirmation from the association that it performs primary source verification. ○ Sealed transcripts: Received directly from the school or, if a practitioner submits transcripts to the organization that are in the institution's sealed envelope with an unbroken institution seal, NCQA accepts this as primary source verification if the organization provides evidence that it inspected the contents of the envelope and confirmed that transcript shows that the practitioner completed (graduated from) the appropriate training program. Note: If the practitioner states that education and training were completed through the AMA's Fifth Pathway program, the organization must confirm it through primary-source verification from the AMA.

	For non-doctors of medicine and osteopathy. • The state licensing agency may be used, if it performs primary source verification. – The organization must: ▪ Obtain and maintain on file a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of education and training information for the specific practitioner type, <i>or</i> ▪ Obtain and maintain evidence of the applicable state statute for the practitioner type requiring the licensing agency, to obtain verification of education and training directly from the learning institution. Psychologists - graduation from professional school (PhD, PsyD, EdD) ○ Professional School Post-doctoral Fellowship ○ Professional Training Institution Advanced Practice Nurses ○ Professional School (Masters Program) Approved Equivalent to Primary Source ○ National Register of Health Service Psychologists ○ State Licensing agency, if above conditions are met
Credential: Board Certification ○ Verification Time Limit: 180 calendar days* <u>Physicians (MD/DO)</u>: not required but must be verified if practitioner lists it on the application. If practitioner is board certified, verifying board certification fully meets standards for education and training. <u>Advanced Practice Nurses</u>: required and must be verified. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	Physician (MD, DO) board certification: ○ American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided. Advanced Practice Nurse board certification ○ American Nurses Credentialing Center (ANCC) ○ American Academy of Nurse Practitioners (AANP) Psychologists (PhD, PsyD, EdD): ○ Association of State and Provincial Psychology Boards (ASPPB) Approved Equivalent to Primary Source ○ AMA Physician Master File. ○ AOA Official Osteopathic Physician Profile Report or AOA Physician Master File. ○ National Register of Health Service Psychologists ○ For Psychologists and Advanced Practice Nurses, the state licensing agency may be used, if it performs primary source verification. The organization must: ○ Obtain and maintain on file a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of education and training information for the specific practitioner type, <i>or</i>

	○ Obtain and maintain evidence of the applicable state statute for the practitioner type requiring the licensing agency, to obtain verification of education and training directly from the learning institution. Please refer to the applicable CMS, DHS, &/or NCQA standards required for other practitioner types.
Credential: State and Federal Sanctions and Exclusions Medicaid and Medicare Sanctions Restrictions on Licensure Limitations on scope of practice Exclusions and limitations related to fraud and abuse and Opt In/Opt Out status ○ Verification Time Limits: 180 calendar days* The OIG and the Opt In/Opt Out listing must be queried for sanctions and limitations prior to presenting a practitioner to the Committee for review. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable).	Sources for Licensure Sanctions: Physicians: ○ Appropriate state agencies ○ Federation of State Medical Boards (FSMB) ○ National Practitioner Databank (NPDB) Non-physician behavioral healthcare professionals: ○ Appropriate state agency ○ NPDB ○ State licensure or certification board Sources for Medicare/Medicaid Sanctions ○ AMA Physician Master File entry ○ FSMB ○ List of Excluded Individuals and Entities (maintained by OIG; OIG-LEIE), available over the Internet ○ Government Services Administration/System for Award Management (GSA/SAM) ○ Medicare and Medicaid Sanctions and Reinstatement Report, distributed to federally contracting organizations ○ NPDB ○ State Medicaid agency or intermediary and the Medicare intermediary ○ Trailblazers.com – Opt In/Opt Out Website Please refer to the applicable CMS, DHS, NCQA, standards required for non-doctors of medicine and osteopathy.
Credential: Malpractice Insurance ○ Verification Time Limit: 180 calendar days* The Provider Network must obtain confirmation of the past five year history of malpractice settlements; the five-year period may include residency or fellowship years; however, confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship does not need to be obtained. Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	○ National Practitioner Data Bank ○ Malpractice Carrier
Credential: Work History ○ Verification Time Limit: 180 calendar days* NCQA does not require primary-source verification of work history; the organization must obtain a minimum of five years of relevant work history through the practitioner's application or CV; relevant experience includes work as a healthcare professional; if the practitioner has practiced fewer than five years from the date of	○ CV and/or Completed Work History section on application ○ Documented visual verification of above for gap analysis

verification of work history, it starts at the time of initial licensure; experience practicing as a non-physician health professional (e.g., registered nurse, nurse practitioner, clinical social worker) within the five years should be included. A gap exceeding 30 days must be reviewed and clarified either verbally or in writing; a CV or application must include the beginning and ending month and year for each position in the practitioner's employment experience; verbal communication must be appropriately documented in the credentialing file; <u>a gap in work history that exceeds 30 days must be explained in writing.</u> Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)	
Credential: Professional Peer Reference ○ Verification Time Limit: 180 calendar days*	○ Written documentation obtained directly from peer(s) (mail, email, phone, fax receipt)

* The 180 days begins calculating on the date of the practitioner's attestation, or the first signed PSV, whichever is first. The end of the calculation period is the date of the BHD Provider Network Credentialing Committee decision or Medical Director action on Committee's behalf, when permissible.

A checklist may be utilized by the verifier in lieu of authenticating each individual verification obtained. The checklist must include a listing for each item verified, the date each item was verified and the name of the source that was utilized for each verification.

The Credentialing Committee shall make an approval decision on an application within 30 days of completion. The practitioner shall be notified in writing within 60 calendar days of the Committee's or Medical Director's decision. The credentialing staff shall be responsible for preparing such communications, on behalf of the Credentialing Committee Chair. The notification shall include the specific decision and the date of the decision. Types of decisions are described in section IX.C. If the decision is not to approve or the approval includes limitations or restrictions to participation, the notification shall include instructions, in writing, on how to appeal a denied, limited or restricted request for credentialing.

C. Practitioner Office Site Quality:

The initial credentialing process includes an on-site office evaluation and medical record review for all new agencies that apply to provide service for Provider Network members. As part of the site review for mental health and AODA practitioners, standards for access to services, including emergency coverage and appointment availability are reviewed in order to assure reasonable access to services for provider network members/service recipients. Medical groups and group practices do not need a separate site visit for each practitioner.

The site evaluation includes but is not limited to:

- Practitioner information (i.e. licenses/certifications, background checks, etc.)
- Office policies/general information
- Physical plant/physical accessibility
- Scheduling/appointments availability
- Availability of emergency equipment (as applicable)

- Medication storage policies and procedures
- Medical record keeping format including forms, practices and procedures
- Access/on-call coverage policies and procedures

The results of the office site evaluation and medical record keeping review are considered in the initial credentialing decision-making process. Practitioners with evaluation scores that fall below the threshold of 80% or that lack essential elements are subject to corrective action and re-review to monitor compliance as a requirement for enrollment in the BHD Provider Network.

Agencies/practitioners whose site evaluation reveals substandard scores will be monitored by the BHD Provider Network Coordinator for corrective action. Agencies/practitioners will be required to submit evidence of correction in non-compliant areas within a prescribed time frame not to exceed three (3) months for existing Network agencies/providers and prior to enrollment in the Network for new agencies/providers.

IX. RECREREDENTIALING: PRACTITIONERS

A. Process and Requirements:

Recredentialing of practitioners is completed at least every thirty-six (36) months. Recredentialing may occur more often if the Credentialing Committee determines that more frequent recredentialing is appropriate.

The BHD Provider Network recredentials all practitioners within 36 months of their last credentialing or recredentialing date (or before end of credentialing approval period if approved for a lesser period of time). Recredentialing must be completed by the last day of the same month in which the previous credentialing approval occurred (i.e., if approval took place on March 12, reapproval must take place not later than March 31). The intent of the recredentialing process is to identify any changes that may affect a practitioner's ability to perform the services that s/he is under contract to provide.

All application requirements detailed in Section: VIII-A are applicable to the recredentialing process. All verification time frames detailed in Table: VIII-B are applicable to the recredentialing process.

Each practitioner must complete and sign the BHD Provider Network Recredentialing Application that includes the professional disclosure questions and attestation that the information given is correct and gives the BHD Provider Network the right to verify the information. The following information is obtained and verified according to the standards and utilizes the sources listed under Initial Credentialing:

- State licenses (unrestricted, current and valid)
- DEA registration (if applicable; current and valid)
- Additional Education, if applicable
- Board certification
- Malpractice coverage
- Malpractice claims
- Sanction information

B. The Recredentialing Process Shall Include Performance-Monitoring Information:

Sources of such performance-monitoring information may include one or more of the following:

- Member grievances/complaints
- Member and Practitioner/Provider satisfaction surveys
- Utilization Management
- Risk Management
- Quality improvement activities, performance quality measures, quality deficiencies, and/or trending patterns
- Site Assessment
- Medical Record Keeping Practices/Treatment Assessments

C. Re/Credentialing Decision:

Each practitioner will receive one of the following designations from the Committee or Medical Director Chair acting on behalf of the Committee:

1. Approved without reservation
2. Approved with reservation (credentialing approval may be less than three years)
3. Not approved due to competency or professional behavior concerns (final decision)

The BHD Provider Network has the right to make the final determination about which practitioners may participate within its network. If the BHD Provider Network documents unfavorable information (e.g., excessive malpractice claims, deficient site visits and sanctions) about a specific practitioner during the credentialing or recredentialing process, it may choose to approve, deny, restrict, or not credential or recredential the practitioner.

The approval decision shall be determined by majority vote. The Chair has the prerogative to abstain, vote on all matters, or vote only in the event of need to break a tie. An abstention is not a vote, and is not counted. In the event of a tie, the motion is lost.

X. TERMINATION, RESTRICTION OR SUSPENSION

A. Termination by Credentialing Committee

The BHD Provider Network Credentialing Committee may decide to deny or terminate the participation status of any practitioner. The Committee may rely upon any of the following as a basis for denial or termination.

1. A determination, based upon failure to meet one or more of the BHD Provider Network Professional Criteria for Acceptance or any other information available to the Credentialing Committee, that the practitioner has not adequately demonstrated that he or she would provide safe, high-quality care to all BHD Provider Network members.
2. The practitioner has engaged in uncooperative, unprofessional, or abusive behavior towards one or more BHD Provider Network members, BHD Provider Network employees, or members of the Credentials Committee or Mental Health Board.

B. Termination by BHD Provider Network Credentialing Staff

Notwithstanding any provision in this Credentialing Program, the BHD Provider Network Credentialing Staff may terminate the participation status of any practitioner, in accordance with terms of the BHD Provider Network contract. The BHD Provider Network Credentialing staff may terminate the credentialing process for a practitioner who has not returned required credentialing information that is necessary to process their application for participation. Credentialing staff may administratively terminate a practitioner who has not returned required recredentialing information that is necessary to process their application for continued participation.

Credentialing staff shall immediately terminate a practitioner upon notice that the practitioner's license has been revoked or suspended, that the practitioner has been excluded from federal, state or local government programs, or that the practitioner otherwise fails to meet the minimum requirements of the BHD Provider Network's Professional Criteria for Acceptance.

Applications from practitioners seeking to participate with the BHD Provider Network will not be processed if the practitioner is currently excluded from federal, state, or local government programs, or if the practitioner must otherwise automatically be excluded from participation.

C. Immediate Restriction, Suspension or Termination

The BHD Chief Medical Officer or his/her physician designee has the authority to immediately restrict, suspend or terminate the participation status of a practitioner to prevent the threat of imminent danger to the health of any individual. Such immediate restriction, suspension or termination shall not initially exceed fourteen days pending the outcome of an investigation to determine the need for a professional review action. The BHD Chief Medical Officer shall make a good faith effort to consult with the Credentialing Committee Chair and/or BHD Provider Network Administrators and Quality Review Directors prior to taking such action. Any immediate restriction, suspension, or termination exceeding fourteen days requires notice to the affected practitioner of the appeals process and right to a hearing.

XI. PRACTITIONER RIGHTS AND RESPONSIBILITIES

A. To Correct Erroneous Information

The BHD Provider Network's policies do not preclude practitioners' rights to review and correct erroneous information obtained and used to evaluate their credentialing application from outside primary sources. Such information could include, but is not limited to malpractice insurance carriers, state licensing boards, the OIG-LEIE, GSA/SAM, etc.

Upon notification of discrepancy, the applicant shall have 30 days to correct erroneous information submitted by other parties and/or to correct his/her own information or the processing of his/her application shall be terminated.

The practitioner shall not be permitted to review or otherwise have access to peer review protected information, such as peer references and recommendations, when applicable. The BHD Provider Network is not required to reveal the source of information, if the information was not obtained to meet credentialing verification requirements or if the law prohibits disclosure.

Notifications to practitioner to correct erroneous information submitted by a source shall clearly state:

- The time frame for reply
- The format for submitting corrections/changes
- The person to whom corrections/changes must be submitted

B. To Review Information

The BHD Provider Network ensures that practitioners can access their own information obtained by the BHD Provider Network during the credentialing process and used to support their credentialing application, with limitations.

C. To Be Informed Of Application Status

The BHD Provider Network's policy is to notify a practitioner of his/her application status upon request. The process allows for phone calls, emails, letters, or faxes from practitioners. If the credentialing staff receives a request it shall be responded to within five (5) business days of receipt

The Credentialing Department staff can advise the practitioner, once key information is verified, of the following information via phone or in writing, if requested by the practitioner:

- The date the application was received
- The status of the application – pending for additional information, etc.
- The date the application is tentatively scheduled to be presented to the Committee/Chair
- Answer any questions the practitioner may ask
- Prior to disclosing any confidential practitioner information via phone, the following must be verified by the Credentialing staff and confirmed by the practitioner:
 - Practitioner's full name
 - Practitioner's primary office location
 - Practitioner date of birth or last 4 digits of social security number (SSN)

D. To Be Notified Of His/Her Rights

Each prospective and existing practitioner has the right to be notified of the aforementioned rights and will be notified via one or more of the following methods:

- Applications
- Contracts
- Policies
- Mail
- Email
- Fax
- Website
- Other Suitable Method

E. To Be Responsible For Reporting Status Changes to the Credentialing Committee

Each prospective and existing practitioner shall report promptly (within two business days) to the Credentialing Committee any of the following:

- Any and all notices of investigation or challenge to any licensure or registration, any discipline or voluntary or involuntary limitation or relinquishment of such licensure or registration.
- Any and all voluntary or involuntary terminations of Medical Staff/professional membership or voluntary or involuntary limitations, reductions, or losses of clinical privileges at any facility.
- The circumstances surrounding any and all involvements in professional liability actions, including notice of injury, claim or intent to file and all final judgments, settlements, or dismissals, even if not resulting in monetary damages.
- Any arrest, indictment, pending charges or conviction to a felony, a serious or gross misdemeanor, any crime or municipal violation involving dishonesty, assault, sexual misconduct or abuse, or abuse of controlled substances or alcohol.
- Any and all notices of reprimand, censure, exclusion, sanction, suspension, or disqualification by Medicare, Medicaid, CLIA or other health care program or any notice of investigation that could lead to such an action.
- Any other change in status of information maintained in the credentials file, including but not limited to, change in name, practice address, contact information, Board certification attainment or lapse, provider enrollment certification, etc.

XII. CREDENTIALING FILE CONFIDENTIALITY AND RETENTION

Credentialing files shall be retained for not less than seven (7) years from date of practitioner separation from the BHD Provider Network.

Credentialing files are considered protected and confidential. Electronic files shall be password protected or otherwise restricted to allow access by only staff directly involved in BHD Provider Network credentialing processes and decisions. File cabinets containing practitioner files shall be locked and/or secured after normal business hours within a locked room. Offices containing practitioner credentialing files shall be secured, as practical or business appropriate, after normal business hours. If files are archived and shipped to an offsite secure file retention company, there shall be a file destruction date set to seven (7) years post-separation from the Provider Network. A list of these files shall be maintained for reference and secured by employee password. Electronic files shall be backed up regularly.

All non-public information collected during the credentialing process is considered confidential. Access to credentialing information is limited to authorized individuals and is accessible to the applicant except for the information protected under [Wisconsin Stat. §§ 146.37, 146.38](#) and [Title IV-Health Care Quality Improvement Act SEC 411 \[42 U.S.C. sec 11111 et seq\] Professional Review](#).

XIII. REINSTATEMENT

If a practitioner is credentialed and leaves the network voluntarily or in such a way that the BHD Provider Network has not terminated the practitioner for quality issues or any other adverse or egregious event, she/he may re-enter the network within thirty (30) calendar days. S/he must submit a written explanation to include activities during the absence, and complete a recredentialing application. The practitioner will not have to go through the primary source verification process if all documents remained unrestricted, current and valid during the absence period. The Committee Chairperson and/or the Committee retain the authority to approve or disapprove absences, on a case-by-case basis, regardless of the time frame absent from the network.

XIV. ONGOING MONITORING

The BHD Provider Network monitors practitioner sanctions, grievances/complaints and quality issues between credentialing cycles and takes appropriate action(s) to improve practitioner performance when it identifies occurrences of poor quality. The BHD Provider Network acts on important quality and safety issues in a timely manner by reporting such occurrences at monthly credentialing meetings. If an occurrence requires urgent attention, the Chief Medical Officer or designee will address it immediately; engage the Committee if necessary, and appropriate action(s) will be taken to ensure quality. On an ongoing monitoring basis, the BHD Provider Network collects and takes appropriate intervention and/or action by:

A. Collecting and Reviewing Medicare and Medicaid Sanctions

The BHD Provider Network will review sanction information within 30 calendar days of being posted on the [OIG Report Website](#).

B. Collecting and Reviewing Sanctions or Limitations on Licensure:

The BHD Provider Network Quality or Credentialing Staff will review sanction information within 30 calendar days of release. In areas where reporting entities do not publish sanction information on a set schedule, the BHD Provider Network Quality or Credentialing Staff will query for this information at least every six months. The Wisconsin DSPS publishes discipline information on a quarterly basis, but Board updates are available on the [WDSPS](#) website on a regular basis and may be queried for new actions, at any time.

C. Collecting and Reviewing Grievances/Complaints:

The BHD Provider Network may evaluate both the specific grievance/complaint and the practitioner's history of issues. Evaluation of the practitioner's history of grievances/complaints will occur at least every six months; if a practitioner has had two complaints within a six month period or any other pattern or trend is identified, or if a practitioner has a combination thereof, the information will be presented at the next Credentialing Committee Meeting for discussion.

D. Collecting and Reviewing Information from Identified Adverse Events:

The BHD Provider Network monitors for adverse events at least every six months to determine if there is evidence of poor quality that could affect the health and safety of the members. Depending on the nature of the adverse event, the BHD Provider Network will implement actions and/or interventions

based on its policies and procedures when instances of poor quality is identified. When practitioner specific matters are identified, those matters shall be referred to the Credentialing Committee for review.

XV. NONDISCRIMINATORY PRACTICES

The BHD Provider Network conducts each Committee meeting in a nondiscriminatory manner. All credentialing decisions will be based on the BHD Provider Network professional criteria for acceptance. The BHD Provider Network does not make credentialing decisions based on an applicant's race, gender, age, disability, creed, color, sexual orientation, marital status, military service membership, arrest/conviction *record (unless offense is substantially related to professional services and/or licensed activity)*, national origin, any physical or mental impairment that after any legally-required reasonable accommodation does not preclude abilities to perform services, client population served or any other basis prohibited by law.

All committee members responsible for credentialing decisions sign a statement affirming nondiscrimination for credentialing decisions. Periodic audits of practitioner grievances/complaints will also be conducted to determine if there are grievances/complaints alleging discrimination.

In credentialing practitioners, the BHD Provider Network shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner, prospective or existing, who is acting within the scope of his or her license or certification under state law solely on the basis of the license or certification.

If a practitioner or group of practitioners is declined network participation, the reason for denial by the Committee shall be communicated, in writing, within 60 calendar days of the Committee's final decision.

This prohibition does not preclude the BHD Provider Network from refusing to grant participation to a practitioner if there is no network need.

XVI. CREDENTIALING APPEAL REVIEW PROCESS

The Committee shall implement a mechanism to resolve disputes with participating practitioners regarding actions by the Provider Network that relate to either:

- (1) a participating practitioner's status within the network or
- (2) any action by the Provider Network related to a practitioner's professional competency or conduct.

In the case of a practitioner where the Committee makes an adverse determination and rejects the application, the Committee shall specify one of the two following reasons for the adverse determination:

A. Business or Administrative

- Not related to the practitioner's competence or professional conduct

B. Competence and/or Professional Conduct – Quality Related

- As it affects or may affect the health and welfare of a member
- Occurrences of this type, for physicians and non-physicians, may be reported to the National Practitioner Data Bank, the Department of Safety and Professional Services, American Medical Association, Office of Inspector General and/or Department of Health and Human Services.

The Committee shall review all available information and notify each practitioner via certified mail of the decision to decline, suspend, reduce or terminate network participation. In the event of an adverse event and prior to termination, a range of actions to improve performance may be provided to the practitioner (i.e., restrict a practitioner to perform specific duties, require oversight by another participating practitioner, periodic reviews of medical records, require continuing medical education course(s), require attendance at in-service(s), etc.). All practitioners adversely impacted shall receive instructions, in writing, on how to appeal a denied request for credentialing.

XVII. DELEGATED CREDENTIALING

The BHD Provider Network may opt to delegate credentialing responsibility and authority for designated group practices or entities where the following conditions are met:

- The group practice or entity agrees to provide to the BHD Provider Network a copy of its Credentialing Program, including documentation of the professional criteria to be evaluated in the credentialing processes and mechanisms for their verification and review. The criteria and processes must be deemed equivalent to those established by the BHD Provider Network.
- There is a written agreement that states the scope of delegated activities and delegate's accountabilities to the BHD Provider Network.
- The group practice or entity agrees to provide the BHD Provider Network with any modifications to its Credentialing Program.
- The group practice or entity agrees to cooperate with the BHD Provider Network's requests to audit the Group's credentialing and/or recredentialing processes at least annually.
- The group practice or entity agrees to provide the BHD Provider Network with timely updates concerning additions and terminations of its practitioners.

A list of group practices and other organizations or entities to which credentialing responsibility and authority have been delegated is maintained by the BHD Provider Network's credentialing and quality staff.

XVIII. DUAL CREDENTIALING AND CONTRACTING

A. Dually Credentialed:

The BHD Provider Network grants dual credentialing to participating practitioners who can satisfactorily demonstrate the appropriate level of education and training in the specialties s/he wishes to practice. Appropriate education and training must be provided to the BHD Provider Network, and if not, there must be satisfactory evidence, as determined by the BHD Provider Network, of experience and hours of practice in the desired specialties. These types of practitioners are considered “dually credentialed” practitioners. For example: A psychiatrist who has completed a fellowship can act as a sub-specialist within that area, i.e., child psychiatry, geriatric psychiatry, forensic psychiatry.

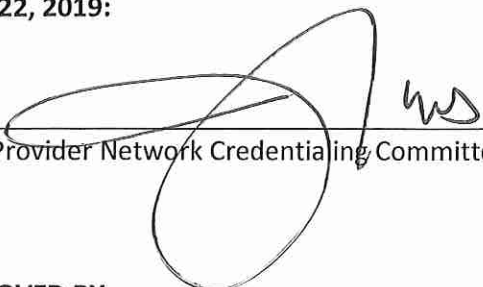
B. Dually Contracted:

The BHD Provider Network considers those practitioners contracted directly with the BHD Provider Network as a licensed independent practitioner and with a provider organization or with more than one provider organization as “dually contracted” practitioners. Dually contracted practitioners shall not be required to complete separate credentialing applications for each provider/agency but must be authorized as a credentialed practitioner to provide services with each contracted provider/agency with which she or he is affiliated.

XIX. CREDENTIALING PROGRAM DESCRIPTION SIGNATURE PAGE

Effective Date: July 1, 2019

**RECOMMENDED FOR APPROVAL BY THE PROVIDER NETWORK CREDENTIALING COMMITTEE ON
MAY 22, 2019:**



BHD Provider Network Credentialing Committee (Chair)

6/18/19

Date

APPROVED BY:



Community Access to Recovery Services Administrator

6/24/19

Date



Wraparound Milwaukee Administrator

6/20/19

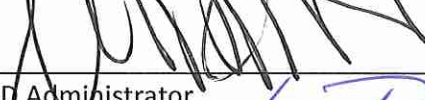
Date



BHD Chief Medical Officer

6/18/19

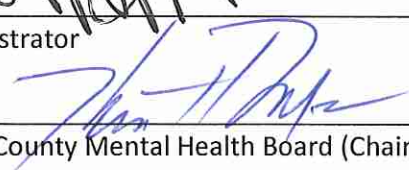
Date



BHD Administrator

6/20/19

Date



Milwaukee County Mental Health Board (Chairman)

6-20-19

Date

Original Effective Date: July 1, 2019

Reviewed Date(s):

Revised Date(s):

ADDENDA

ADDENDUM A: BHD Provider Network Practitioner Credentialing/Recredentialing Appeals Process

ADDENDUM B: BHD Provider Network Credentialing Structure and Governance

ADDENDUM A

BHD PROVIDER NETWORK PRACTITIONER CREDENTIALING/REREDENTIALING APPEALS PROCESS

RIGHT TO APPEAL

If a determination is made by the BHD Provider Network Credentialing Committee to deny or restrict a practitioner's participation request; or to suspend, restrict or revoke a participating practitioner's status, the practitioner is provided with a written explanation of the rationale for the Committee's decision and a description of the appeal rights available to him/her. The practitioner is afforded the opportunity to review the information submitted in support of their application except for any information that is protected by state peer review or other law.

During the time an individual's appeal for initial participation is being considered she/he may not provide care or treatment to BHD Provider Network members. During the time an individual's appeal for continued participation is being considered she/he may provide care or treatment to BHD Provider Network members, if there is reasonable belief that there is no significant potential for patient harm and his/her current credentialing approval period has not expired.

In addition to restrictive actions or denials imposed by the Credentialing Committee, any immediate restriction, suspension or termination of a practitioner's participating status by the BHD Chief Medical Officer, Medical Director or his/her physician designee which exceeds fourteen days shall include notification to the practitioner of his/her right to an appeal. A practitioner may not appeal such a decision if the restriction, suspension, or termination does not exceed fourteen days during which time an investigation is being conducted to determine the need for further action.

RECONSIDERATION PROCESS – FIRST LEVEL

If a practitioner's participation request has been denied or restricted or a participating practitioner's participation status has been restricted, suspended, revoked, or denied, the practitioner may request reconsideration of the determination to the **BHD Provider Network Credentialing Committee**. A request for reconsideration must be submitted in writing within 30 days of the date of the notice of the challenged action. A request shall be considered submitted upon mailing (postmark, email, facsimile or by hand delivery with date/time of receipt noted). Failure to submit a written request for reconsideration within this 30-day period will be deemed a waiver of the practitioner's right to appeal. Such request for reconsideration must address the issues identified by the Credentialing Committee through the provision of additional information and copies of appropriate supporting documentation.

Upon receipt of a request for reconsideration, the Credentialing Committee shall review all new information, including the supporting documentation submitted by the practitioner, and then votes to overturn or uphold the original determination. The decision of the Credentialing Committee is communicated in writing to the practitioner within 14 days of the decision.

If the Credentialing Committee upholds its original decision, the practitioner must be given information concerning his/her right to a hearing and a summary of the rights in the hearing. This process is described below.

HEARING PROCESS – SECOND LEVEL APPEAL

Within 30 days of receipt of notification of the Credentialing Committee decision to uphold a practitioner's restriction, suspension, revocation, or termination, the practitioner has the right to request a hearing before an Appeals Committee. A request shall be considered submitted upon mailing (postmark, email, facsimile or by hand delivery with date/time of receipt noted). If a hearing is requested within the 30 days, the applicant must be given written notice setting forth the following:

1. Date, time and place of the hearing. The hearing date will not be less than thirty (30) days from the date the practitioner receives the hearing notice, unless a shorter period is mutually agreed to by the parties.
2. A list of witnesses (if any) expected to testify at the hearing on behalf of BHD Provider Network.
3. The practitioner's right to representation by an attorney or other person of the applicant's choice.
4. The practitioner's right to have a record made of the proceedings.
5. The practitioner's right to call, examine, and cross-examine witnesses.
6. The practitioner's right to present evidence determined to be relevant by the hearing committee, regardless of its admissibility in a court of law.
7. The practitioner's right to submit a written statement at the close of the hearing.
8. That the practitioner's right to the hearing may be forfeited if the applicant fails, without good cause, to appear.

APPEALS COMMITTEE – SECOND LEVEL

An Appeals Committee shall be an ad hoc committee composed of not less than five (5) individuals jointly selected by the Chief Medical Officer, the Credentialing Committee Chair and the CARS or Wraparound Administrator, as applicable. One (1) member shall be a member of the BHD Executive Team and one member shall be a BHD Provider Network Medical Director. Other Appeals Committee members shall be professional peers of the affected practitioner. Members of the Appeals Committee, other than the required Executive Team member, may be network practitioners, BHD Wraparound or Cars Staff, BHD hospital medical staff or allied health professional staff or may be out of network practitioners recommended by the Chief Medical Officer or a Provider Network Medical Director.

After listening to and reviewing all evidence, the Appeals Committee shall meet and privately discuss the evidence presented for the purpose of making a final determination. The Appeals Committee may vote to uphold, reject, or modify the decision of the Credentialing Committee.

Decisions will be communicated, in writing, to the practitioner within 30 days of the decision. Such decisions are final.

In accordance with requirements under the HCQIA, the majority of the voting members on the appeals committee shall be professional peers of the affected practitioner.

EXCLUSIONS FROM APPEAL

Practitioners who meet the criteria below are not eligible for the credentialing appeals process:

- 1) A breach or termination in the practitioner's contract with the BHD Provider Network
- 2) A suspended, revoked or terminated professional license
- 3) A suspended, revoked or terminated Drug Enforcement Administration registration
- 4) Listed on the OIG Exclusions List
- 5) Listed on any ~~County~~ or State Exclusions List
- 6) Wisconsin Caregiver Law required exclusions
- 7) Any other automatic exclusion required by law or regulation
- 8) Failure to submit a complete and accurate credentialing or recredentialing application

PLEASE NOTE

- At all levels, the practitioner has the burden of establishing that s/he meets BHD Provider Network's standards for participation.
- At all levels, the practitioner may submit additional written evidence to correct the record of erroneous information within thirty (30) calendar days of his or her intention to appeal.
- At the BHD Provider Network's discretion, all appeals filed after the 30-calendar day timeframe are at risk for not being accepted. Appeals received outside of the 30 calendar day timeframe for filing shall be reviewed on a case-by-case basis.
- The practitioner will have exhausted all appeal rights at the conclusion of the 2nd Level Appeal Hearing process.
- The recommendation of the Credentialing Committee Appeal's Panel shall be final.
- The BHD Provider Network's Appeal process is modeled after the requirements in the Health Care Quality Improvement Committee Act of 1986. The practitioner has no procedural rights, other than those set forth herein or required by law.
- The BHD Provider Network reserves the right to make the "final" decision (i.e., uphold or overturn) at all appeal, panel and/or hearing levels (i.e., 1st or 2nd), and no further appeal rights shall apply.

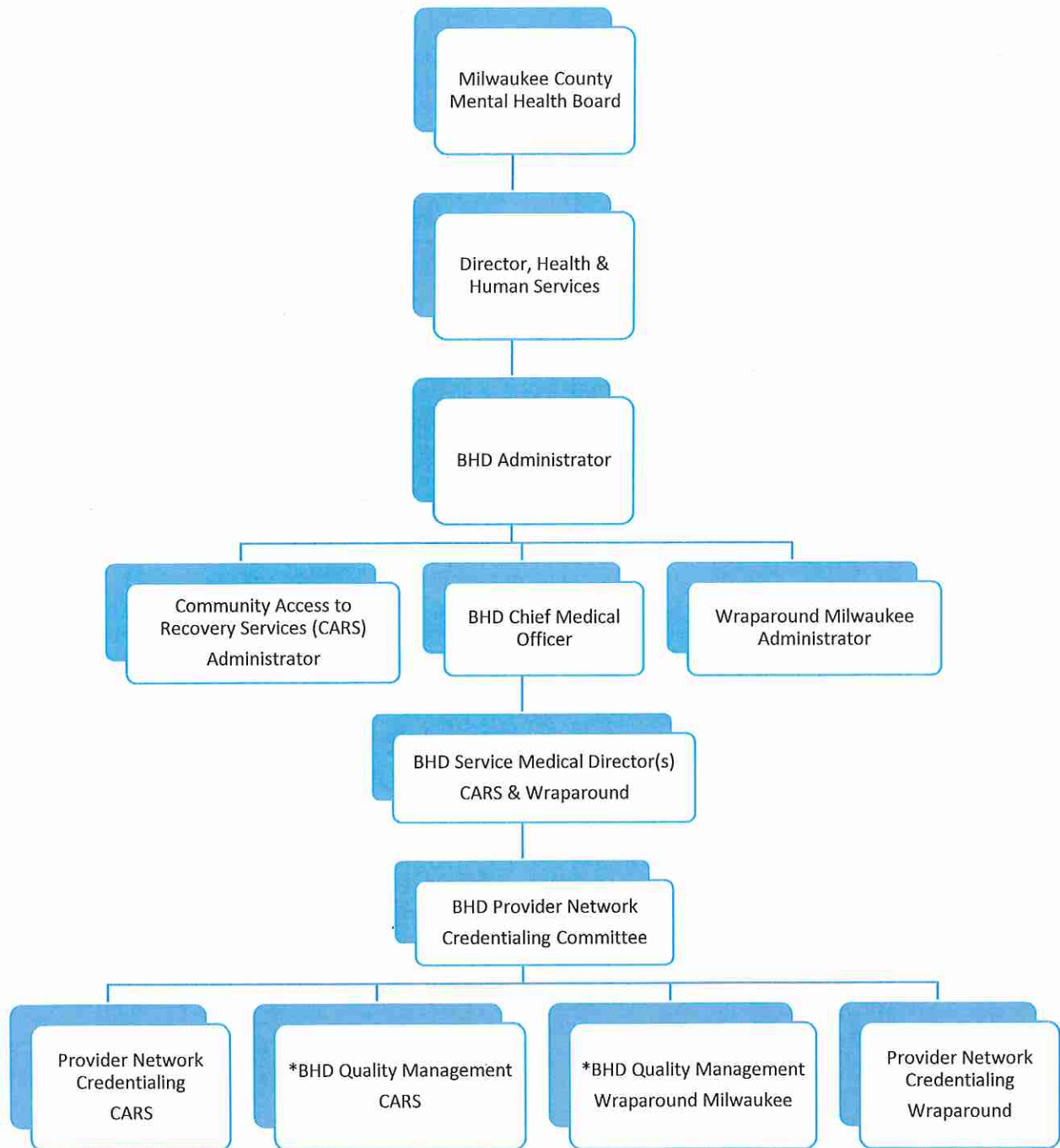
BHD PROVIDER NETWORK – PRACTITIONER CREDENTIALING/RE-CREDENTIALING

CREDENTIALING DENIAL, RESTRICTION OR LIMITATION DECISION - APPEAL REQUEST FORM		
Practitioner's Name		
Practitioner's Specialty		
Practitioner's Address		
Practitioner's Phone #		Fax #:
Practitioner's E-Mail		
Credentialing Denial Reason		
Practitioner's Rebuttal / Comments		
<i>If additional space is required, please attach using a separate sheet.</i>		
I am requesting the type of appeal checked below. I understand that I am not required to attend document only investigations.		
Select 1 Option only ☐ Level 1 ☐ Level 1 ☐ Level 2	• Committee Review and Appeal – Document Review/Investigation only • Expanded Review – Meet with Committee and Appeal Document Review/Investigation • Appeal Committee/Hearing (only applicable following Level 1 appeal and Committee restriction or denial decision was upheld) *Applicants are allowed one appeal under Level 1 and Level 2 subject to timely request and conditions specified within the Appeals Process.	
Practitioner's Signature:		Date:
PLEASE NOTE: The Appeal Request Form must be completed, signed and dated <u>by the practitioner</u> who is filing the appeal in order to be considered valid. If there is supporting documentation, attach it to the Appeal Request Form.		

RETURN TO: BHD Provider Network Credentialing Committee
 Attn: John H. Schneider, MD, FAPA, Chairperson
 9455 W. Watertown Plank Road
 Milwaukee, WI 53226

ADDENDUM B

BHD PROVIDER NETWORK CREDENTIALING PROGRAM ORGANIZATIONAL STRUCTURE AND GOVERNANCE



*Quality Management functions, as they pertain to Provider Network practitioner matters



Current Status: *Active*

PolicyStat ID: 6629757



Date Issued: 7/1/2019
Effective: 7/1/2019
Last Approved Date: 10/28/2019
Last Revised Date: 10/28/2019
Next Review: 10/27/2021

Owner: *Lora Dooley: Medical Service Manager*
Policy Area: *Provider Network-Credentialing and Impaneling*

References:

Provider Network Credentialing Program

Approved by the BHD Provider Network Credentialing Committee on 5/22/2019 and by the Mental Health Board on 6/20/2019.

Effective: July 2019

SCOPE:

The scope of the Credentialing Program is comprehensive and includes credentialing, recredentialing and ongoing monitoring of all physicians, licensed clinical and counseling psychologists and advanced practice nurses applying for new or on-going participation as BHD Provider Network practitioners with Community Access to Recovery Services (CARS) and/or Wraparound Milwaukee.

Attachments

[2019 Provider Network Credentialing Program \(Official Copy-approved by MHB 6-20-19\).pdf](#)
[2019 Provider Network Credentialing Program \(Searchable Document\).pdf](#)

Approval Signatures

Step Description	Approver	Date
Mental Health Board	Michael Lappen: BHD Administrator	10/28/2019

Step Description	Approver	Date
	Michael Lappen: BHD Administrator	10/28/2019
	John Schneider: Executive Medical Director	10/23/2019
	Brian McBride: ExDir2 – Program Administrator	10/8/2019
	Amy Lorenz: Exdir1-Psychcrisisvsdi	9/3/2019
Credentialing Chair	John Schneider: Executive Medical Director	9/3/2019
	Lora Dooley: Medical Service Manager	7/3/2019

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