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North Sound Behavioral Health Organization

Section 1000 – Administrative: Organizational Provider Assessment

Authorizing Source: North Sound BHO; CMS; NCQA Standard 7; Element: A, C and E
Cancels: Approved by: Executive Director
See Also:
Responsible Staff: Contracts Manager Signature: Date: 8/7/2018

POLICY 1027.00

SUBJECT: ORGANIZATIONAL PROVIDER ASSESSMENT

I. Program Purposes and Objectives

North Sound BHO is committed to providing quality care and services to individuals and families receiving behavioral health services. To help support this goal, North Sound BHO completes an assessment of organizational providers with whom it contracts. In addition, North Sound BHO completes a reassessment of all contracted organizational providers every 36 months. Behavioral health providers are required to meet established criteria. North Sound BHO does not contract with organizational providers that do not meet the established criteria.

The decision to accept or deny an organizational provider is based upon primary source verification, secondary source verification, and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

II. Type of Organizational Providers Assessed

The organizational provider types assessed may include, but are not limited to, the following Agencies:

a. **Agencies**	b. **Ambulatory Facilities**	c. **Hospitals**	d. **Nursing/Custodial Facilities**	e. **Residential Facilities**	f. **Other Atypical ***
g. Behavioral Health Agency (BHA)	Adult Mental Health Behavioral Health Center Rehabilitation Center, Substance Use Disorder	Psychiatric Hospital	Assisted Living Facility Assisted Living, Behavioral Disturbances Assisted Living, Mental Illness Intermediate Care Facility, Mental Illness	Community Based Residential Treatment Facility, Mental Illness Psychiatric Residential Treatment Facility Residential Treatment Facility Mental Illness Youth/Children Substance Abuse Disorder Rehabilitation Facility Substance Use Disorder Rehabilitation Facility, Children/Youth	Supported Employment

***Atypical providers** do not provide health care. This is further defined under the Health Insurance Portability and Accountability Act (HIPAA) in Federal regulations and at 45 CFR 160.103. Taxi services, home and vehicle modifications, and respite services are examples of atypical providers reimbursed by the Medicaid program. Even if these atypical providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and do not receive an NPI number. Therefore, atypical providers will not have a Taxonomy code.

III. Approved Accrediting Agencies

Approved accrediting agencies accepted by North Sound BHO are any accrediting agencies that have been deemed by The Centers for Medicare & Medicaid Services (CMS). These include, but are not limited, to the following:

a. Accreditation Association for Ambulatory Health Care (AAAHC);
b. The Accreditation Commission for Health Care, Inc. (ACHC);
c. Board of Certification/Accreditation International (BOC);
d. Commission for Accreditation of Rehabilitation Facilities (CARF);
e. Community Health Accreditation Program (CHAP);
f. Center for Improvement in Healthcare Quality (CIQH);
g. The Council on Accreditation (COA);
h. Compliance Team;
i. DNV Healthcare Inc. (DNVHC);
j. Healthcare Quality Association Accreditation (HQAA);
k. National Committee for Quality Assurance (NCQA);
l. The Joint Commission (TJC);
m. Utilization Review Accreditation Commission (URAC).

IV. Criteria for Participation in the North Sound BHO Network

North Sound BHO has established criteria and sources used to verify these criteria for the evaluation and selection of behavioral health organizational providers for participation in the North Sound BHO network. This policy defines the criteria that are applied to applicants for initial participation, and ongoing participation in the North Sound BHO network.

North Sound BHO reserves the right to exercise discretion in applying any criteria and to exclude behavioral health organizational providers who do not meet the criteria. To remain eligible for participation organizational providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentation provided by North Sound BHO.

Behavioral health organizational providers must meet the following criteria to be eligible to participate in the North Sound BHO network. If the organizational provider fails to provide proof of meeting these criteria, the application will be deemed incomplete and it will result in an administrative denial or termination from the North Sound BHO network. Behavioral health organizational providers that have been denied initial network participation by the Professional Review Committee are not eligible to reapply for participation until one (1) year after the date of denial. Behavioral health organizational providers terminated by the Professional Review Committee or terminated from the network for cause are not eligible to reapply until five (5) years after the date of termination. At the time of reapplication, behavioral health organizational provider must meet all criteria for participation as outlined below.

Criteria	Verification Source	Applicable provider types	Time limit	When required
Application Organizational provider must submit a complete, signed, and dated credentialing application. The application must be typewritten or completed in non-erasable ink. Application must include all required attachments. The organizational provider must sign and date the application attesting their application is complete and correct within 180 calendar days of the credentialing decision. If the organizational provider's attestation exceeds 180 days before the credentialing decision, the organizational provider must attest to the information on the application remains correct and complete but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the organizational provider to update the attestation**.** If North Sound BHO or the Professional Review Committee requests any additional information or clarification, the organizational provider must	• Every section of the application is complete or designated N/A • The attestation is signed and dated within 180 calendar days of the credentialing decision • Every question must be answered and include a detailed explanation where the application indicates necessary.	All provider types	180 Calendar days	Initial Assessment & Reassessment

Criteria	Verification Source	Applicable provider types	Time limit	When required
supply that information in the time-frame requested. Any changes made to the application must be initialed and dated by the organizational provider. White-out may not be used on the application rather the incorrect information must have a line drawn through it with the correct information written/typed in. All reassessment information must be submitted by the organizational provider within the timeframe requested. The application and/or attestation documents cannot be altered or modified.				
License, Certification, Registration If applicable to operate in the state, organizational provider must hold a current, valid license, certification or registration to operate in their specialty area(s) in every state in which they will provide care and/or services for North Sound BHO Members.	Verified directly with the agency that issued the license, certification or registration. This verification is conducted by one of the following methods: • On-line directly with agency • Confirmation directly from the agency documented in writing. The verification must include: • The scope/type of license, certification or registration • Expiration date of licensure, certification	All applicable provider types	180 Calendar days	Initial Assessment & Reassessment

Criteria	Verification Source	Applicable provider types	Time limit	When required
	or registration, if applicable • Current status of license, certification or registration			
Organizational provider's credentialing program The organizational provider must attest to verifying the following on their application for all of their employees rendering services for the organization: 1. The appropriate state license, certification or registration source is checked for all new employees or contracted service providers prior to rendering services. The license, certification or registration must be current and in good standing with the states where they will be rendering services to North Sound BHO Members. The organizational provider will check the appropriate state license, certification or registration source at least annually and upon expiration for existing and contracted service providers in order to ensure that every employee providing services holds a current license, certification or registration in good standing. 2. On-line exclusion lists for the HHS Office of Inspector General (OIG) and System Award Management (SAM) for all new employees, care providers, prior to providing services and existing	• The attestation must be current within 180 calendar days of the credentialing decision. • Every question must be answered and include a detailed explanation where the application indicates necessary.	All provider types	180 Calendar days	Initial Assessment & Reassessment

Criteria	Verification Source	Applicable provider types	Time limit	When required
employees or contracted service providers and on a monthly basis to ensure that no state or federally excluded individual(s) perform(s) any function related to any state or federal health care program. The organizational provider will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a state or federal health care program. 3. Criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. The organizational provider does not employ or contract with any individual convicted of a felony for a health-care related crime, including, but not limited, to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance(s).				
State sanctions, restrictions, limitations or conditions of license, certification or registration, sanctions by Medicare/Medicaid, accrediting agencies or state and federal agencies At the time of initial application, the organizational provider's state license(s), certification(s) and or registration(s) must be currently free of any restrictions, limitations, conditions or sanctions (formal or	The organizational provider must answer all the questions in the credentialing program pertaining to these issues and will provide explanations to answers where indicated. In addition, all of the following sources are verified directly and if there are any sanctions, restrictions or limitations, completed documentation	All provider types	180 Calendar days	Initial Assessment & Reassessment

Criteria	Verification Source	Applicable provider types	Time limit	When required
informal) and there should be no such open or pending investigations. The organizational provider also must not have any of the following sanctions/exclusions imposed by Medicare, Medicaid, accrediting agencies or other state and federal agencies: 1. Stop placement status 2. Denial of payment status 3. Temporary management status 4. Pending state charges, actions 5. Excluded or expelled status 6. Loss of accreditation, licensure or certification status At the time of reassessment, if the organizational provider is found to have any of these sanctions, restrictions, limitations or conditions, they will be deemed a level 2 file to be reviewed by the Professional Review Committee.	regarding the action will be obtained from the agency: • Agency(s) issuing the license(s), certification(s) or registration(s) • The HHS Office of Inspector General (OIG) web site. • The System for Award Management (SAM) website is queried • Applicable state Medicare/Medicaid agency(s) who publish lists of sanctioned/excluded providers • Applicable Accrediting agency(s)			
Disclosure of Ownership and Controlling Interest for Organizational Provider -Form The organizational provider, person(s) with ownership or controlled interest with the organizational provider and managing employees of the organizational provider must not have ever been: a) Convicted of a felony or pled guilty to a felony for a health-care related crime, including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution,	Organizational provider completes the Disclosure of Ownership and Controlling Interest form by indicating each individual who has ownership and/or a controlling interest in the organization. The organizational provider will also answer all questions on the form pertaining to these issues and will provide detailed explanations to any yes answers.	All provider types	36 Months	Initial Assessment & Reassessment

Criteria	Verification Source	Applicable provider types	Time limit	When required
prescription, or dispensing of controlled substance. b) Excluded, expelled or suspended from any federally funded programs, including but not limited to, the Medicare or Medicaid programs c) Excluded, expelled or suspended from any state funded programs including but not limited to Medicare or Medicaid. If an organizational provider indicates they are entirely state or federally funded on the Disclosure of Ownership and Controlling Interest form, the organizational provider is only required to sign and date the form and does not have to complete any additional sections of the form.				
Disclosure of Ownership and Controlling Interest for Organizational Provider – Verification of Information The following categorical details are collected and required on the Disclosure of Ownership and Control Interest during the credentialing and recredentialing process: **a)** Detailed identifying information for any individual who has ownership or controlling interest in the individual/entity being contracted if that individual has a history of criminal activity related to Medicaid, Medicare, or Title XX services (see 42 CFR §455.106).	North Sound BHO searches the following sources for all individual names and entities listed on the Disclosure of Ownership and Control Interest Form: • The HHS- Inspector General, Office of Inspector General (OIG) web site. • The System for Award Management (SAM) website • Medicare Opt-Out • Each state's specific Program Integrity Unit	All provider types	180 Calendar Days	Initial Assessment & Reassessment

Criteria	Verification Source	Applicable provider types	Time limit	When required
b) Detailed identifying information for all individuals who exercise operational or managerial control either directly or indirectly over daily operations and activities (see 42 CFR §455.101). **c)** Detailed identifying information for all individuals or entities that have a 5% or more ownership or controlling interest in the individual/entity being contracted (see 42 CFR §455.104)				
Accreditation or Certification for inpatient, residential or ambulatory behavioral healthcare providers and all other organizational providers that are licensed, registered or certified. Organizational provider must meet at least one of the following requirements: a) Be accredited through an accrediting agency that has approval from the Centers for Medicare and Medicaid (CMS) services for deeming authority of accreditation. b) Non-accredited organizational providers must be approved and have passed inspection by CMS or the applicable state agency. The CMS or state survey may not be greater than three years old at the time of verification for inpatient, residential or ambulatory behavioral healthcare providers.	For organizational providers that are accredited, North Sound BHO primary source verifies the accreditation is current and in good standing directly with the accrediting agency. For organizational providers that are non-accredited, North Sound BHO obtains evidence of one of the following: a) A copy of the most recent CMS or state survey including approved corrective action(s). b) A copy of a letter from CMS, or the applicable state agency which shows the facility agency, that shows the facility was reviewed and indicates it passed inspection. c) Primary source verification directly	Inpatient, Residential and Ambulatory Behavioral Healthcare Providers and All other organizational providers that are licensed, registered or certified.	180 Calendar days	Initial Assessment & Reassessment

Criteria	Verification Source	Applicable provider types	Time limit	When required
If an organizational provider is pending corrective action for an inspection conducted by CMS or applicable state agency, North Sound BHO will review the organizational provider as a level 2 credentialing file. If the Professional Review Committee votes to approve, the organizational provider will be placed on a watch status to follow up on compliance with the corrective action. c) North Sound BHO conducts an onsite quality assessment if the organizational provider does not meet one of the two previously listed criteria under A or B. **POLICY EXCEPTION:** North Sound BHO does not conduct site visits for non-accredited organizational providers when the state or CMS has not conducted a site review when the provider is in a rural area as defined by the U.S. Census Bureau.	from CMS or the state indicating the survey was completed and passed inspection. For organizational providers not accredited or who have not had a CMS or state survey, a quality assessment will be completed by North Sound BHO and will not be more than 180 days at the time of decision.			
Medicare Participation Evidence that the organizational provider has been approved for Medicare participation or is certified by the appropriate agency for provision of applicable services.	Evidence that the organizational provider has been approved for Medicare participation by one of the following: • Primary source verification of Medicare participation with CMS • A copy of the letter sent by CMS to the	All provider types	Not Applicable	Initial Assessment & Reassessment

Criteria	Verification Source	Applicable provider types	Time limit	When required
	organizational provider indicating their approval of Medicare participation			
Professional Liability Insurance Unless otherwise noted in Addendum A of this policy, organizational provider must have current professional malpractice liability coverage with limits that meet North Sound BHO criteria specifically outlined in this policy. The insurance must be through a commercial carrier or statutory authority. If a facility does not meet the insurance requirements, as listed in Addendum A, the health plan may use their discretion to determine if the limits and coverage are acceptable.	Professional liability insurance is verified by one of the following methods: A copy of the insurance certificate showing: • Name of commercial carrier or statutory authority • The type of coverage is professional liability or medical malpractice insurance • Dates of coverage (must be currently in effect) • Amounts of coverage • Name of the organizational provider • Certificate must be legible Current organizational provider application attesting to current insurance coverage. The application must include the following: • Name of commercial carrier or statutory authority • The type of coverage is professional liability or medical malpractice insurance	All provider types	Must be in effect at the time of decision	Initial Assessment & Reassessment

Criteria	Verification Source	Applicable provider types	Time limit	When required
	• Dates of coverage (must be currently in effect) • Amounts of coverage Organization providers maintaining coverage under a federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance. A copy of the Federal Tort or Self-Insured letter or an attestation from the organizational provider showing active coverage are acceptable. Confirmation directly from the insurance carrier verifying the following: • Name of commercial carrier or statutory authority • The type of coverage is professional liability or medical malpractice insurance • Dates of coverage (must be currently in effect) • Amounts of coverage			
DEA or CDS Certificate If applicable to the organizational provider type, provider must have a current and unrestricted federal Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate.	• On-line directly with the National Technical Information Service (NTIS) database. • On-line directly with the U.S. Department of	Applicable provider types	Must be in effect at the time of decision and verified	Initial Assessment & Reassessment

Criteria	Verification Source	Applicable provider types	Time limit	When required
	Justice Drug Enforcement Administration, Office of Diversion Control • Current, legible copy of DEA or CDS certificate • On-line directly with the state pharmaceutical licensing agency, where applicable		within 180 Calendar Days	
NPI Organizational provider must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).	• On-line directly with the National Plan & Provider Enumeration System (NPPES) database.	All provider types except atypical provider types	180 Calendar Days	Initial Assessment & Reassessment

Burden of Proof

The organizational provider shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the North Sound BHO network. If the organizational provider fails to provide this information, the application will be deemed incomplete and it will result in an administrative denial or termination from the North Sound BHO network.

The Assessment File

North Sound BHO creates and maintains an electronic file for each organizational provider that applies for participation in the North Sound BHO network. Electronic files are maintained in a document management system.

All information relating to the organizational providers described throughout this policy are retained in the file. North Sound BHO retains all this information for every assessment cycle for ten (10) years following the end of the providers association with North Sound BHO.

V. Credentialing Application

At the time of initial assessment and reassessment, the organizational provider must complete an application designed to provide North Sound BHO with information necessary to perform a comprehensive review of the organizational provider. The application must be completed in its entirety. The organizational provider must attest that their application is complete and correct within

180 calendar days of the decision to approve or deny participation in the North Sound BHO network. The application must be completed in typewritten text or in legible non-erasable pen. Pencils or erasable ink will not be an acceptable writing instrument for completing applications. North Sound BHO will accept faxed, digital, electronic, scanned or photocopied signatures. A signature stamp is not acceptable on the attestation.

VI. The Process for Making Decisions

All organizational providers requesting participation with North Sound BHO must complete an application. To be eligible to submit an application the organizational provider must meet all the criteria outlined above in the section titled "Criteria for Participation in the North Sound BHO Network". Organizational providers requesting initial participation may not provide care to North Sound BHO Members until the credentialing process is complete and the final decision has been rendered.

North Sound BHO completes a reassessment of its contracted organizational providers at least every 36 months. Approximately 6 months prior to the assessment due date, a request will be sent to the organizational provider requesting completion of an application.

During the initial and reassessment application process, the organizational provider must:

a. Submit a completed application within the requested timeframe
b. Attest to the application within the last 180 calendar days
c. Provide North Sound BHO adequate information to prove they meet all criteria for initial participation or continued participation in the North Sound BHO network.

Once the application is received, North Sound BHO will complete all the verifications as outlined above. In order for the application to be deemed complete, the organizational provider must produce adequate information to prove they meet all criteria for initial participation or continued participation in the North Sound BHO network. All fields within the application must be completed, all required attachments must be included, detailed explanations must be provided where the application indicates necessary and any additional information requested by North Sound BHO must be provided.

If the organizational provider does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and North Sound BHO will discontinue processing of the application. This will result in an administrative denial or termination from the North Sound BHO network.

At the completion of the application and primary source verification process, each file is quality reviewed to ensure completeness. During this quality review process, each file is assigned a level based on the guidelines below. Files assigned a level 1 are considered clean files and the Medical Director(s) responsible for credentialing has the authority to review and approve them. Files assigned a level 2 are reviewed by the North Sound BHO Professional Review Committee. North Sound BHO employees have the right to raise an organizational provider file from a Level 1 to a Level 2 if they believe the file should be reviewed by the Professional Review Committee. However, North Sound BHO employees and the Medical Director, never have the right to use their discretion of lowering an organizational provider file to a Level 1 when it meets the guidelines below as a Level 2. The Medical Director has the right to request the Professional Review Committee review any file. The Professional Review Committee has the right to request to review any file.

VII. Professional Review Committee Review Guidelines:

a. Level 1 – Clean File

1. Organizational provider meets all criteria for participation as outlined in the section titled Criteria for Participation in the North Sound BHO Network and does not meet any of the criteria outlined above in Level 2.
2. At reassessment, organizational provider's record has not changed since the last assessment cycle and everything was previously reviewed and determined acceptable by the Professional Review Committee.

b. Level 2 –File must be reviewed by Professional Review Committee

1. The state license(s), certification(s) and or registration(s) has any restrictions, limitations, conditions or sanctions (formal or informal) currently open[1], pending investigations or occurring within the past 10-years.
2. The organizational provider currently has or has ever had any of the following sanctions imposed by Medicare, Medicaid, accrediting agencies or other state and federal agencies:

    i. Stop placement status
    ii. Denial of payment status
    iii. Temporary management status
    iv. Pending state charges, actions
    v. Excluded or expelled status
    vi. Loss of accreditation, licensure or certification status

3. Organizational provider is currently pending corrective action for an inspection conducted by CMS or applicable state agency.
4. Organizational provider has ever had any legal actions excluding medical malpractice.
5. Organizational provider has ever been convicted of a crime, excluding misdemeanors.
6. Any governmental agency ever investigated, suspended, revoked, or taken any other action against organizational provider's license to conduct business.
7. Organizational provider has ever been assessed a penalty, conviction or suspension by the Medicare or Medicaid programs or is currently under investigation.
8. Any individually licensed, certified or registered practitioners employed by the organizational provider has ever been convicted of a crime, excluding misdemeanors.
9. A third-party payer has ever revoked, reduced, denied or suspended organizational provider's participation due to inappropriate utilization management or any other quality of care issues.
10. Any managing employee or person with an ownership or control interest has ever been or is currently excluded from participation in a government program (e.g., Medicare/Medicaid).

[1] If a provider's application is denied solely because a provider has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the provider may reapply as soon as provider is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

11. Organizational provider does not meet the minimum insurance limits and/or coverage requirements as listed in Addendum A.
12. Organizational provider has ever been involved in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the organizational provider's professional conduct of the health, safety or welfare of North Sound BHO members.
13. Organizational provider engages or has ever engaged in acts, which North Sound BHO, in its sole discretion, deems inappropriate.
14. Organizational provider has a pattern of member complaints or grievances in which there appears to be a concern regarding the quality of service provided to North Sound BHO members.
15. Organizational provider has not complied with North Sound BHO's quality assurance program.
16. Organizational provider is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
17. Organizational provider has displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
18. Organizational provider makes any material misrepresentation or omission to North Sound BHO concerning licensure, registration, accreditation, insurance, certification, disciplinary history or any other material matter covered in the application or related materials.

At each Professional Review Committee meeting, organizational provider files assigned a Level 2 are reviewed by the Professional Review Committee. All of the issues are presented to all the Professional Review Committee members and then open discussion of the issues commences. After the discussion, the Professional Review Committee votes for a final recommendation. The Professional Review Committee can recommend approving, deny, terminate, approve on watch status, place on corrective action or defer their decision pending additional information. The North Sound BHO Medical Director has the authority to make the determination regarding participation in the North Sound BHO network. When justifiable circumstances exist, organizational providers/providers who do not meet certain criteria may be approved. The Professional Review Committee must explicitly review and recommend approval of any exceptions. Each exception is specific to the situation for which the exception is made and is not intended to establish a precedent for any future Professional Review Committee recommendations.

VIII. Process Used for Managing Assessment Files that Meet Criteria

The Medical Director responsible for credentialing has the authority to approve organizational providers with clean files assigned a Level 1. The Medical Director reviews a formal report listing the results of the assessment for each organizational provider designated Level 1 with clean credentials files. Once the Medical Director makes the determination to approve the organizational providers listed on the clean file report, they/their designee signs and dates the approval form. This sign-off date is considered the decision date. The Medical Director can request to have any organizational provider's file reviewed at the next scheduled Professional Review Committee meeting. When this occurs, the organizational provider will not be considered approved until Professional Review Committee reviews and makes a determination.

A report of the organizational providers approved by the Medical Director will be presented at each Professional Review Committee meeting for the Professional Review Committee members to review.

IX. Timeliness of Verifications

Many credentialing elements have time-sensitive factors that are identified within the table located in the section of this policy titled 'Criteria for Participation in the North Sound BHO Network'. North Sound BHO is responsible for ensuring and documenting that none of the time-sensitive credentialing factors are more than 180 calendar days old at the time of the credentialing decision. When assessing performance against timeliness requirements, North Sound BHO counts backward from the date of the Professional Review Committee's decision or Medical Director's approval. North Sound BHO does not count forward from the date on which the credentialing application was received or from the date of verification of a specific credential. Credentials must be verified within the specified time limits and be valid at the time of the Professional Review Committee's or Medical Director's review and approval. The organizational provider may not provide care to Members until the credentialing process is completed and the final decision is rendered.

X. Provisional Credentialing

It can occasionally be in the best interest of Members to make organizational providers available prior to completion of the entire initial credentialing process. In this case, if allowable by the state regulatory agency, North Sound BHO may complete provisional credentialing for a newly licensed organizational provider that has not yet had a CMS/State survey or an accreditation survey. An organizational provider can only be provisionally credentialed once.

At a minimum, North Sound BHO requires the following to be completed prior to approval of provisional credentialing:

a. A complete, signed, and dated credentialing application;
b. A current attestation within 180 calendar days;
c. Primary-source verification of a current, valid license to operate in the state;
d. Current professional liability insurance showing dates and amounts of coverage; and
e. Primary source verification of any sanctions/exclusions imposed by Medicare, Medicaid, accrediting agencies or other state and federal agencies. Organizational provider must not have any sanctions/exclusions imposed to be provisionally credentialed.

Each of these elements must be primary-source verified within 180 calendar days of the provisional credentialing decision. North Sound BHO follows the same process for presenting provisional credentialing files to the Professional Review Committee or Medical Director as it does for the regular credentialing process.

Full credentialing will be completed within 60-days after the CMS or accreditation survey has been completed.

XI. Notification of Discrepancies in Credentialing Information

North Sound BHO will notify the organizational provider immediately in writing if credentialing information obtained from other sources varies substantially from that provided by the organizational provider. Examples include but are not limited to actions on a license, sanctions or loss of accreditation status. North Sound BHO is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law. Please also refer to the section below titled 'Organizational Provider's Rights to Correct Erroneous Information'.

XII. Notification of Credentialing Decisions

A letter is sent to every organizational provider with notification of the Professional Review Committee or Medical Director's decision regarding their participation in the North Sound BHO network. This notification is sent within 2 weeks of the decision. Copies of the letters are filed in the organizational provider's credentials files. Under no circumstance will notifications letters be sent to the organizational provider later than 15 calendar days from the decision.

XIII. Organizational Provider Rights to Correct Erroneous Information

Organizational providers have the right to correct erroneous information in their credentials file. Organizational providers are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

North Sound BHO will notify the organizational provider immediately in writing if credentialing information obtained from other sources varies substantially from that provided by the organizational provider. Examples include but are not limited to actions on a license or loss of accreditation status. North Sound BHO is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

The notification sent to the organizational provider will detail the information in question and will include instructions to the organizational provider indicating:

Their requirement to submit a written response within 10 calendar days of receiving notification from North Sound BHO.

In their response, the organizational provider must explain the discrepancy, may correct any erroneous information, and may provide available proof.

The organizational provider's response must be sent to North Sound BHO. Attention: Credentialing Committee at 301 Valley Mall Way, Ste.110, Mount Vernon, WA 98273.

Upon receipt of notification from the organizational provider, North Sound BHO will document receipt of the information in the organizational provider's credentials file. North Sound BHO will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the organizational provider's credentials file. The organizational provider will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the organizational providers', the Credentialing Department will notify the organizational provider. The organizational provider may then provide proof of correction by the primary source body to North Sound BHO's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

If the organizational provider does not respond within 10 calendar days, their application processing will be discontinued, and network participation will be administratively denied or terminated.

XIV. Organizational Provider Right to be Informed of Application Status

Organizational providers have a right, upon request, to be informed of the status of their application. Organizational providers applying for initial participation are sent a letter when their application is received by North Sound BHO and are notified of their right to be informed of the status of their application in this letter. Organizational providers are also notified of their right in the North Sound BHO Provider Manual sent to them at the time of initial contracting.

The organizational provider can request to be informed of the status of their application by telephone, email or mail. North Sound BHO will respond to the request within two (2) working days. North Sound BHO may share with the organizational provider where the application is in the credentialing process to include any missing information or information not yet verified.

XV. Change of Ownership

All Organizational Provider Types (excluding hospitals):

If a participating organizational provider is sold (or leased) resulting in a change of ownership between credentialing cycles, the organizational provider will be initially credentialed.

XVI. Ongoing Monitoring of Sanctions

North Sound BHO monitors providers between assessment cycles and takes appropriate action against providers when occurrences of poor quality are identified.

a. Medicare and Medicaid sanctions

The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a report every month of individuals and entities that have been excluded from Medicare and Medicaid programs. Within 30 calendar days of its release, a report is run to identify any potential matches between sanctioned providers and North Sound BHO providers and/or individuals with ownership and/or a controlling interest in the organizational provider. The Credentialing Department reviews the report of potential matches and completes the research to determine if there is indeed an exact match. If the Credentialing Department identifies a North Sound BHO provider or an individual with ownership and/or a controlling interest in the organizational provider on the OIG exclusion report, the Credentialing Department notifies the Contracting Department, Utilization Management, Compliance Department and the Internal Quality Management Committee. North Sound BHO immediately terminates the provider's contract effective the same date the sanction was implemented and sends an email notification to the Credentialing Department confirming the termination was completed. The Contracting Department ensures no claims will be paid to this provider and no authorization can be generated to this provider. The Credentialing Department maintains a log which indicates the date each OIG report was released, the date the report was reviewed by North Sound BHO staff and indicating if there were any matches found between the OIG report and North Sound BHO's provider network.

North Sound BHO also monitors for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent). North Sound BHO queries every provider in the North Sound BHO provider network against each state's published report within 30 calendar days of its release. The Credentialing Department reviews any potential matches and completes the research to determine if there is indeed an exact match. If the Credentialing Department identifies a North Sound BHO provider on the report, the Credentialing Department notifies the following North Sound BHO departments: Claims, Contracting, Utilization Management, Compliance and the Internal Quality Management Committee. North Sound BHO immediately terminates the provider's contract effective the same date the sanction was implemented and sends an email notification to the Credentialing Department confirming the termination was completed. If a provider is found to be sanctioned/excluded/terminated from any state's Medicaid program, the provider will be terminated with North Sound BHO and for every line of

business. The Information System/Fiscal Department ensures no claims will ever pay to this provider and no authorization can ever be generated to this provider. The Credentialing Department maintains a log which indicates the date each Medicaid exclusions report was released, the date the report was reviewed by North Sound BHO staff and indicating if there were any matches found between the OIG report and North Sound BHO's provider network.

b. System for Award Management (SAM)

North Sound BHO monitors the SAM once per month to ensure providers and/or individuals with ownership and/or a controlling interest in the organizational provider have not been sanctioned. If the Credentialing Department identifies a North Sound BHO provider or an individual with ownership and/or a controlling interest in the organizational provider on SAM, the Credentialing Department notifies the Contracting Department, Provider Information Systems/Fiscal, Utilization Management, , Compliance and the Internal Quality Management Committee. North Sound BHO immediately terminates the provider's contract effective the same date the sanction was implemented and sends an email notification to the Credentialing Department confirming the termination was completed. The Provider Information Systems/Fiscal Department ensures no claims will pay to this provider and no authorization can be generated to this provider. The Credentialing Department maintains a log which indicates the date each SAM check was completed and indicating if there were any matches found.

c. Member Complaints/Grievances

North Sound BHO has a process in place to investigate provider-specific complaints from members upon their receipt. North Sound BHO evaluates both the specific complaint and the provider's history of issues, if applicable. The history of complaints is evaluation for all providers at least every six (6) months.

d. Adverse Events

North Sound BHO has a process in place for monitoring adverse events at least every six (6) months. An adverse event is an injury that occurs while a member is receiving behavioral health care services from a provider.

XVII. Range of Actions

The North Sound BHO Professional Review Committee can take one of the following actions against organizational providers who fail to meet standards or who fail to meet performance expectations:

a. Monitor on a Watch Status
b. Require formal corrective action
c. Deny of network participation
d. Terminate from network participation
e. In cases where the Medical Director determines the circumstances pose an immediate risk to patients, an organizational provider may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

This applies to all organizational providers who are contracted by North Sound BHO. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. The purpose of this policy is to provide a mechanism for implementation of monitoring on watch status, requiring formal corrective action, suspension or termination of North Sound BHO providers.

If at any point, an organizational provider fails to meet the minimum standards and criteria or fails to meet performance expectations regarding quality of care the Professional Review Committee may act to implement one of these actions. Termination may be taken after reasonable effort has been made to obtain all the facts of the matter.

a. Criteria for Denial or Termination Decisions by the Professional Review Committee;
The criteria used by the Professional Review Committee to decide to deny or terminate an organizational provider from the North Sound BHO network include, but are not limited to, the following:

1. The organizational provider's state license(s), certification(s) and or registration(s) has any restrictions, limitations, conditions or sanctions (formal or informal) currently open[2], pending investigations or occurring within the past 10-years.
2. The organizational provider currently has or has ever had any of the following sanctions imposed by Medicare, Medicaid, accrediting agencies or other state and federal agencies:
    i. Stop placement status
    ii. Denial of payment status
    iii. Temporary management status
    iv. Pending state charges, actions
    v. Excluded or expelled status
    vi. Loss of accreditation, licensure or certification status
3. Organizational provider is currently pending corrective action for an inspection conducted by CMS or applicable state agency.
4. Organizational provider has ever had any legal actions excluding medical malpractice.
5. Organizational provider has ever been convicted of a crime, excluding misdemeanors.
6. Any governmental agency ever investigated, suspended, revoked, or taken any other action against organizational provider's license to conduct business.
7. Organizational provider has ever been assessed a penalty, conviction or suspension by the Medicare or Medicaid programs or is currently under investigation.
8. Any individually licensed, certified or registered practitioners employed by the organizational provider has ever been convicted of a crime, excluding misdemeanors.
9. A third-party payer has ever revoked, reduced, denied or suspended organizational provider's participation due to inappropriate utilization management or any other quality of care issues.
10. Any managing employee or person with an ownership or control interest has ever been or is currently excluded from participation in a government program (e.g., Medicare/Medicaid).
11. Organizational provider does not meet the minimum insurance limits and/or coverage requirements as listed in Addendum A or B.
12. Organizational provider has ever been involved in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the organizational provider's professional conduct or the health, safety or welfare of North Sound BHO members.

[2] If an organizational provider's application is denied solely because a provider has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the provider may reapply as soon as provider is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

13. Organizational provider engages or has ever engaged in acts, which North Sound BHO, in its sole discretion, deems inappropriate.

b. Monitoring on a Committee Watch Status

North Sound BHO uses the category "watch status" for providers whose initial or continued participation is approved by the Professional Review Committee with follow-up to occur. The Professional Review Committee may approve a provider to be monitored on watch status when there are unresolved issues or when the Professional Review Committee determines that the provider needs to be monitored for any reason.

When a provider is approved on watch status, the Credentialing Department conducts the follow-up according to the Professional Review Committee direction. Any unusual findings are reported immediately to the North Sound BHO Medical Director to determine if immediate action is necessary. Every unusual finding is reviewed in detail at the next Professional Review Committee meeting for review and determination.

c. Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, North Sound BHO may work with the provider to establish a formal corrective action plan to improve performance, prior to, or in lieu of suspending or terminating their participation status.

A corrective action plan is a written improvement plan, which may include, but is not limited to the following:

1. Identifying the performance issues that do not meet expectations;
2. What actions/processes will be implemented for correction;
3. Who is responsible for the corrective action;
4. What improvement/resolution is expected;
5. How improvements will be assessed;
6. Scheduled follow-up, monitoring (compliance review, normally not to exceed six (6) months).

Within 10 calendar days of the Professional Review Committee's decision to place provider on a corrective action plan, the provider will be notified via a certified letter from the Medical Director. Such notification will outline:

1. The reason for the corrective action; and
2. The corrective action plan.

If the corrective actions are resolved, the provider's performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Professional Review Committee may recommend that the provider continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate provider response to corrective action will be brought to the Professional Review Committee for review and recommendation.

d. Summary Suspension

In cases where the Medical Director becomes aware of circumstances that pose an immediate risk to individuals, a meeting will be held immediately with North Sound BHO Legal Counsel, the Medical Director and the Credentialing Committee. After discussing the facts, the provider may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

Such summary suspension shall become effective immediately upon imposition, and the Medical Director/Designee shall promptly notify the provider of the suspension, via a certified letter. Notification will include the following:

1. A description of the action being taken
2. Effective date of the action
3. The reason(s) for the action and/or information being investigated
4. Information (if any) required from the provider
5. The length of the suspension
6. The estimated timeline for determining whether to reinstate or terminate the provider

Upon initiation of the suspension, the Medical Director and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Professional Review Committee. The Professional Review Committee has the authority to implement corrective action, place conditions on the provider's continued participation, discontinue the suspension or terminate the provider.

e. Termination

After review of appropriate information, the Professional Review Committee may determine that the provider does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Professional Review Committee may then recommend terminating the provider.

If the provider is terminated, within 10 calendar days of the Committee's recommendation, the provider is sent a written notice of North Sound BHO's intent to terminate them from the network, via certified mail from the Medical Director, which includes the following:

1. A Description of the action being taken
2. Reason for termination

The action is reported to the applicable North Sound BHO Government Contracting Department within 15-calendar days of the effective date of the action. The Government Contracting Department is then responsible for notifying other state agencies as required in the contracts between North Sound BHO and the State entities.

Related Policies

Organizational Provider Credentialing

XVIII. Addendum A – North Sound BHO LLC. Organizational Provider Requirements for Professional Liability Insurance Coverage

Organizational Providers categories outlined under section 'Type of Organizational Providers Assessed'	Professional Liability Insurance Requirements
a. Agencies	Required if they have licensed professional employees, $1million/$2million
b. Ambulatory Health Care Facilities	Required if they have licensed professional employees, $1million/$3million
c. Atypical Providers	None
d. Residential Treatment Facilities	$1million/$3million