Jefferson Center for Mental Health

Individual Partner Mental Health Centers

Provider Credentialing and Re-Credentialing

The following policy will be reviewed on an annual basis unless revisions are requested prior then the policy will be reviewed at the time of request. Reviewed and Revised 5/13/2020 Vicki Mackenzie.

Jefferson Center for Mental Health is committed to maintaining an individually credentialed staff network. This is done by having all JEFFERSON CENTER FOR MENTAL HEALTH staff follow the same NCQA compliant credentialing and re-credentialing process, except for the final decision step which is made by the combined committee of Jefferson Center for Mental Health Credentialing Committee, with final approval by the Medical Director for JEFFERSON CENTER FOR MENTAL HEALTH.

**National Committee of Quality Assurance Compliance**:

JEFFERSON CENTER FOR MENTAL HEALTH’s credentialing and re-credentialing program complies with the standards of the National Committee for Quality Assurance (NCQA) for the credentialing and re-credentialing of participating providers. Jefferson Center for Mental Health’s credentialing program includes policies and procedures for detection and reporting of incidents of questionable practice, in compliance with Colorado statutes and regulations, the Health Care Quality Improvement Act of 1986 and NCQA standards.

**Non-discrimination:**

All credentialing and re-credentialing performed by Jefferson Center for Mental Health complies with CFR-438.214. The recruitment of providers and subsequent credentialing and re-credentialing process and decisions are made without consideration of the individual’s race, ethnic/national identity, gender, age, or sexual orientation. Efforts are made to track special needs of the Members who seek services at JEFFERSON CENTER FOR MENTAL HEALTH and to build a JEFFERSON CENTER FOR MENTAL HEALTH provider network to respond to the special needs. Further, participating providers are not discriminated against because they serve high risk groups or specialize in conditions that require costly treatment.

**Role of Medical Director:**

The Medical Director for Jefferson Center for Mental Health maintains oversight and ultimate responsibility for credentialing and re-credentialing activities involving staff of JEFFERSON CENTER FOR MENTAL HEALTH who serve members of JEFFERSON CENTER FORM MENTAL HEALTH health plan. This role includes attendance at the Credentialing Committee meetings as requested by the chair of the Credentialing Committee.

The signature of the Medical Director establishes the official date for credentialing and re-credentialing for all candidates. The signature date of the Medical Director is the entered into the data bases maintained by JEFFERSON CENTER FOR MENTAL HEALTH.

**Role of the Credentialing Committee:**

The credentialing and re-credentialing process and recommendations are vested in the collaborative Credentialing Committee which is multi-disciplinary in nature, including but not limited to, representatives from Human Resources, Peer Specialist, Licensed Clinicians, Psychologist and members of the clinical staff. The membership of the CREDENTIALING COMMITTEE is adequately representative of the staff from JEFFERSON CENTER FOR MENTAL HEALTH to effectively do the work of the organization. Members of the committee agree to keep all information confidential unless disclosure of such information is required by law. All members are required to sign a Confidentiality Agreement which is updated annually.

**Credentialing and Re-Credentialing Criteria and Primary Source Verification Resources:**

JEFFERSON CENTER FOR MENTAL HEALTH does not delegate any credentialing activities. The CREDENTIALING COMMITTEE has established the following as the criteria to be reviewed and verified, as appropriate, for all practitioners who are applicants for credentialing and for licensed practitioners for re-credentialing. A Primary Source Verification log will be included in all credentialing and re-credentialing packets which will be dated, signed and stored in the Credentialing/Re-Credentialing packet which will be located in a secured cabinet or secure HRIS system. All PSV information is received via individual databases (OIG, SAM, Medicare OPT-OUT, National Student Clearinghouse, or individual College or University, NPDB, DEA, ABMS, ANCC, etc.) which will be dated and stored in a secure location with the Credentialing/Re-credentialing applications.

1. Evidence that the applicant has a current and valid license; Source, Copy of the license and Colorado Department of Regulatory Agency Verification
2. Presence of a valid DEA or CDS certificate if applicable; Source: Copy of DEA certificate and online inquiry via DEA website [Registration (usdoj.gov)](https://deadiversion.usdoj.gov/drugreg/index.html)
3. Work history covering the past five years with gaps of greater than 6 months explained in writing by the applicant; Source: Copy of resume and, if required, written explanation from the applicant covering gaps greater than 6 months.
4. Confirmation of clinical privileges if applicable; Source: Written verification from the hospital(s) facilities where privileges have been granted.
5. Evidence of board certification if applicable; Source: Written verification from the appropriate medical specialty board, ABMS (American Board of Medical Specialties), ANCC (American Nurses Credentialing Center).
6. Explanation related to an adverse malpractice history via the carrier and/or a National Practitioners Data Bank (NPDB) query; Source: Written documentation from the carrier of satisfactory resolution of an adverse claim.
7. Evidence of highest degree earned; Source: National Student Clearinghouse verification on file along with a copy of the applicant’s degree or official transcripts.
8. Evidence that the applicant has not been excluded from participation in federally funded programs including Medicare and Medicaid; Source: Copy of Office of Inspector General (OIG), National Practitioners Data Bank (NPDB), Systems Award Management (SAM) on file.
9. Evidence the applicant does not have adverse claims in the Systems Award Management (SAM) database.
10. Medicare Opt-Out list is queried to verify providers name does not appear on the list.

**Prohibited Relationships:**

Jefferson Center for Mental Health does not employ or contract with any providers that are excluded from participation in federal health care programs under Title XI of the Social Security Act Sections 1128 and 1128A. By practice JEFFERSON CENTER FOR MENTAL HEALTH verifies through the Office of Inspector General (OIG) List of Excluded Individuals/Entities and any applicable state licensing authorities that the individual and organizational providers are in good standing and that there are no Medicare or Medicaid actions or sanctions.

Monthly OIG verification checks are completed on all employees of JEFFERSON CENTER FOR MENTAL HEALTH AND ALL BOARD MEMBERS.

**Procedures:**

1. **Credentialing of Individual Providers:**

All JEFFERSON CENTER FOR MENTAL HEALTH provider employees, who provide clinical services, are applicants for initial credentialing (licensed or non-licensed, degree or non-degreed) and are credentialed by the collaborative JEFFERSON CENTER FOR MENTAL HEALTH Credentialing Committee. A list of licensed staff that is credentialed is provided in Appendix D. Credentialing is completed based on the following procedures:

Each applicant is required to complete and submit the current Colorado Health Care Professional Credentials Application along with any additional supplemental information required by Jefferson Center for Mental Health within 14 days of employment. Employment is contingent on the Credentialing Coordinator receiving all information from the employee withing two weeks of their hire date.

To ensure the confidentiality of credentialing information , the individual credentialing files are maintained in a secure, locked location throughout the process by the Human Resource staff of JEFFERSON CENTER FOR MENTAL HEALTH. Relevant information is entered into the data bases (EHR and HRIS systems) maintained by JEFFERSON CENTER FOR MENTAL HEALTH. Electronic Credentialing files are housed in a secure folder in our secure system only accessible to the following, Practice Manager, CFO, HR Manager and Director and Credentialing Coordinator. Only authorized individuals at JEFFERSON CENTER FOR MENTAL HEALTH are involved in initial and updated data entry for both the HER and HRIS data bases.

Information in the databases is used to generate reports related to the status of the individuals’ credentialing and re-credentialing and ultimately forms the bases of Network Adequacy Reports for the Department of Healthcare Policy and Financing (HCPF) and Provider Directories. Information is kept consistent by updating Internal Provider Information forms upon re-credentialing or by notification of any changes by the provider themselves.

The completed application and required supplemental documents are submitted to the Credentialing Coordinator for JEFFERSON CENTER FOR MENTAL HEALTH. All information is sent and tracked via email and reports generated via the EHR system.

1. Within 30 days from receiving the credentialing packet, the Credentialing Coordinator completes the process of primary source verification and the credentialing packet for each applicant is prepared for presentation to the Credentialing Committee.
2. Within 180 days of any expiring information and the attestation statement date, the Credentialing Committee reviews the packet, using the Credentialing Committee Checklist (See Appendix B) to verify that all of the information is complete and accurate. This information is presented to the CREDENTIALING COMMITTEE, if the information is complete and accurate the CREDENTIALING COMMITTEE recommends the candidate for credentialing and prepares the packet for Medical Director approval and signature. The file is placed in a “pended” category if discrepancies are noted or there is need for additional information.
3. If discrepancies are noted or the file contains erroneous information the CREDENTIALING COORDINATOR will contact the applicant within (5) working days by email to inform the applicant of the discovery of erroneous or missing information. The applicant has two weeks to submit the requested additional information by email or provide clarification as needed for subsequent review by the CREDENTIALING COMMITTEE. Most modifications to the Credentialing application are primarily made by the employee. The CREDENTIALING COORDINATOR, and a designated HR team member (currently the Manager of Human Resources), who serves as the back up for the Credentialing Coordinator) are authorized users and can make modifications to the Credentialing application. Modifications are only permitted by authorized users, as defined above, prior to the final review by the Medical Director. Modifications will only occur under the following circumstances; when more current information may be required, for example a verification expired during the credentialing review, an error or omission made on the Credentialing application by the employee, a request from a Credentialing Committee member for clarification or additional information. Deletion of credentialing data is prohibited.
4. Applicants who do not meet the credentialing requirements are reviewed with the Medical Director prior to being sent a Denial of Credentials letter within 30 days of the CREDENTIALING COMMITTEE recommendation and concurrence of the Medical Director; the letter informs them of the basis for the denial, describes their rights to appeal, and outlines the appeals process.
5. Upon approval by the Medical Director, applicants who meet credentialing requirements are notified in writing by Human Resource staff of the JEFFERSON CENTER FOR MENTAL HEALTH within 60 days of the committee’s decision.
6. The signature date of approval by the Medical Director is established as the official date of credentialing for the practitioners. This official approval date is entered into the data bases maintained by the Credentialing Coordinator at JEFFERSON CENTER FOR MENTAL HEALTH.
7. The approval date becomes the date around which monitoring and tracking by the Credentialing Coordinator which ensures that re-credentialing of licensed providers is completed within 36 months. Information in the databases is used to generate reports related to the status of the individuals’ credentialing and re-credentialing to ensure re-credentialing is completed within the 36-month due date.
8. NCQA standards are followed and maintain by the Credentialing Coordinator and updated annually.
9. All Policies, Procedures and Processes will be audited annually by the internal Credentialing Audit Team (comprised of members from Human Resources, the Credentialing Committee and Practice Management). The annual audit will include a sampling of completed credentialing files (specifically five (5) initial credentialing files and five (5) re-credentialing files. The Practice Management team will be responsible for the oversight of the annual audit. The internal , annual audit will ensure the compliance of policies, procedures, accreditation standards, and the restriction of system and unauthorized modifications.
10. **Ensuring the Credentialing Process is Nondiscriminatory**

The JEFFERSON CENTER FORM MENTAL HEALTH Credentialing and Re-Credentialing Committee does not make decisions based on an applicant’s race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes. Monitoring of non-discriminatory credentialing and re-credentialing practices is conducted at least annually. In order to ensure the credentialing process is nondiscriminatory the following are in place:

Any applicant complaints, alleging discrimination, is referred to the appropriate JEFFERSON CENTER FOR MENTAL HEALTH Human Resource Department of Investigation. The JEFFERSON CENTER FOR MENTAL HEALTH Human Resource Department may request a corrective action of the credentialing committee if discriminatory practices are identified. At the same time the applicant is provided information on the appeal process (See section D).

1. **Provider Rights during the Credentialing and Re-Credentialing Process:**
2. Providers have the right to review all information obtained by JEFFERSON CENTER FOR MENTAL HEALTH during any phase of the initial credentialing process, including the source of the information , unless prohibited or protected by law. During the Re-Credentialing process, the Provider has the right to review all information, during any phase of the process, except the Compliance Review document. Providers may request to review their Credentialing packet and supporting documentation by emailing Human Resources Department at JEFFERSON CENTER FOR MENTAL HEALTH. Providers are notified of their right to review their Credentialing information in the Credentialing Overview document, and in the Credentialing and Re-Credentialing emails that are sent out to all clinical providers.
3. Providers can ask for the status of their Credentialing application at any point during the Credentialing or Re-Credentialing process. Providers can call or email the Credentialing Coordinator directly to inquire about the status of their Credentialing application. The Credentialing Coordinator will respond back to the Provider (typically within 48 hours, excluding weekends) by either email or phone with current status on their Credentialing application. Again, all information and documents will be shared during the initial Credentialing process and only the Compliance Review document is unable to be shared with any Provider that is being Re-Credentialed.

3. The JEFFERSON CENTER FOR MENTAL HEALTH Credentialing Coordinator will notify the applicant in writing of any information obtained during the credentialing process that does not meet JEFFERSON CENTER FOR MENTAL HEALTH credentialing verification standards or that varies substantively from the information provided by the applicant.

4. Copies of all application and credentialing and re-credentialing verification policies and procedures are available upon written request by contacting the JEFFERSON CENTER FOR MENTAL HEATLH Credentialing Coordinator.

5. Incomplete Credentialing applications will be returned to the applicant for correction with details and deadline for submission. The applicant will resubmit the application to the Credentialing Coordinator within 14 business days of notification of missing or incomplete information via email. The modified information will be added to tracking checklist including the date it was received. All modifications will be made by the employee unless the employee permits changes by the Credentialing Coordinator only.

6. Applicants will be notified in writing by the Credentialing Coordinator if the decision is to deny access to the network. The written notification includes the basis for denial and provides information about the appeals process. JEFFERSON CENTER FOR MENTAL HEALTH providers who are denied admission to the Center’s network are unable to serve clients of JEFFERSON CENTER FOR MENTAL HEALTH. Their continued employment with JEFFERSON CENTER FOR MENTAL HEALTH is contingent upon successful completion and approval of the Credentialing/ Re-credentialing packet.

7. To ensure confidentiality all information obtained for credentialing purposes shall be stored in a secure place. Only authorized individuals shall view or obtain the information. Users of the HRIS, HER and Electronic Credentialing files shall always use good security practices. This includes not divulging passwords and security information to others, logging out of applications when not using them for a period, not leaving logged-in computers unattended and not distributing Center software. Screen-saver password requirements and delay settings implemented for security reasons are not to be altered in any manner. Policies and procedures regarding laptops, cellphones and portable storage, as detailed in Remote, Mobile and Portable Device Policy, shall be followed. As per CMS guidelines all records will be maintained for a minimum of ten years.

8. All applicants for credentialing and/or re-credentialing have the right to be informed of the status of their application and their rights to appeal any decisions made during the process. Notification of these rights is provided in writing at the time of application. Any requests for the status of the Credentialing/Re-Credentialing process will also be responded to via email.

**D. Provider Rights to Appeal:**

In the event that the initial application for credentialing is denied based on failure of the applicant to comply with all applicable credentialing criteria, the right to appeal the decision is offered to the applicant. This same right to appeal and appeals process is extended to the provider in the event that the provider’s status as a practitioner is altered based on sanctions applied by the organization due to issues of quality of care or other service-related issues. Such actions may include but are not limited to corrective action, suspension, or termination.

**The appeals process includes:**

1. **If the CREDENTIALING COMMITTEE’S preliminary review finds that there may be sufficient cause to deny credentials, the applicant will be notified in writing by the Chair of the CREDENTIALING COMMITTEE. The written notification includes the reason for the action and summary of the appeal rights and process.**
2. **The applicant will have 30 working days from the receipt of the notice to appeal the decision and request a hearing in writing to the Chair. The applicant has the right to be represented by an attorney or another person of their choice and to appear before the CREDENTIALING COMMITTEE with legal counsel.**
3. **The appeal is presented to the Appeals Committee, members of which, except for the Chair, are not members of the CREDENTIALING COMMITTEE and includes appropriate licensed clinical staff with at least one member who is a peer of the applicant. The Chair of the CREDENTIALING COMMITTEE is not a voting member of the Appeals Committee and is present solely to ensure appeal procedures are followed. The Appeals Committee will make a recommendation to the Medical Director, who will determine the final decision.**
4. **The Appeals Committee meeting will occur on or before the next regularly scheduled CREDENTIALING COMMITTEE meeting. The applicant will be notified in writing within (5) days by the Chair of the CREDENTIALING COMMITTEE. The notification will include the specific reasons for the decision.**

**Consistent with JEFFERSON CENTER FOR MENTAL HEALTH re-credentialing and contracting standards providers are continuously monitored to ensure compliance with all contractual requirements including licensure, accreditation, and professional liability insurance, and compliance with JEFFERSON CENTER FOR MENTAL HEALTH Corporate Compliance Program. Also, providers are checked monthly against the Office of Inspector General List of Excluded Individuals and Entities (LEIE) to ensure that they are not listed as an excluded provider. Should reporting to outside entities be necessary, JEFFERSON CENTER FOR MENTAL HEALTH Human Resources team will be responsible for notifying the appropriate authorities when incidents are required to be reported. Reporting will occur when knowledge and appropriate review of reportable incidents occur, in compliance with all applicable reporting timeframes and guidelines specific to the entity/entities the report is being made to.**

1. **Ongoing Monitoring of Provider Performance:**

**In between re-credentialing cycles, a variety of strategies are employed to monitor and investigate concerns about provider performance including:**

1. **Clinical record reviews using JEFFERSON CENTER FOR MENTAL HEALTH approved Compliance Review checklists to be completed and approved by Supervisor.**
2. **Monitoring of grievances and complaints from Members as tracked and reported by the Office of Consumer Affairs.**
3. **Reports of professional misconduct by JEFFERSON CENTER FOR MENTAL HEALTH**
4. **Monitoring of encounter record and billing and claims accuracy**
5. **Monthly checks against Office of Inspector General and Colorado Department of Regulatory Agencies reports of Medicaid or licensure sanctions or limitations.**
6. **If JEFFERSON CENTER OF MENTAL HEALTH initiates any adverse licensure or professional review actions against a provider, a report will be made to the National Practitioner Data Bank and the Colorado Department of Regulatory Agencies. A copy of the report will be maintained in the JEFFERSON CENTER FOR MENTAL HEALTH’S personnel file for the provider.**
7. **If that providers status as a practitioner is altered based on sanctions applied by the organization due to issues of quality care or other service related issues the practitioner could be subject to actions that may include but are not limited to corrective action, suspension or termination.**
8. **Any on-going adverse actions that involve clinical staff will be monitored on a monthly basis.**
9. **Re-Credentialing:**

**All licensed providers will be re-credentialed by the CREDENTIALING COMMITTEE at least every 36 months. See Appendix C for a list of licensed providers that are re-credentialed. The following re-credentialing procedures include:**

1. **Upon approval by the Medical Director for initial credentialing, the official signature date is entered into the data bases maintained by JEFFERSON CENTER FOR MENTAL HEALTH. At the same time, the date for re-credentialing is entered so that timely reports can be generated to initiate the re-credentialing process.**
2. **A monthly report is generated that indicates all JEFFERSON CENTER FOR MENTAL HEALTH Staff that is eligible for re-credentialing in the next 180 days. Written notice is sent to all eligible providers via email along with a copy of their previous credentialing application.**
3. **There is a standing item on each meeting agenda related to monitoring and** tracking the timelines for both credentialing and re-credentialing.
4. The application and related documentation are submitted to the Credentialing Coordinator for primary source verifications on the identical criteria that were considered during the initial credentialing process using the same primary source verification resources.
5. The same timelines and procedures as outlined under the initial credentialing process apply to the re-credentialing process.
6. The re-credentialing process also includes an appraisal of the practitioners professional performance, judgement, and clinical competence along with other complaints, member satisfaction, peer review results and annual performance reviews conducted by JEFFERSON CENTER FOR MENTAL HEALTH as compiled by JEFFERSON CENTER FOR MENTAL HEALTH HR staff.
7. All compiled documents are reviewed by the CREDENTIALING COMMITTEE for accuracy and completeness prior to submission to the Medical Director for final approval.
8. The application and primary source verification information (Appendix B) is submitted to the Medical Director for approval.
9. The signature date of approval by the Medical Director is the official date of re-credentialing and is the date recorded in the appropriate data bases for continued monitoring.

1. **Monitoring of JEFFERSON CENTER FOR MENTAL HEALTH Provider Office Sites:**

An initial site visit is conducted on all JEFFERSON CENTER FOR MENTAL HEALTH offices by appropriate JEFFERSON CENTER FOR MENTAL HEALTH Practice Manager or appointed staff familiar with the office site requirements and the credentialing process. All individuals conducting office site visits are provided training in the use of the attached tool and criteria for scoring. In addition, complaints, regarding JEFFERSON CENTER FOR MENTAL HEALTH office sites are addressed as described below:

1. JEFFERSON CENTER FOR MENTAL HEALTH Director of the Office of Member and Family Affairs (OCFA) monitors member complaints or grievances and reports to the JEFFERSON CENTER FOR MENTAL HEALTH Director of Quality Improvement (QI) any complaints or grievances regarding the office site, including physical accessibility and appearance, adequacy of waiting or examining-room space, concerns regarding security and accessibility of medical records, and /or routine, urgent or emergent care availability.
2. Within three weeks of receipt of such a grievance or complaint the JEFFERSON CENTER FOR MENTAL HEALTH Director of QI or delegated staff, trained in conducting office site visits, will conduct an investigation of the site (see Appendix A). A score of less than 90% will result in a request for a corrective action plan (CAP) from JEFFERSON CENTER FOR MENTAL HEALTH.
3. Th CAP is approved by the Director of QI and the Medical Director. A follow-up visit will be conducted every six months until the performance standards are met. Any site visits that require follow-up for subsequent deficiencies will be documented.

 **Organizational Providers**

1. Process for Credentialing Organizational Providers (Ambulatory psychiatric and addiction disorder facilities and clinics, psychiatric and addiction disorder residential treatment centers, 24-hour behavioral healthcare units in general hospitals, other free -standing psychiatric hospitals and treatment facilities, child placement agencies, and others as needed).
2. Good standing of State and Federal licensing will be reviewed and documented by JEFFERSON CENTER FOR MENTAL HEALTH.
3. Good standing with the Office of Inspector General will be reviewed and documented by JEFFERSON CENTER FOR MENTAL HEALTH.
4. Accreditation review.
5. Review of recognized accrediting body credentials (Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF), and Council on Accreditations (COA), National Committee for Quality Assurance (NCQA), or other body as appropriate). An on-site quality assessment may be done.
6. If the facility is non-accredited, then an on-site quality assessment based on the size and complexity of the organizational provider may be done with possible interviews with staff.
7. Facilities that submit a current HCFA or State Agency review in a paper format or that can be verified via the Internet and certification my be able to substitute the HCFA or State Agency review as a site review subject to meeting quality assessment standards.
8. Behavioral healthcare practitioners that practice exclusively within the facility setting do not have to be individually credentialed because they are under the supervision of that facility. If any practitioner provides care to members independently, they are subject to the credentialing standards.
9. All of the above information will be sent to other MHASA’s to which the Organizational Provider wishes to apply for network status.
10. The individual MHASA’s Credentialing Committee will review all of the above information and a decision for inclusion in its Organizational Providers Network will be determined and documented.
11. For those accepted into the network, JEFFERSON CENTER FOR MENTAL HEALTH monitors the subcontractor’s performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State , Jefferson Center Peer Review, consistent with industry standards or State MCO laws and regulations.
12. Process for Re-credentialing Organizational Providers will take place at least every three years and will confirm that the organizational provider remains in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body if applicable.
13. Member complaints, information from quality improvement activities, information from utilization management activities, member satisfaction data, clinical record reviews, and site visits may also be a part of the re-credentialing decision-making process.
14. Behavioral healthcare practitioners that practice exclusively within the facility setting do not have to be individually re-credentialed because they are under the supervision of the facility. If any practitioner provides care to members independently they are subject to the individual provider re-credentialing standards.

 **by Jefferson Center for Mental Health-Credentialing Committee 11/20/2019**

 Appendix A

**OFFICE SITE VISIT CHECKLIST**

**Type of Review:** Follow-Up Member Complaint Date of Site Visit:

**Provider Name:**

**Address:**

**Office Representative Contacted Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. Exterior**

1. Sign(s) visible Yes No
2. Trash properly disposed of Yes No
3. Adequate parking available Yes No
4. Hours posted Yes No
5. Emergency number posted Yes No
6. Building appears in good repair Yes No

*(Total Points Exterior \_\_\_\_\_\_/ 6 possible)*

**2. Provisions for the Physically Disabled**

1. Handicap parking available Yes No
2. Wheelchair accessible entrance Yes No
3. Wheelchair accessible restrooms/exam rooms Yes No
4. Support rails in restrooms Yes No

If no to 2A – D, what accommodations are made?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*(Total Points Handicapped Accessibility / 4 possible)*

**3. Reception Room**

1. Clean/good repair Yes No
2. Exits clearly marked Yes No
3. Adequate seating for patients Yes No
4. Adequate Lighting Yes No

*(Total Points Reception Room\_\_\_\_\_\_\_/ 4 possible)*

**4. Office Rooms/Restrooms**

Number of Rooms: \_\_\_\_\_\_\_\_ Number of Restrooms: \_\_\_\_\_\_\_\_\_

1. Clean/good repair Yes No
2. Hand washing facilities in each exam room and restroom Yes No
3. Separate receptacles for paper waste and hazardous waste Yes No

*(Total Points Rooms and Rest Rooms\_\_\_\_\_\_\_\_/ 3 possible)*

**5. Medical Records**

1. Secure/confidential filing system Yes No
2. Legible file markers Yes No
3. Records easily located Yes No

*(Total Points Medical Records\_\_\_\_\_\_\_\_/ 3 possible)*

**6. Appointment Availability**

1. Routine office visit offered within 7 days Yes No
2. Urgent care within 24 hours Yes No
3. Emergency care within one hour Yes No

*(Total Points Appointment Availability\_\_\_\_\_\_\_\_/ 3 possible*

**Total Points: \_\_\_\_\_\_\_\_\_\_\_\_\_\_/ 23 possible SCORE: \_\_\_\_\_\_\_\_**

**Initial Credentialing -JCMH Individuals Credentials Committee Checklist**

**Applicant Name**: **\_\_\_\_\_\_\_\_\_\_\_\_ Licensed: \_\_\_\_\_\_\_** **Date:** **\_\_\_\_\_\_\_\_\_\_**

1.\_\_\_\_\_**Attestation date: \_\_\_\_\_\_\_\_\_\_** is within 180 days of the date of the Credentialing Committee

2. \_\_\_\_\_Doctors/Nurses as applicable, **DEA** Certification is verified and is current (DEA certificate and Verification from DEA website on file along with copy of applicant’s DEA certificate.

3.\_\_\_\_\_ If Applicable, **Board Certification** is verified (American Board of Medical Specialties, **ABMS** or American Nurses Credentialing Center for Board Certified Nurse Practitioners **ANCC**.) If candidate claims to be board certified, confirmation from the appropriate specialty board is required from the candidate and/or specialty board in the form of certificate or letter.

4.\_\_\_\_\_**Education**-the highest degree has been verified and agrees with the application. (This can be done by having a **current active CO license** or by providing a copy of **Diploma**, **official transcripts** or degree verification from the National Student Clearinghouse (**NSC**-**verification on file**) or verified directly through the college or university.

5.\_\_\_\_\_For licensed staff, State license has been verified, agrees with application, and is **current without any actions or sanctions**. If there are any actions/sanctions they must be reviewed once all info. concerning the account is in the file. (Copy of license and **DORA** verification on file).

6. \_\_\_\_\_**Malpractice Insurance** is current and present in file for $1 mil and $3 mil for mental health service, if not a JCMH staff provider. If any litigations or claims, they must be reviewed once all info.concerning the account is in the file. If applicable, documentation of the satisfactory resolution of claims history issues is in the file. (**NPDB** report is on file.)

7.\_\_\_\_\_Verification that the **DHHS (OIG List)** has been verified and there are no Medicare or Medicaid actions or sanctions. If there are any actions/sanctions, file must be reviewed once all info. concerning the account is in the file. (**OIG** report showing no reports found on file.

8**.\_\_\_\_\_ Medicare OPT OUT has been queried to verify applicant does not appear** on list.

9.\_\_\_\_\_**SAM** (Systems Award Management) list is verified and no sanctions were found.

10.\_\_\_\_\_**Work history** is verified for at least **5 years** with gaps in employment of **180 days or more accounted for**. (If any gap, written explanation is included or verification from HR)

11.\_\_\_\_\_\_ As applicable, **current hospital and other facility affiliations** are listed and there is no history of dismissal, revocation, suspension, limiting, denial, refusal, voluntary surrender or formal notice of action against privileges. If any actions of the above then must be reviewed once all info. concerning account is in the file.

12.\_\_\_\_\_**Attestation to all items is “NO”** (Any questions with a “yes” will have been reviewed including written documentation of satisfactory resolution).

13.\_\_\_\_\_**Attestation/Participation Statement has been signed and dated.**

**Credentialing Committee members are required to recommend this applicant for Medical Director Approval:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**JCMH MEDICAL DIRECTOR APPROVAL**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

¨APPROVAL NOTIFICATION SENT TO APPLICANT DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

¨APPROVAL DATE ENTERED IN AVATAR DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **ReCredentialing – JCMH Individual Credentials Committee Checklist**

Applicant Name: **\_\_\_\_\_\_\_\_\_\_**LIC: **\_\_\_\_\_\_\_\_\_**Date: **\_\_\_\_\_\_\_\_\_**Prev. Cred Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1.\_\_\_\_\_**Attestation** date **\_\_\_\_\_\_\_\_\_\_\_**is **within 180 days** of the date of the Credentialing Committee review. 2.\_\_\_\_\_\_\_\_Doctors/Nurses as applicable, **DEA** Certification is verified and is current (copy of DEA Certificate and verification from DEA Website on file.

 3.\_\_\_\_\_\_\_\_Education – The highest degree has been verified and agrees with application. This can be done by having a current active Colorado license, by providing a **copy of diploma**, official graduation transcript or verification by **NSC or directly through College or University**.

4.\_\_\_\_\_\_\_\_For licensed staff, license has been verified by **DORA**, agrees with appl. and is current without actions/sanctions. If there are any actions/sanctions they must be reviewed prior to Committee review.

5.\_\_\_\_\_\_\_\_Malpractice Insurance is current and present in file for $1 and $3 mil for M.H service, if not JCMH staff provider. If any litigations or claims on **NPDB**, must be reviewed once all info concerning the account is in the file.

6.\_\_\_\_\_\_\_\_Verification that the DHHS (**OIG** List) has been verified and there are no Medicare or Medicaid actions or sanctions. If there are any actions or sanctions, then must be reviewed once all info concerning the account is in the file.

7.\_\_\_\_\_\_\_\_**Medicare Opt Out** has been queried to verify applicant does not appear on list

8.\_\_\_\_\_\_\_\_Work history is verified for **at least 5 years** with any **gaps in employment of 90 days or more accounted for**.

 9.\_\_\_\_\_\_\_\_**SAM (Systems Award Management)** has been verified and no sanctions were found.

10.\_\_\_\_\_\_\_If applicable, Board Certification is verified (American Board of Specialties-**ABMS** or American Nurses Credentialing Center for Board Certified Nurse Practitioners –**ANCC**. If candidate claims to be Board Certified confirmation from the appropriate speciality board is required from the candidate and specialty board in the form of certificate or letter.

11.\_\_\_\_\_\_\_\_As applicable, **current hospital and other facility affiliations** are listed and there is no history of dismissal, revocation, suspension, limiting, denial, refusal, voluntary surrender or formal notice of action against privileges. If any actions of the above, then must be reviewed once all information is in file.

12.\_\_\_\_\_\_\_\_Attestation to all items is “no”. If any questions have a “yes”, then, must be reviewed once all information concerning the account is in the file.

13.\_\_\_\_\_\_\_Attestation/Participation Statement has been signed and dated.

14.\_\_\_\_\_\_\_\_To the best of our knowledge, the provider has complied with applicable Provider agreements, Provider billing manuals and/or Provider bulletins

15. \_\_\_\_\_\_\_\_To the best of our knowledge, the provider has complied with applicable federal and state statutes and regulations.

16.\_\_\_\_\_\_\_\_To the best of our knowledge, the provide, either by omission or commission, has not endangered the health, safety or well-being of a JCMH consumer.

17.\_\_\_\_\_\_\_\_To the best of our knowledge, the provider has not demonstrated a pattern of abuse, meaning inconsistent fiscal, business, or medical practices.

18.\_\_\_\_\_\_\_\_To the best of our knowledge, the provider has demonstrated quality clinical work.

19.\_\_\_\_\_\_\_\_To the best of our knowledge, the provider has demonstrated quality customer service

 **Credentialing Committee members are required to recommend this applicant for Medical Director approval\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 JCMH Medical Director Approval\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Notification Sent to Applicant Date \_\_\_\_\_\_\_\_\_\_\_\_ Approval Date Entered in Avatar Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix D**

**LICENSE TYPES**

Licensed Professional LPC

Licensed Social Worker LSW

Licensed Clinical Social Worker LCSW

Licensed Marriage and Family Therapist LMFT

Registered Pharmacist Rph

Doctor of Pharmacy PharmD

Certified Addiction Technician CAT

Certified Addiction Specialist CAS

Licensed Addiction Counselor LAC

Licensed Practical Nurse LPN

Registered Nurse RN

Advanced Practice Nurse APRN

Clinical Nurse Specialist CNS

Licensed Psychologist LP

Medical Doctor MD

Doctor of Osetopathic Medicine DO

Drug Enforcement Agency DEA

**2021 Credentialing Committee Members**

Vicki Mackenzie- HR Manager

Karen Hess-Credentialing Coordinator

Katie Loesch- LPC

Olivia Lawson-LPC, LAC

Charity Miller-LCSW

Alyssa Stevens-LPCC

Joshua Mitchell-Peer Specialist