

Provider Responsibilities

Coverage when the Provider is Unavailable

Providers are responsible for arranging 24-hour/7 days per week coverage for their clients. Please Note: Use of hospital emergency departments or a Community Mental Health Center is unacceptable unless a contractual arrangement exists. NBH suggests setting up a voicemail with the phone number of the call coverage therapist when call coverage is needed. The voicemail can state that if the client is a danger to self or others, to go to the nearest emergency room.

Provider Availability

All NBH providers are expected to see Medicaid consumers within the following guidelines:

ROUTINE: Within seven (7) calendar days of a request for a routine appointment.

URGENT: Urgent care shall be available within twenty-four (24) hours.

EMERGENCY: Emergency condition means a condition when acute symptoms are of sufficient severity that the prudent layperson, or one who possesses an average knowledge of health and medicine, could reasonable expect that the absence of immediate medical attention or mental health services could result in the following:

- (1) Placing the health, safety, and/or well being of the individual, or another person in serious jeopardy.
- (2) Leaving the person in a state of psychiatric impairment so severe that the person could not be reasonable expected to take care of him/herself.

In all cases, providers must notify NBH immediately at the following numbers:

Northeast Behavioral Health, L.L.C... (888) 296-5827
Larimer Center for Mental Health..... (970) 494-4200
Centennial Mental Health Center (970) 522-4392
North Range Behavioral Health (970) 347-2120

Emergency psychiatric admissions of up to 72 hours will be authorized if the consumer's situation meets emergency hospitalization criteria. Refer to Section Five after that period. Providers must follow the inpatient concurrent review process. All NBH providers must offer 24-hour emergency access to their consumers and have formal arrangements or emergency coverage. For details, please

refer to the next section, titled Coverage Then the therapist is Unavailable.

Emergency telephone contacts must be responded to within 15 minutes. For in-person emergency services the acceptable standards are:

- In-person within one (1) hour of contact in urban and suburban areas.
- In-person within two (2) hours of contact in rural areas and frontier areas.

The standard applies to the time that occurs for a qualified mental health professional to contact the consumer requesting emergency services. If a consumer does not accept the offered appointment and chooses a later appointment the intent of the standard has been met, so long as the offered appointment is within the prescribed timeframes as stated above.

Pre-authorization

Pre-authorization is required for all services with the exception of emergency care provided by a hospital emergency department. (Refer to the Utilization Management section of this manual for further information.)

CCAR (Colorado Client Assessment Record)

The CCAR is required for all clients who receive services that have been pre-authorized.

Review of Medicaid Rights and Benefits with Clients

Providers are required to provide the following written materials to a client at the first appointment. Providers should be prepared to discuss and answer questions regarding these materials, specifically with regard to a client's Medicaid rights and benefits. The Disclosure Statement should be completed, signed by the client or parent/guardian, and filed in the client's chart. A copy of the Disclosure Statement should be given to the client. All written materials are available in both English and Spanish from NBH.

Consumer Handbook

Providers are required to have copies of Consumer Handbook and to give the client a copy. Providers should specifically reference and discuss with the client the sections regarding services and rights and responsibilities

Advance Directives

Providers should ask client if he/she has completed Advance Directives and, if so, request a copy for the client's chart. If not, give client an Advance Directives brochure.

EPSDT (Early Periodic Screening Diagnosis & Treatment)

For clients under 21 years of age, Providers are required to ask if the client has a primary care provider and if they are receiving health screens. If they are not, they may qualify for the EPSDT program, which is a federal program that requires States to assist clients in getting these services. Providers will give the client an EPSDT brochure.

Postings

Providers are required to post information on Consumer Rights and Responsibilities, Grievances, Privacy Practices and how to contact the Ombudsmen. NBH has provided this information on a poster and requires that Providers hang the poster in their reception area. NBH has also provided Ombudsmen Fliers to be posted and can be handed out to clients. NBH has all postings available in English and Spanish.

Provider Complaints

NBH follows the DOI and HCPF rules (effective July 1, 2001) in addressing Provider complaints. Providers may file a complaint with NBH at any time to express dissatisfaction. Providers may express their complaint in written or verbal form to the Provider Coordinator at 970-347-2360. Upon receipt of the complaint, the Provider Coordinator conducts a review within fifteen (15) working days and notifies the Provider of the results of the review within two (2) working days of the resolution.

Provider Confidentiality Requirements

The contractual relationship between NBH and Providers, as well as the relationship between the Provider and Consumers establish the following requirements related to confidentiality:

- Providers agree to maintain the medical and claims-related data concerning services provided to Consumers that they would maintain in the normal course of business.
- Providers must insure that each Consumer's medical record is treated as confidential so as to comply with all applicable provisions of HIPAA, local, State, and Federal laws and regulations regarding the confidentiality of records.
- Upon reasonable notice, and during normal business hours, the Provider permits NBH and appropriate State and Federal authorities to inspect and make copies of the medical records of Members for the purpose of assessing quality of care, medical necessity or the nature and extent of costs and services provided, or for the purpose of investigating Member appeals.

- Providers will cooperate with NBH to ensure that all consents or authorizations for release of information are in conformity with applicable State and Federal laws and regulations governing the release of records, or any information contained in the record.
- Providers will also ensure that any records meet all applicable Federal and State laws related to the storage, transmission, and maintenance of records including all applicable standards of HIPAA.

Program Integrity

NBH will obtain from each Participating Provider a Disclosure of Ownership and Control Information as part of the contracting process.

NBH will report to the National Practitioner Data Bank and to the appropriate state regulatory board all adverse licensure or professional review actions that we take against any Participating Provider.

NBH will report possible instances of Medicaid fraud to the Department within ten (10) business days of receipt of information. This information will include specific background information, the name of the Provider, and a description of how NBH became knowledgeable about the occurrence

Credentialing and Recredentialing

NBH will comply with the standards of the National Committee on Quality Assurance (NCQA) for initial credentialing and recredentialing of providers in the NBH provider network. NBH may also use information from the accreditation of primary care clinics by the Joint Commission on Accreditation of Health Care Organization (JCAHO) to assist in meeting NCQA credentialing standards.

NBH will respect the confidentiality of providers and has an appeals process, which allows providers the opportunity to correct erroneous information.

NBH will not contract with providers excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Act. NBH verifies non-exclusion on the website of the HHS Office of Inspector General prior to contracting with a provider.

NBH will not contract with or include in its Network employees of any community mental health center independent of their employment at the community mental health center.

NBH does not offer an Incentive Plan, i.e., any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan member, to any of its physicians within the network.

NBH will request a copy of and document that laboratory-testing sites have a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of

Registration with a CLIA number. This will be done during the contracting period and as Certificates expire.

Types of Practitioners Credentialed and Re-credentialed by NBH

NBH's provider network generally consists of, but is not limited to, Doctors of Medicine (MDs), Doctors of Osteopathic Medicine (DOs), PhD, PsyD, LPsy, LCSW, LPC, LMFT, RN, NP, CNS or RXN and other licensed independent practitioners with whom it contracts or employs, and who render services or authorize services to members, and who fall within the Contractor's scope of authority and action.

NBH assesses organizational providers with which it intends to contract. These providers include hospitals, residential care facilities, Community Mental Health Centers, outpatient provider groups, and child placement agencies. Please see Organizational Credentialing below.

Verification Sources Used

The following information is verified from primary sources, unless otherwise indicated, and is no more than 180 days old at the time of the credentialing decision.

- Education Verification – The National Student Clearinghouse or copy of diploma
- Licensure – State of Colorado Mental Health Licensing
- Medicare/Medicaid Sanctions – HHS Office of Inspector General: Exclusions Database and (NPDB)
- State Sanctions/Criminal background – Colorado Bureau of Investigation
- Claims History – National Practitioner Data Bank (NPDB)
- Child Abuse History – Colorado Department of Human Services: Background Investigation Unit

Criteria for Credentialing and Re-credentialing

NBH will utilize this criterion to outline the minimum requirements to be met by an applying network practitioner.

Professional Criteria:

Psychiatrists:

- Must be a Doctor of Medicine (MD) or Doctor of Osteopathy (DO)
- Must be board certified or eligible, as defined by the American Board of Psychiatry and Neurology
- Must be licensed in the State of Colorado
- Must possess current DEA certificate
- Must possess current State Controlled Substance Registration certificate
- Must complete a training program approved by the American Council

of Graduate Medical Education (ACGME) or Osteopathic approved training program in psychiatry

- Must possess an Education Council for Foreign Graduates (ECFMG) certificate, if graduate of foreign medical school

Psychologists:

- Must be licensed independently as a clinical psychologist at the highest level in the State of Colorado
- Must possess a Doctoral Degree in Psychology (PhD, PsyD, LPsy) from an accredited college or university

Social Workers:

- Must possess a Master's Degree in Social Work from a graduate school of social work accredited by the Council on Social Work Education
- Must be licensed by the State of Colorado or certified to practice at the highest level of independent practice in the State of Colorado

Psychiatric Nurses/Clinical Specialists (APN/NP/CS/CNS/RXN):

- Must possess a Master's degree in psychiatric nursing from an accredited college or university
- Must be licensed by the State of Colorado to practice at the highest level of independent practice in the State of Colorado
- If RXN, must be licensed by the State of Colorado with prescriptive authority privileges

Other Clinicians (Licensed Marriage and Family Therapist, Licensed Professional Counselors):

- Must possess a Master's degree in field of practice from an accredited college or university
- Must be licensed by the State of Colorado or certified at the highest level of independent practice in the State of Colorado

Clinical Experience

All eligible practitioners must have a minimum of three years post licensure experience in a mental health/substance abuse setting providing direct patient care. The credentialing committee can waive this requirement if the provider is in a rural or underserved area.

Providers Excluded from Participation

In conjunction with policies and procedures developed and administered by the Human Resources and Provider Relations Departments, all current and NBH or Center new employees and all subcontracted clinical providers are screened to determine whether they have been (1) convicted of a criminal offense related to health care; or (2) listed by federal agency as debarred, excluded or otherwise

ineligible for federal program participation, as required by current federal and state laws. The latter is verified through the Office of Inspector General Exclusions Database at the HHS website.

Providers Who Serve High-risk Populations

NBH does not discriminate against providers who serve high-risk populations. NBH has determined that 75% of its population meets the HCFA definition of Special Health Care Needs. As such this population requires intensive treatments such as home based services, intensive case management services, residential treatments, and inpatient treatments and recruits these providers intentionally.

High Volume Practitioners

In-person audits, which included a site review, are conducted for most providers within the NBH service area. High volume practitioners must have a site visit prior to initial credentialing as well as every re-credentialing period.

High Volume for existing providers and facilities: NBH defines high volume as any provider or organization that increases its number of consumers served by twenty-five percent as compared to the previous fiscal year, unless that provider or organization serves four clients or less in that fiscal year.

High Volume for new providers and facilities: For initial credentialing, NBH will ask for the number of Medicaid consumers seen over the past two years. NBH will use the average penetration rate to determine the possible number of consumers served. If this number is 15 or greater, the provider or organization is considered high volume. Mental Health Centers and FQHC's are considered high volume facilities.

Procedures for Change in Practitioner Status

All decisions about altering the practitioner's relationship with NBH include, but are not limited to issues of quality of care and service, information submitted by the practitioner, as well as objective evidence.

Decisions are guided by mental health consumer care considerations. Causes for sanctions include but are not limited to:

- The clinical competence of NBH practitioner
- The care or treatment of a mental health consumer
- Violation of ethical standards or the policies, rules or regulations of NBH
- Behavior or conduct that is considered lower than the standards of safe and prudent practice
- Failure to achieve satisfactory utilization, cost and quality review results
- Non-compliance with terms and agreements set forth in the contract or corporate compliance guidelines
- Failure to comply with provider policies and procedure manual
- Failure to submit re-credentialing materials within requested timeframes

- Failure to comply with quality improvement activities

Change of Practice Location

If a current provider moves to a location, leaves a group practice, or opens a new location within the NBH service area, the practitioner is required to notify NBH within 30 days. NBH will conduct an office site visit within 30 days of notification of the practitioner's move.

Provider Information Changes

To avoid a delay in reimbursement of submitted claims, Providers must notify NBH to update records with changes to any of the following demographic information:

- Employment of a billing service
- Primary mailing address changes
- Billing address changes
- Practice/service address changes
- Telephone number changes
- Facsimile number changes
- E-mail address changes
- Name change(s)
- Employee Identification Number (EIN)
- Social Security Number (SSN)
- National Practitioner Identification Number (NPI)

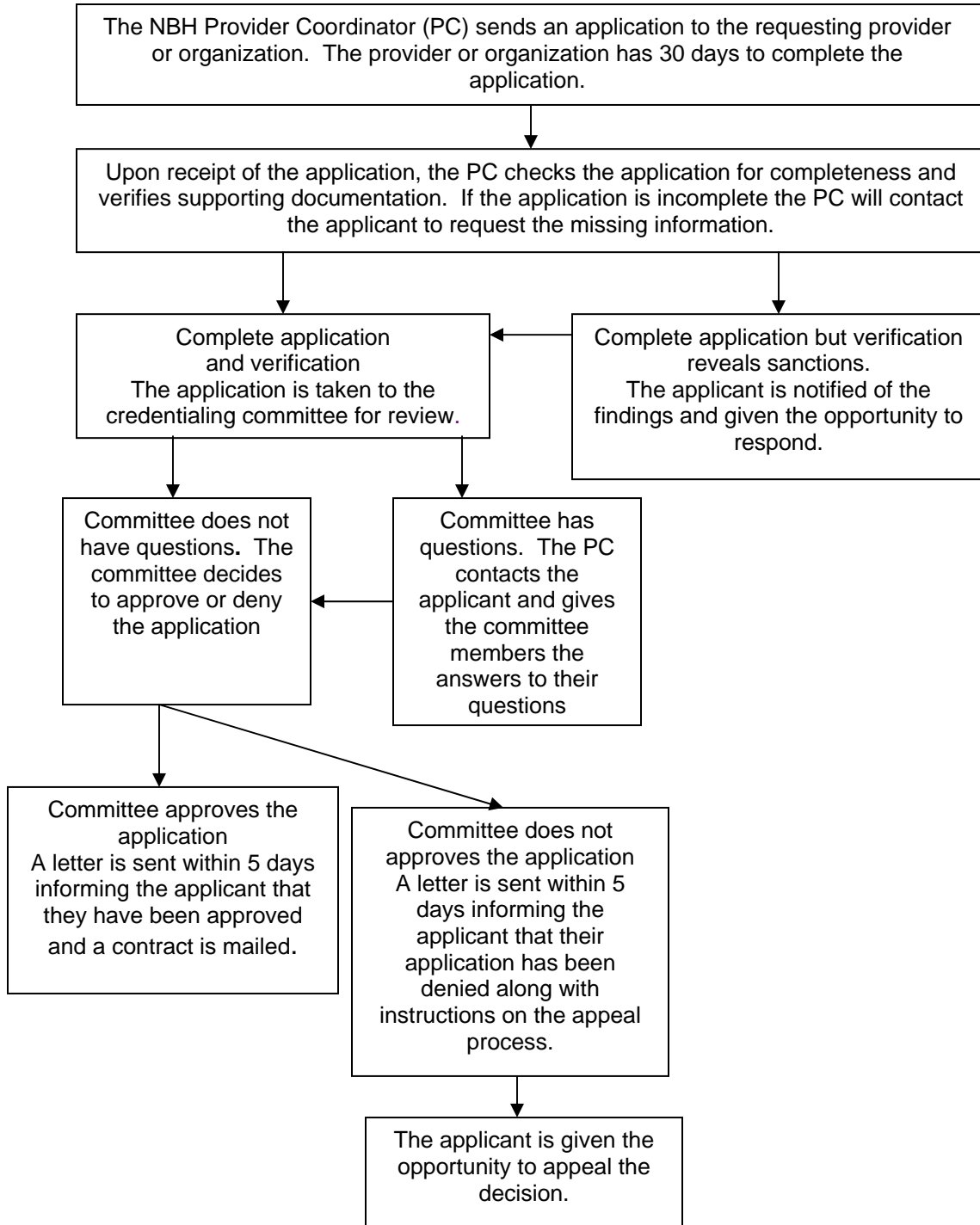
Any changes to Provider records must be submitted in writing to the address below, faxed to (970) 392-1354, or via the NBH website.

NBH
Provider Coordinator
1306 11th Avenue
Greeley, CO 80631

Credentialing Process – refer to flow sheet below for details

- Provider requests participation in the NBH Independent Provider Network
- Provider completes the Colorado Health Care Professional Credentials Application, addendum packet and releases of information to NBH to request CBI background check and Child Abuse Registry check.
- NBH conducts Primary Source Verification in accordance with NCQA standards.
- Once all the information has been verified, the Provider Coordinator will review the file and approve it as a “clean file,” deeming the file ready for the Credentialing Committee to review.
- The application is presented to the NBH Credentialing Committee.
- If the NBH Credentialing Committee approves the provider for participation in the Independent Provider Network, the provider is notified within 5 business days.

Credentialing Process



Process for Managing Credentialing Files

A current file is maintained on-site for each provider contracted with or employed by NBH. The information contained in the file includes by is not limited to the following:

- A current application and CV, which includes a minimum five years of relevant work history
- Current State Professional License to practice
- Current DEA license, as applicable
- Current Professional Liability Policy face sheet
- Hospital Staff Privileges, as applicable
- Evidence of professional medical education including ECFMG, as applicable
- Evidence of Board Certification, as applicable
- NPDB (National Practitioners Data Bank) query, to confirm the past five years of history of malpractice settlements from the malpractice carrier, as applicable
- FSMB (Federation of State Medical Boards) query, as applicable
- Evidence of site review, as applicable
- Child Abuse Registry Query (youth providers only)
- Colorado Bureau of Investigation (CBI) Query
- List of Excluded Individuals and Entities (maintained by OIG) to monitor Medicare and Medicaid sanction activity, as applicable

Results of the verification process and who was contacted will be documented in the credentialing file. A cover sheet that includes this information will be in each file. NBH uses the NMS program to track timeframes and required documentation. This system will also generate reports regarding when re-credentialing is required, when professional liability coverage and licensure will expire and any additions and deletions to the network. NBH will not send claims payments to providers without current credentialing, insurance, and licensure. The files will include the date the Credentialing Committee approved the provider or organization and the answers to any questions the committee had regarding the application.

Non-Discrimination

Credentialing decisions are not based on race, ethnic/national identity, gender, age, sexual orientation or the types of procedure or patient in which the practitioner specializes. The Compliance Committee will review all denials into the network to ensure discrimination was not a factor in the decision to deny.

Practitioner Notification when credentialing information varies from application

See Practitioner Rights

Practitioner Notification of Credentialing Decisions

Practitioners are notified of credentialing and re-credentialing decisions in writing within 60 calendar days of the Credentialing Committee's decision.

- Applicant Approved by the Credentialing Committee

If the credentialing committee approves the applicant, a letter of acceptance is sent to the Applicant.

- Applicant Not Approved by the Credentialing Committee

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. The applicant will be notified of their appeal rights via a denial letter.

The appeals process includes:

1. If the Credentialing Committee's preliminary review finds that there may be sufficient cause to deny credentials, the Chair of the Credentialing Committee will notify the applicant in writing. The applicant will have seven (7) working days from the date of receipt of the notice to appeal the decision in writing to the Chair.
2. The Credentialing Coordinator will present the appeal to the Credentialing Committee at its next regularly scheduled meeting for discussion. The decision of the Credentialing Committee will be presented to the Medical Director for review and considered final at this point. The Credentialing Coordinator will notify the applicant in writing within five (5) days.

Procedures to Maintain Confidentiality

- NBH Credentialing Files are stored in Locked Files behind 2 locked doors
- NBH Credentialing Database has restricted access to credentialing staff only
- Documents distributed for review at Credentialing Committee meetings are collected and destroyed

Provider Directory

A list of network providers is available on the NBH website, www.northeastbho.org. Providers are requested via the quarterly provider newsletter to verify the accuracy of the listings. The source of the information comes from the NMS credentialing database.

Practitioners Rights

- Practitioners maintain the right to review the information submitted in the support of their credentialing application.
- Practitioners will be notified in writing of any information obtained during the organization's credentialing process that varies substantially from the information provided to NBH by the practitioner. The provider will have 30

days from the date of notification to respond in writing. The notification will instruct the provider to direct their response to the NBH Provider Coordinator. The Provider Coordinator will document the receipt of the corrections in the credentialing file.

- The practitioner maintains the right to correct erroneous information.
- The information collected during the credentialing process will be kept confidential, except as otherwise required by law.
- Practitioners maintain the right, upon request, to be informed of the status of their credentialing or re-credentialing application.

Notification of Providers of Their Rights

Providers will be notified of their rights in the credentialing or re-credentialing application addendum packet, which is sent to practitioners with their Colorado Health Care Professional Credentials Application. Should a provider not be accepted into the network, they will be notified of their appeal rights via a denial letter. A template of the letter can be found with the forms at the end of this section.

Initial Credentialing Verification

The following information is verified from primary sources, unless otherwise indicated, and is no more than 180 days old at the time of the credentialing decision.

Doctors of Medicine and Doctors of Osteopathic Medicine

- A current valid license to practice verified by the State Medical Board
- Clinical privileges are confirmed either by oral or written form, from the practitioner's primary inpatient admitting organization or from an NBH designated participating hospital
- A valid DEA or CDS certificate, as applicable
- Verification of the highest level of credentialed education and training attained
 - If the practitioner is board certified verification of board certification fully meets this requirement
- Completion of residency training:
 - Confirmation from the residency training program, or
 - Entry in the AMA Physician Master File, or
 - Entry in the AOA Physician Master File
- Graduation from medical school:
 - Confirmation from the medical school, or
 - Entry in the AMA Physician Master File, or
 - Entry in the AOA Physician Master File
 - Confirmation from the Education Commission for Foreign Medical

Graduates for International medical graduates licensed after 1986

- Verification of Board Certification by:
 - › Entry in the ABMS Compendium; or
 - › Entry in the AMA Physician Master File, or
 - › Entry in the AOA Physician Master File
 - › Confirmation from the appropriate specialty board
- Five years of work history should be included on the application or a curriculum vitae (primary source verification is not required)
- A copy of the providers current Malpractice Coverage indication a minimum coverage of \$1 million per occurrence and \$3 million per aggregate
- Verification of the last five (5) years of history of malpractice settlements from the malpractice carrier or query the National Practitioner Data Bank

Doctors of Psychology (PhD, PsyD, LPsy), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC), Nurse Practitioners or Clinical Nurse Specialists (NP or CNS/CS)

The following information is verified from primary sources, unless otherwise indicated, and is no more than 180 days old at the time of the credentialing decision:

- A current valid license to practice verified by the appropriate State Licensing Board
- Clinical privileges are confirmed either by oral or written form, from the practitioner's primary mental health consumer admitting organization, as applicable
- Verification of graduation from accredited college or university
- Minimum possession of a Master's degree or Doctorate in field of practice from an accredited college or university
- Licensure by the state of Colorado or certified at the highest level of independent practice in the state of Colorado
- Five years of work history should be included on the application or a curriculum vitae (primary source verification is not required)
- A copy of provider's current malpractice insurance indicating a minimum coverage of \$1 million per occurrence and \$3 million aggregate
- Verification of the last five (5) years of history of malpractice settlements from the malpractice carrier or query the National Practitioner Data Bank

Application and Attestation

The provider completes the Colorado Health Care Professional Credentials Application Form which includes a statement regarding:

- Reasons for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license or felony conviction
- History of loss or limitation of privileges or disciplinary activity
- Current malpractice insurance coverage
- Attestation of correctness and completeness of the application

Initial Sanction Information

The following information is reviewed and included in the credentialing files:

- NPDB query, which includes Medicare and Medicaid Sanctions
- State Board of Medical Examiners query
- Federation of State Medical Boards query
- Colorado Child Abuse Registry query
- Colorado Bureau of Investigation query

Practitioner Office Site Quality

NBH will accept a survey report rather than conduct a site visit when a practitioner has an office located in an accredited organization. For non-accredited facilities, NBH will conduct an initial site visit on all high volume practitioners at such time as the number of active NBH clients approaches the “high volume” criteria.

NBH Credentialing staff will contact the provider to schedule a site visit at a mutually agreeable time. NBH will not conduct unscheduled visits. The provider will be supplied with the site visit audit tool and an explanation of relevant NBH standards prior to the site visit. Office site visit review form will be used in all site visits.

Providers are expected to meet 80% compliance against all of the following required site visit items:

- Physical accessibility
- Physical appearance
- Adequacy of waiting - and examining – room space
- Availability of appointments
- Adequacy of treatment record keeping
- Required signage displayed

The provider or office representative will receive a copy of the site visit review form at the conclusion of the site visit.

If the provider does not meet the 80% standard, a request for an action plan will be given to the provider within 10 days and a follow-up site visit will be conducted

within 90 days. The provider may be suspended from the network if the office does not meet NBH's standards after the second audit.

Site Visits and Ongoing Monitoring

The Director of Quality Improvement is responsible for site visits and ongoing monitoring of the quality of care and performance standards of practitioners. Refer to section for Quality Improvement for further information regarding clinical reviews and medical/treatment record requirements.

NBH monitors complaints via the Office of Consumer and Family Affairs and the Compliance Officer's hotline.

The NBH Director of Quality Improvement will conduct a site visit and reevaluate the site every six months or more often if appropriate until compliance is met when:

- A complaint is received from a member regarding the quality of a practitioners office site
- A problem with the quality of a practitioner's office site is discovered during a clinical quality review.

The Director of Quality Improvement will report the findings to the appropriate NBH core committee.

Recredentialing Verification and Cycle Length

Re-credentialing will take place within 36 months after the date of the previous credentialing decision. The Re-credentialing process will begin at least 90 days prior to the date at which initial Credentialing or Re-credentialing will expire.

The following information is verified from primary sources, unless otherwise indicated, and is no more than 180 days old at the time of the credentialing decision.

Doctors of Medicine and Doctors of Osteopathic Medicine

- A current valid license to practice verified by the State Medical Board
- Clinical privileges are confirmed either by oral or written form, from the practitioner's primary inpatient admitting organization or from an NBH designated participating hospital
- A valid DEA or CDS certificate, as applicable
- Verification of Board Certification by:
 - › Entry in the ABMS Compendium; or
 - › Entry in the AMA Physician Master File, or
 - › Entry in the AOA. Physician Master File
 - › Confirmation from the appropriate specialty board
- A copy of the providers current Malpractice Coverage indication a minimum coverage of \$1 million per occurrence and \$3 million per

aggregate

- The provider completes an application which includes a statement regarding:
 - › Reasons for any inability to perform the essential functions of the position, with or without accommodation
 - › Lack of present illegal drug use
 - › History of loss or limitation of privileges or disciplinary activity
 - › Current malpractice insurance coverage
 - › Attestation of correctness and completeness of the application
- The following information is reviewed and included in the credentialing files:
 - › Appropriate State Licensing Board query
 - › Verification of Exclusions from the Office of Inspector General Exclusions Database at the HHS website
 - › Colorado Bureau of Investigation (CBI) Query
 - › Colorado Child Abuse Registry query (youth providers only)
 - › NPDB query, which includes Medicare and Medicaid Sanctions

Doctors of Psychology (PhD, PsyD, LPsy, EDD), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC), Nurse Practitioners or Clinical Nurse Specialists (NP or CNS/CS)

The following information is verified from primary sources, unless otherwise indicated, and is no more than 180 days old at the time of the credentialing decision:

- A current valid license to practice verified by the appropriate State Licensing Board
- A copy of provider's current malpractice insurance indicating a minimum coverage of \$1 million per occurrence and \$3 million aggregate
- The provider completes an application which includes a statement regarding:
 - › Reasons for any inability to perform the essential functions of the position, with or without accommodation
 - › Lack of present illegal drug use
 - › History of loss or limitation of privileges or disciplinary activity
 - › Current malpractice insurance coverage
 - › Attestation of correctness and completeness of the application

- The following information is reviewed and included in the credentialing files:
 - › Appropriate State Licensing Board query
 - › Verification of Exclusions from the Office of Inspector General Exclusions Database at the HHS website
 - › Colorado Bureau of Investigation (CBI) Query
 - › Colorado Child Abuse Registry query (youth providers only)
 - › NPDB query, which includes Medicare and Medicaid Sanctions

Provider information/file is summarized on the re-credentialing checklist. The Credentialing Coordinator prepares the re-credentialing report on provider utilization and quality information for the Credentialing Committee to review.

The Credentialing Committee will also review information from the NPDB, licensure board, Medicare/Medicaid sanctions, and performance data.

Based on the decision from the Credentialing Committee, the practitioner will receive an acceptance or denial letter within 7 days. The denial letter will include the appeal process.

The re-credentialing process is identical to the credentialing process except:

- Primary source verification does not re-collect educational verification
- Provider utilization data, and any complaints and quality information is presented for consideration in the decision making process

Ongoing Monitoring

NBH monitors disciplinary actions from the State and the Office of Inspector General on a monthly basis. The provider coordinator will get the information from the appropriate website and pull the reports. The names on the reports will be checked against the providers in the NBH provider network.

For State disciplinary actions, a notice of action letter is sent to the provider asking the provider to respond to sanction. Per the NBH provider contracts, providers have 30 days to notify NBH to any sanctions against them. The credentialing committee will follow-up on the sanction and the medical director will sign off on any recommendation the committee makes.

For OIG sanctions, the employee or subcontract will be terminated as NBH contractually cannot hire or affiliate with anyone on the list.

NBH also monitors complaints, adverse events, and instances of poor quality via:

- Office of Consumer and Family Affairs
- NBH Quality Improvement Department
- NBH Compliance Hotline
- Provider satisfaction survey

- Consumer report card
- Annual provider chart audit

Notification to Authorities and Practitioner Appeal Rights

Range of Actions/Sanctions available to NBH:

- Suspension of all of any part of participation privileges/provider agreement – (if suspension is placed into effect, the investigation shall be completed within thirty (30) days of the suspension)
- Imposition of terms of probation
- Imposition of a requirement of consultation
- Termination of provider agreement

Immediate termination will be invoked for loss of any state license, indictment or conviction of a felony or any criminal charge related to his/her practice; loss of staff privileges at a participating hospital; failure to take such action that would result in the imminent danger to the health and/or safety of any individual; and, where reasonable circumstances are deemed appropriate by NBH.

Any behavior deemed inappropriate and/or detrimental to an NBH participant is cause for immediate review by the Medical Director. Review results will be reported to the Credentialing Committee for further sanctions or termination of the contract.

Sanctions that may be undertaken without Credentialing Committee recommendation includes:

- Temporary suspension, which may be initiated only upon agreement between the Medical Director, Director of Utilization Management, and the Executive Director.
- Probationary status, which may be initiated by the Medical Director, Director of Utilization Management, or the Executive Director.

Notification to Practitioner

The practitioner shall be notified in writing within 7 days of the sanction taken, including termination.

Practitioner's Appeal Process

Refer to the Quality Improvement section of this manual for the appeals process.

Reporting Requirements to External Authorities

All physicians and licensed clinicians are subject to reporting of adverse actions to the appropriate State Board and the National Practitioner Data Bank.

Notification to the Department of Health Care Policy and Financing

In accordance with Section H.10.d: NBH will notify the Department, in writing, of its decision to terminate any existing Provider agreement where such Termination shall cause the delivery of Covered Services to be inadequate in a given area. The written notice shall be provided to the Department at least ninety (90) calendar days prior to termination of the services unless the termination is based upon quality or performance issues. The notice to the Department shall include a description of how NBH shall replace the provision of Covered Services at issue.

If a network provider chooses to leave the NBH network, NBH will notify the Department, in writing, within 10 business days, provided that the network is inadequate. NBH will also specify the action that will be taken to restore the adequacy of the network.

NBH uses a contract cover sheet that must be signed off when a contract is terminated, to track compliance with the Department notification requirement. The Department also requires a quarterly network adequacy report from NBH to verify adequacy of the network.

Assessment of Organizational Providers

“*Organization*” indicates Community Mental Health Centers, Child Placement Agencies, Group Practices, Hospitals, Home Health Organizations and Nursing Homes, Residential Facilities, and Rehabilitation Facilities.

The applicant must complete the *NBH Organizational Provider Credentialing Application*. The application must contain the original signature of the Chief Operating Officer, Administrator or other appropriate designated health care organization representative. The signature of the organization representative serves as an attestation of the credentials, operational, financial, and quality performance information summarized on and included with the application. The signature also serves as a release to verify credentials externally.

Procedure:

Participation Request or Network need is determined.

Provider Coordinator sends *NBH Organizational Application* by mail or email to the organization. The application is also available on the NBH website.

Organization provider applicants will submit, with their completed applications:

- Copy of all current organization licenses including, but not limited to:
 - › Mental Health Day Program (including day treatment and partial hospitalization)
 - › Outpatient Mental Health Services
 - › Mental Health Residential Treatment Facilities

- Mental Health Crisis Stabilization Units
- Psychosocial Rehabilitation
- Mental Health Case Management
- Mental Health Hospital Facilities
- All general surgical hospitals operating a unit or program to provide mental health services.
- Copy of JCAHO, CARF, CHAP, or COA accreditation certificate, if applicable.
- Status of certification for Medicaid or Medicare participation and numbers if participating.
- Policy and procedure ensuring staff is qualified for their position (if not accredited)
- Copy of declaration page proving current Professional & General liability coverage demonstrating the following NBH requirements:

	<u>Malpractice</u>	<u>General Liability</u>	
Organization	\$3,000,000	\$3,000,000	per occurrence
Hospital	\$5,000,000	\$5,000,000	in aggregate

- Malpractice history from the insurance carrier covering the last 5 years
- Copy of the last HCFA, Health Facilities Division survey report (Hospitals only)
- Copy of the Mental Health Services or CO Department of Human Services Site survey report
- Copy of the Mental Health Services Designation Certificate
- Attestation/Release signed by a Director
 - Attestation that their organization conducts background investigations on all employees, interns, volunteers and contract agents having contact with clients, consisting of at least the following, prior to hire:
 - A name search through the Colorado Bureau of Investigation;
 - A reference from the licensing board for licensed persons;
 - A check of the Central Registry of Child Abuse for persons having unsupervised contact with clients under age 18; and
 - A check of references of former employers for clinical staff.

The NBH Provider Coordinator reviews all information and when the application is complete, presents the credentials to the NBH Credentialing Committee. The Credentialing Committee does the following:

- Reviews documents.
- If there is no accreditation status, the annual Colorado Division of Mental Health Site Survey visit results will be reviewed in lieu of a site

visit and will include, at a minimum, a review of clinical treatment records to ensure compliance with mental health documentation standards as set forth by the Colorado Division of Mental Health. When deficiencies are identified related to services to Medicaid recipients, the Provider's corrective action plans will be requested and reviewed by the NBH Credentialing Committee for further action if necessary.

- Makes determination regarding participation.
- Provider Coordinator documents determination in committee minutes.

Site visits for Non-Accredited Organizational Providers

NBH will accept a CMS or state review in lieu of a site visit for non-accredited Organization Providers. If the Organizational Provider does not have a CMS or state review, NBH will conduct an onsite quality assessment to ensure that the Organization credentials its practitioners in accordance with NCQA standards.

NBH also requires that all Non-Accredited Organizational Providers attach a copy of the Policy and Procedure or documented process used to ensure that direct care providers are legally and professionally qualified for the position to which they are appointed and for the performance of privileges granted. All licensed staff are to be credentialed by the organization in accordance with NCQA guidelines with re-credentialing required every three years. All organizations must also attest that the proper background investigations are verified.

Organizational Provider Notification

Organizations are notified of credentialing and re-credentialing decisions in writing within 60 calendar days of the Credentialing Committee's decision.

- Applicant Approved by the Credentialing Committee

If the credentialing committee approves the applicant, a letter of acceptance into the NBH network is sent.

- Applicant Not Approved by the Credentialing Committee

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. The applicant will be notified of their appeal rights via a denial letter.

The appeals process includes:

1. If the Credentialing Committee's preliminary review finds that there may be sufficient cause to deny credentials, the Chair of the Credentialing Committee will notify the applicant in writing. The applicant will have seven (7) working days from the date of

receipt of the notice to appeal the decision in writing to the Chair.

2. The Credentialing Coordinator will present the appeal to the Credentialing Committee at its next regularly scheduled meeting for discussion. The decision of the Credentialing Committee will be presented to the Medical Director for review and considered final at this point. The Credentialing Coordinator will notify the applicant in writing within five (5) days.

Procedures for Change in Organization Status

All decisions about altering the organizations relationship with NBH include, but are not limited to issues of quality of care and service, information submitted by the organization, as well as objective evidence.

Decisions are guided by mental health consumer care considerations. Causes for sanctions include but are not limited to:

- The clinical competence of NBH organization
- The care or treatment of a mental health consumer
- Violation of ethical standards or the policies, rules or regulations of NBH
- Behavior or conduct that is considered lower than the standards of safe and prudent practice
- Failure to achieve satisfactory utilization, cost and quality review results
- Non-compliance with terms and agreements set forth in the contract or corporate compliance guidelines
- Failure to comply with provider policies and procedure manual
- Failure to submit re-credentialing materials within requested timeframes
- Failure to comply with quality improvement activities

Range of sanctions available to NBH:

- Suspension of all of any part of participation privileges/organizational agreement – (if suspension is placed into effect, the investigation shall be completed within thirty (30) days of the suspension)
- Imposition of terms of probation
- Imposition of a requirement of consultation
- Termination of provider agreement

Immediate termination will be invoked for loss of any state license, indictment, or conviction of a felony or any criminal charge related to the organization; failure to take such action that would result in the imminent danger to the health and/or safety of any individual; and, where reasonable circumstances

are deemed appropriate by NBH.

Any behavior deemed inappropriate and/or detrimental to an NBH participant is cause for immediate review by the Medical Director. Review results will be reported to the Credentialing Committee for further sanctions or termination of the contract.

Sanctions that may be undertaken without Credentialing Committee recommendation includes:

- Temporary suspension, which may be initiated only upon agreement between the Medical Director, Director of Utilization Management, and the Executive Director.
- Probationary status, which may be initiated by the Medical Director, Director of Utilization Management, or the Executive Director.

Notification to the Organization

The organization shall be notified in writing within 7 days of the sanction taken, including termination.

Organizational Appeal Process

Please refer to the Quality Improvement Policies and Procedures for the appeals process.

Organization Provider Recredentialing

Re-credentialing will take place every three years. The Re-credentialing process will begin at least 90 days prior to the date at which initial credentialing or re-credentialing will expire.

Follow procedures for Organization Provider Credentialing.

All requirements and documents listed for Organization Credentialing will be current at the time of credentialing and re-credentialing.

Expedited Credentialing/Single Case Agreements (SCA's)

When a Medicaid eligible client requests a specific provider who is not currently contracted with NBH, or when NBH has a need to recruit a provider with specialized training or expertise, a SCA is established. Prior to entering into an SCA, NBH reviews and/or verifies the following provider information:

- Licensure;
- Resume
- Degree(s)/diploma(s);
- Proof of liability insurance coverage;
- Child abuse registry if applicable
- HHS and criminal background checks.

The SCA contract is completed within thirty (30) days of receipt of the SCA

application from the provider.

Providers and Facilities that do not wish to contract with NBH

NBH requires that all individual providers and facilities contract with NBH by either joining the NBH network or signing a single case agreement in order for NBH to process and pay claims. NBH grants one exception to this policy. If an inpatient organization will not contract with NBH and the services can not be provided at another organization (due to distance, severity of the client, etc...) NBH can process and pay claims for that organization. The utilization manager will make the decision and the rates will be set by NBH.

Provider Agreements

NBH will be responsible for all work performed by Providers. NBH will monitor services rendered by Providers for quality, appropriateness, and patient outcomes. NBH will also monitor for compliance with requirements for Medical records and data reporting.

NBH shall have a written agreement with each provider which specifies the activities and reporting responsibilities of the provider. The agreement includes provisions for revoking the agreement or imposing other sanctions if the provider's performance is inadequate. No agreement shall in any way relieve NBH of any responsibility for the performance of duties required under the contract with HCPF.

If NBH identifies deficiencies or areas for improvement, NBH will collaborate with the Provider through an action plan agreed upon by both the Provider and NBH.

Provider Terminations and Sanctions

VOLUNTARY: If a provider chooses to terminate from the network, a written request must be submitted to NBH Provider Relations Department. NBH will acknowledge receipt of the request, coordinate consumer related services with the clinical department, and notify the provider of the final termination date. (Authorization for treatment will continue for up to 90 days after the practitioner leaves the network.)

INVOLUNTARY: Non-adherence to performance standards, non-adherence to contract stipulations, violations of state/federal laws, or fraud may result in termination from NBH's Provider Network.

PERFORMANCE STANDARDS: Critical areas monitored include:

- › Professional and ethical conduct;
- › Patterns of practice contrary to NBH's procedural standards;
- › Patterns of service delivery;
- › Failure to cooperate with review and audit process; and
- › Consistent failure to meet documentation standards.

If performance standards are suspect, NBH will contact the network provider by certified mail to alert the network provider to the issue(s) and review the appropriate documentation or requirements for an Action Plan. NBH may sanction providers for deficits in performance standards. Sanctioned providers will not be allowed to accept new Medicaid clients and will not be re-authorized to provide services to current clients until acceptable changes are made. Continual failure to comply with performance standards may result in termination. Provider and the Colorado Department of Health Care Policy and Financing will be given ninety (90) days' written notice.

NON-COMPLIANCE TO CONTRACT STIPULATIONS: NBH may place a sanction on the provision of services by the provider. Regarding contract stipulations refer to the contract (Articles III). Continual non-compliance will result in immediate termination from the network. If sanctioned a written notice by certified mail will be sent to the provider. If participation in the network is terminated, a written notice by certified mail will be sent to the provider and the Colorado Department of Health Care Policy and Financing

VIOLATION OF STATE/FEDERAL LAWS, OR FRAUD: NBH periodically verifies a provider's standing with state licensure and law enforcement agencies, the Office of Inspector General, Child Registry, and the National Practicers' Data Bank. Non-compliance report from these agencies may result in a placement of a sanction on the provision of services by the provider. Continual non-compliance will result in immediate termination from the network. If sanctioned a written notice by certified mail will be sent to the provider. If participation in the network is terminated, a written notice by certified mail will be sent to the provider and the Colorado Department of Health Care Policy and Financing.

QUALITY OF CARE CONCERNS: Refer to the Policy and Procedures regarding Quality of Care Concerns.

Appeals

Network providers who are sanctioned or terminated from the network have the right to appeal. The NBH Credentialing Committee hears such appeals. Network providers must submit their written appeal within 30 days. Network providers eligible for written appeals will be notified of their appeal rights at the time they are notified about a sanction or termination. Filing an appeal will not stay the sanctions imposed by NBH.

Monitoring

The Quality Improvement Committee (QI) will be responsible for the monitoring of service provided by Participating Providers for quality, appropriateness, and patient outcomes. In addition, the Committee will monitor for compliance with requirements for Medical Records and documentation. An audit of charts will be done annually; more often if deficiencies or areas for improvement are found. On-site audits may be performed.

The QI will collaborate with Providers in the development of an action plan if deficiencies or areas for improvement are found during an audit. It will monitor the actions plan for outcomes. A summary of the action plan and outcomes, with recommendations for sanctions or termination of contract if outcomes are not positive, will be reported to the Compliance Committee.

The Quality Improvement Committee will report to the Compliance Committee an overall summary of its findings. The Compliance Committee will review any action plan outcomes to determine continuation of contract or termination of contract if outcomes are not positive.

MEDICAID DISCLOSURE STATEMENT

NORTHEAST BEHAVIORAL HEALTH

<p>NAME: _____</p> <p>MEDICAID #: _____</p> <p>CLINICIAN NAME: _____</p> <p>DEGREES, CREDENTIALS, LICENSES: _____</p>	<p>DATE OF BIRTH: _____</p>
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The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Department of Regulatory Agencies. Questions and complaints may be addressed to the Grievance Board, which is located at:

**DEPARTMENT OF REGULATORY AGENCIES
MENTAL HEALTH SECTION
1560 BROADWAY, ROOM 1340
DENVER, CO 80202
303-894-7766**

You may also contact the Director of Consumer and Family Affairs, if you have any concerns or complaints about the way you have been treated or about the services you have received.

**CAROL STAPLES, DIRECTOR OF CONSUMER AND FAMILY AFFAIRS
NORTHEAST BEHAVIORAL HEALTH, LLC
1300 N 17TH AVENUE
GREELEY, CO 80631
1-888-296-5827 OR 970-347-2367**

You also have the option of directly contacting the Colorado Mental Health Services at 303-762-4088 if you have a complaint you wish to register.

My rights and responsibilities and the mental health benefits of Medicaid were discussed with me.

Yes No (Refer to the Consumer Handbook)

Consumer Handbook

I have received the Consumer Handbook in the mail Yes No Do not know

If not, one has been given to me by staff member. Yes No

Advance Directives (For adults only)

Do you have an Advance Directives? Yes No Do not know

If yes, please bring a copy for our records.

If not, an Advance Directives brochure was given to me by staff member. Yes No

EPSDT (for clients under 21 years of age)

I was asked if I had a primary care provider and if I had received a health screen. Yes No

If not, an EPSDT brochure was given to me by staff member, Yes No

I have been informed of my counselor's degrees, credentials and licenses. I acknowledge that I have received or have been offered a Consumer Handbook, Advance Directives brochure, EPDST brochure (if applicable). I understand my rights and responsibilities as a client.

Client Signature (Parent or Legal Guardian)	Date
Clinician Signature	Date

Give copy of this form to client.

NBH Credentialing Application Denial Letter Template (on letterhead)

Date

Provider or Organization

Address

Address

RE: Denial of Application into the NBH Provider Network

Dear _____:

NBH regrets to inform you that the credentialing committee has denied your credentialing application due to the following:

- 1.
- 2.
- 3.

Appeal Process: You have the right to appeal this decision. Appeals must be submitted in writing within seven (7) working days of receipt of this letter. The Credentialing Coordinator will present your appeal to the Credentialing Committee at its next regularly scheduled meeting for discussion. The decision of the Credentialing Committee will be presented to the Medical Director for review. The Medical Director's decision will be considered final. You will be notified of the decision, in writing, within five (5) days by the Credentialing Coordinator.

Sincerely,

Credentialing Committee Chair

Ombudsman for Medicaid Managed Care *“Helping You Solve Problems with Your Health/Mental Health Care”*

The Ombudsman for Medicaid Managed care program is a statewide resource for members of Medicaid Managed Care. Independent from your health plan /mental health plan, the Ombudsman will work with you to get your questions answered and help to resolve problems quickly and fairly.

Who can the Ombudsman help?

- Children and adults eligible for Medicaid who are in need of or who receive mental health services
- Denver Health Medicaid Choice members
- Rocky Mountain Health Plan members
- Primary Care Physician Program members

Why would you call the Ombudsman?

- You are unhappy with care or services provided
- You want or need assistance accessing covered services
- A Medicaid managed care covered service has been denied, reduced or stopped
- You were treated unfairly or disrespectfully
- To learn about your rights and responsibilities
- Assistance with filing grievances or appeals
- As a resource for when you just are not sure who to call

To contact the Ombudsman for Medicaid Managed Care:

- **303-830-3560** within Metro Denver (Spanish available)
- **1-877-435-7123** outside Metro Denver (Spanish available)
- **TTY: 1-888-876-8864** for hearing impaired
- **Fax: 303-832-8352**
- **Email: help123@maximus.com**
- **Web address: www.healthcolorado.org**

Ombudsman para el Cuidado de Salud Administrada por Medicaid *“Ayudándole A Resolver Problemas con su Cuidado De Salud Física Y Mental”*

El Ombudsman (defensor del pueblo) para el programa de Cuidado de Salud administrada por Medicaid es un recurso estatal para miembros de algún plan de Cuidado de Salud administrado por Medicaid. Independiente de su plan de salud física/mental, el Ombudsman trabajará con usted para contestarle sus preguntas y ayudarle a resolver sus problemas pronto y justamente.

¿A quien puede ayudar el Ombudsman?

- A niños y adultos elegibles para Medicaid con necesidad de cuidado mental
- Miembros de Denver Health Medicaid Choice
- Miembros de Rocky Mountain Health Plan
- Miembros del programa (PCPP) Primary Care Physician Program

¿Porque llamar al Ombudsman?

- Si no está contento con el cuidado de salud o los servicios brindados
- Si quiere o necesita asistencia con servicios ya cubiertos
- Un servicio cubierto se le ha negado por su plan de salud de Medicaid
- Si usted fue tratado en una manera injusta o irrespetuosa
- Para aprender acerca de sus derechos y responsabilidades
- Como un recurso para cuando no sabe a quien llamar

Para contactar al Ombudsman para el Cuidado de Salud por Medicaid

- Llame:303-830-3560 dentro del área metro de Denver (español disponible)
- 1-877 435-7123 fuera del área metro de Denver (español disponible)
- TTY:1-888-876-8864 para personas con problemas auditivos
- Fax: 303-832-8352
- Correo Electrónico: help123@maximus.com
- Nuestra página en Internet al:www.healthcolorado.org