COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY AND PROCEDURES MANUAL				
Chapter **Program Quality**	**Section** **Provider Network Management**	**Chapter** **05**	**Section** **05**	**Subject** **01**
Subject **Credentialing Program**	**Authorization** Melissa Hall		**Approved: 12/27/16** **Replaces: #03-01-04** **Dated 07/29/14**	

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I. PURPOSE: To assure that clinical oversight, management, and services are provided by providers who are fully qualified, competent and in good standing. In addition, this policy sets the expectation and guidelines for contract and sub-contract providers, within Gogebic Community Mental Health Authority's (CMHA) provider network, to comply with applicable rules and regulations including, but not limited to, the Balanced Budget Act (BBA), Michigan Department of Health and Human Services (MDHHS), applicable Accreditation standards and NorthCare Network's Credentialing Program.

II. APPLICATION: All professional providers of clinical services employed directly, contracted, or subcontracted by CMHA.

III. DEFINITIONS:

A. Certify: To confirm formally or verify information

B. Clean Application: The provider has completed all applicable sections of the NorthCare Network Credentialing Application; and where indicated that provider has signed, initialed and dated the credentialing application; and all necessary support documentation has been submitted and is included with the credentialing application in the provider's file. The provider meets the credentialing criteria as stated in this policy, which is approved by the credentialing committee. Credentials verification supports the provider meets credentialing criteria and there are no issues to report to the credentialing committee.

C. Contractor: Any provider, supplier, distributor, vendor or firm (person or entity) that furnishes services under primary contract with Gogebic CMHA.

D. Credentialing: (As defined by the American Society of Addiction Medicine and the American Managed Behavioral Healthcare Association) The process of reviewing, verifying, and evaluating a practitioner's credentials (i.e., professional education, clinical training, licensure, board and other certification, clinical experience, letters of reference, other professional qualifications, and disciplinary actions) to establish the presence of specialized professional background required for membership, affiliation, or a position within a healthcare organization or system. The result of credentialing is that a practitioner is granted membership in a medical staff or provider panel. Delegation of this function to an organizational provider must be monitored for the same standards required for CMHA's Credentialing Committee.

E. Credentialing Committee: A committee of professional peers led by a senior clinical staff leader. The committee membership should reflect required members and ad hoc members to assure appropriate peer review for each provider. This committee has the final authority to approve or disapprove applications by providers for participation on the organization's provider panel and delegates authority for approval of clean credentialing applications to the identified Senior Clinical Staff.

F. **Grievance:** A formal complaint made on the basis of something that somebody feels is unfair.

G. **National Practitioner Databank (NPDB):** The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Office of Workforce Evaluation and Quality Assurance, Practitioner Data Banks Branch is responsible for the management of the National Practitioner Databank (NPDB). Located on the internet at www.npdb.hrsa.gov.

H. **Organizational Providers (Facilities):** Organizational providers are providers with whom CMHA contracts and that directly employ and/or contract with individual providers to provide healthcare services. Examples of organizational providers include, but are not limited to hospitals, nursing homes, substance abuse agencies, residential providers and vocational providers.

I. **PIHP (Prepaid Inpatient Health Plan):** In Michigan and for the purposes of the MDHHS/PIHP contract, a PIHP is defined as an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 438. In Medicaid regulations Part 438., Prepaid Health Plans (PHPs) that are responsible for inpatient services as part of a benefit package are now referred to as "PIHP". The PIHP also known as a Regional Entity under MHC 330.1204b or a Community Mental Health Services Program also manages the Autism iSPA, Healthy Michigan, Substance Abuse Treatment and Prevention Community Grant and PA2 funds.

J. **Individual Practitioner/Provider:** Any individual that is engaged in the delivery of healthcare services and is legally authorized to do so by the State in which he or she delivers the services.

K. **Primary Source Verification:** Verification based on information obtained directly from the issuing source of the credential.

L. **Senior Clinical Staff Person:** The appointed leadership role of the credentialing program of at least one senior clinical staff person who has: current, unrestricted clinical license(s); qualifications to perform clinical oversight for the services provided; post-graduate experience in direct patient care; and Board certification (if the senior clinical staff person is an M.D. or D.O.).

M. **Sub-Contractor:** Any provider, supplier, distributor, vendor or firm (person or entity) that furnishes services to or for a primary contractor or another subcontractor.

N. **Verify:** To prove the truth by presenting evidence or testimony.

IV. **POLICY:** Gogebic CMHA will assure service recipient safety and provision of services by competent and qualified behavioral healthcare providers by implementing a comprehensive credentialing and re-credentialing program which includes continuous credential monitoring. Gogebic CMHA is responsible to apply legal, professional and ethical scrutiny to individual and organizational applicants seeking to be credentialed/ recredentialed. The oversight and monitoring of the credentialing of sub-contract provider staff is delegated to direct contractors. This policy does not establish the acceptable scope of practice for any of the identified providers, nor does it imply that any service delivered by the providers identified in the body of the policy is billable or reimbursable.

V. PROCEDURE:

A. General Guidelines-Credentialing Individual Practitioners employed/contracted by Gogebic CMHA

1. Credentialing and re-credentialing must be conducted and documented for the following healthcare providers that are not operating as part of an organizational provider:

- **a)** Physicians (MDs and DOs)
- **b)** Physician Assistants (PAs)
- **c)** Psychologists (Licensed, Limited Licensed and Temporary Limited Licensed Psychologists) (LPs, LLPs, and TLLPs)
- **d)** Master's Social Workers-Licensed and Limited Licensed (LMSW, LLMSW)
- **e)** Bachelor's Social Workers-Licensed and Limited Licensed (LBSW, LLBSW)
- **f)** Registered Social Service Technicians (SSTs)
- **g)** Professional Counselors-Licensed and Limited Licensed (LPCs and LLPCs)
- **h)** Nurse Practitioners (NPs)
- **i)** Registered Nurses (RNs)
- **j)** Licensed Practical Nurses (LPNs)
- **k)** Occupational Therapist (OTRs)
- **l)** Occupational Therapist Assistant (OTAs)
- **m)** Physical Therapist (PTs)
- **n)** Physical Therapist Assistant (PTAs)
- **o)** Speech Pathologist
- **p)** Dietician
- **q)** Certified Addictions Counselor: CADC-Certified Alcohol and Drug Counselor-Michigan or CAADC-Certified Advanced Alcohol and Drug Counselor-Michigan or CADC & CAADC through International Credentialing and Reciprocity Council (IC and RC)
- **r)** Certified Clinical Supervisor (CCS-IC and RC, CCS-Michigan)
- **s)** Certified Criminal Justice Professional (CCJP-IC and RC, CCJP- Michigan
- **t)** Certified Co-occurring Disorders: CCDP-Certified Co-Occurring Disorders Professional or CCDP-D-Certified Co-Occurring Disorders-Diplomat through IC & RC and Michigan
- **u)** Student Interns in approved Master's level educational program for social work, counseling, psychology, or marriage and family therapy

2. CMHA will ensure:

- **a)** That the credentialing and re-credentialing process does not discriminate against:
  1. A healthcare professional, solely on the basis of license, registration or certification; or
  2. A healthcare professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.
- **b)** Compliance with federal and state requirements regarding completion of appropriate background and exclusion checks on all potential employees, students, interns, volunteers, contractors, and board members as part of their screening process (also see CMHA *Background Check* policy #01-04-73).

Federal and/or State requirements may prohibit employment or contracts with

providers who are excluded from participation under either Medicare or Medicaid. CMHA completes Center for Medicare and Medicaid Services (CMS) queries on providers at http://exclusions.oig.hhs.gov and www.sam.gov as part of the application and continuous monitoring process.

B. Initial Credentialing of Individual Providers: At a minimum, the initial credentialing of individual providers requires the review of the application by the Credentialing Committee within 180 days of a completed application with applicant signed attestation page. Primary and secondary source verification must be within six months prior to review. The review and approval of an application must be completed prior to designation as a participating provider in the Provider Directory. (**NOTE**: Gogebic CMHA utilizes NorthCare Network's standard credentialing application for individual providers whether they are employees or contract providers.)

Individual Practitioner Credentialing Application:

1. The standard NorthCare Network Credentialing Application is completed, signed and dated by the provider and attests to the following elements:
- **a)** Lack of present illegal drug use.
- **b)** Any history of loss of license or felony convictions.
- **c)** Any history of loss or limitation of privileges or disciplinary action.
- **d)** An acknowledgement of the ongoing responsibility to notify the employer in a timely manner of any adverse change in licensure or certification status. As soon as the employee is aware or should have been aware of the change, the employer must be notified.
- **e)** Attestation by the applicant of the correctness and completeness of the application.

2. An evaluation of the provider's work history for the prior five years.

3. Verification from primary sources of:
- **a)** Licensure or certification including the expiration of the license or certificate and the date of the verification.
- **b)** Board Certification, or highest level of credentials attained if applicable, or completion of any required internships/residency programs, or other postgraduate training.
- **c)** Documentation of graduation from an accredited school.
- **d)** National Practitioner Databank (NPDB) query or, in lieu of the NPDB query, all of the following must be verified:
  1. Minimum of five-year history of professional liability claims resulting in a judgment or settlement;
  2. Disciplinary status with regulatory board or agency; and
  3. Medicare/Medicaid sanctions.
- **e)** If the individual undergoing credentialing is a physician, then the Physician Masterfile System obtained from the American Medical Association may be used to satisfy the primary source of requirements of (a), (b), and (c) above.

4. A cover letter is required with all credentialing applications sent to providers/

potential providers outlining:

a) Specific staff to contact regarding any specific concerns or communications about the status of their credentialing request.

b) The opportunity to correct incomplete, inaccurate, or conflicting credentialing information.

c) That updated information does not prevent the organization from considering the additions or corrections in the credentialing process and submitting to the credentialing committee even if after correction the application appears to be a "clean application."

5. The CMHA Credentialing Committee delegates approval of clean applications to the Senior Clinical staff person. A clean application is where the provider has completed all applicable sections of the credentialing application; where indicated the provider has signed, initialed, and dated the credentialing application; and all necessary supporting documentation has been submitted and is included in the provider's file. This information will be posted in the Credentialing Committee Team for review by committee members and full committee approval will be documented in the Credentialing Committee meeting minutes.

6. If during the review of an application issues of quality of care emerge, such as missing or inconsistent information, training requirements or consumer safety or malpractice issues, the Senior Clinical staff person may schedule an earlier meeting with the Credentialing Committee

a) The Credentialing Committee will document their investigation of those issues.

b) The Credentialing Committee will make a decision as to whether to approve with (1) no conditions (other than usual probationary period); (2) require a plan of correction along with probation; or (3) deny the request for credentialing.

7. Written Notification of Credentialing Determination within ten (10) days:

a) Written notice to all applicants must be provided within ten days of the Senior Clinical staff person's and/or the Credentialing Committee's decision as to their initial application. At the time of approval, the Senior Clinical staff person will update the internal Provider Directory spreadsheet and ensure that the ELMER staff information and staff details are updated/accurate. Providers will be considered re-credentialed unless otherwise notified in writing.

b) For any adverse determinations made by the Committee, an individual practitioner or organization provider that is denied credentialing or re-credentialing shall be informed of the reasons for the adverse credentialing decision in writing.

c) If an individual or organizational provider disagrees with a credentialing determination to deny, suspend, or terminate for any reason other than lack of need, the matter may be reviewed at a higher level by submitting a written request to the CEO or designee within 30 calendar days of disposition. The request must include the following (see NorthCare's Appeal Request Form):
(a) Reason for dispute.

(b) Documentation to support the appeal.

d) Upon approval of the provider's credentialing application, the provider will be added to the list of providers for CMHA.

8. The Senior Clinical staff person will verify annually that (a) where certification, registration or licensure is required, it is also maintained; (b) that the provider has not been excluded from Medicaid and Medicare participation relating to procurement issues via www.sam.gov and; (c) that the provider has not been excluded from participation in Medicaid and Medicare programs related to health care issues via http://exclusions.oig.hhs.gov.

9. Each employee is responsible to maintain his or her credentials and submit evidence to the Senior Clinical staff person. Evidence will be maintained in the individual's credentialing file. Employees who do not maintain appropriate licensure or certification are subject to disciplinary action to include immediate suspension from service, up to and including dismissal.

10. Employees or contractors who are being investigated or who are sanctioned must notify their supervisor who will notify the Senior Clinical staff person and/or the Credentialing Committee.

C. Provisional Credentialing of Individual Practitioners

Provisional credentialing of providers is intended to increase the available providers in underserved areas and is granted when it is in the best interest of Medicaid Beneficiaries that providers be available to provide care prior to formal completion of the entire credentialing process. This need is based on continuity or quality of care issues. Provisional credentialing shall not exceed 150 days.

1. CMHA will make a decision regarding provisional credentialing within 31 days of receipt of the completed provider credentialing application. For consideration of provisional credentialing, at a minimum, a provider must complete NorthCare Network's Individual Practitioner/Individual Contract Provider Credentialing & Recredentialing Application and primary source verification must be completed on:

a) Licensure or certification;

b) Board certification, if applicable, or the highest level of credential attained; and

c) Medicare/Medicaid sanctions, if any.

2. CMHA's Senior Clinical staff person will review the information obtained and determine whether to grant provisional credentialing for all providers as necessary. CMH will move the credentialing process forward as quickly as possible for providers with provisional status.

D. Continuous Monitoring of Credentials: CMHA uses continuous monitoring of credentials for providers employed by CMHA to monitor their continuing compliance with criteria for participation for CMHA. CMHA reviews Federal and State of Michigan information regarding individual and organizational providers who have received sanctions or limitations on licensure/certification from various agencies as

they are published or available. For continuous monitoring, CMHA utilizes the following systems:

1. Long Term Care Workforce Background Check; alerts CMHA when a provider has been convicted of a crime that excludes him/her from employment at CMHA.

2. Driver's License (PARS for Wisconsin residents; State of Michigan Driving Record Subscription Service for Michigan residents).

3. National Practitioner Data Bank (NPDB) Continuous Query which will alert CMHA of any adverse licensure actions, adverse finding by a State licensing or certification authority, peer review organization negative actions or finding, private accreditation organization negative actions or findings, licensing and certification actions, civil judgments (health care related), criminal convictions (health care related), exclusions from Federal or State health care programs, and other adjudicated actions or decisions (formal or official actions, availability of due process mechanism and based on acts or omissions that affect or could affect the payment, provision, or delivery of a health care item or service).

4. Queries to http://exclusions.oig.hhs.gov and www.sam.gov (see 'Excluded/ Sanctioned Providers' sections of this policy).

5. CMHA's credentialing staff monitor timely renewal of professional credentials/licenses by running the Review Staff Information report within ELMER on at least a quarterly basis.

E. Recredentialing Individual Providers

1. Formal recredentialing of providers at CMHA occurs every two years and is documented at the time of the employees' performance evaluation. The process includes:
   a) An update of the standard application submitted for initial credentialing with a cover letter that includes contact information of how to communicate with credentialing staff regarding application as well as ongoing monitoring of:
      1. Medicare/Medicaid sanctions;
      2. State sanctions or limitations on licensure, registration or certification;
      3. Any validated member/client concerns (including dignity and respect);
      4. CMHA quality issues (such as delivery of quality healthcare through Evidence-based Practices, practice guidelines, and fidelity to standards of treatment);
      5. Abiding by standards of clinical documentation and Quality Improvement record review results that were standards that the identified staff was responsible for executing;
      6. Trainings that have been completed; and
      7. Any corrective action taken.

2. The same procedures outlined in Section B. 1-7 for initial credentialing of individual practitioners are applied to recredentialing applications.

F. Credentialing/Recredentialing Facilities and Other Organizational Providers:

Facilities and other organizational providers must credential staff according to their accreditation and contract with CMHA. A NorthCare Network Organizational Credentialing Application will be completed for initial credentialing and updated at least every two years for re-credentialing; this is monitored as part of site reviews. At a minimum, the initial credentialing of organizational providers requires the review of the application by the Credentialing Committee within 180 days of a completed application with applicant signed attestation page. Primary and secondary source verification must be within six months prior to review. The review and approval of an application must be completed prior to designation as a participating provider in the Provider Directory.

1. The Organizational Provider will complete the standard NorthCare Network Organizational Credentialing Application and update the application for recredentialing. Recredentialing applications require a standard signed attestation attached to the application that verifies a process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a minimum, review of:
   - **a)** Medicare/Medicaid sanctions;
   - **b)** State sanctions or limitations on licensure, registration or certification;
   - **c)** Client concerns which include grievances (complaints) and appeals information including dignity and respect; and
   - **d)** CMHA quality issues such as delivery of quality healthcare through evidence based treatments; practice guidelines and fidelity to standards of treatment; and abiding by agency standards of clinical documentation and other requirements.

2. CMHA will inform all credentialing applicants that the following mechanisms and the specific staff to contact regarding any concerns in the following matters:
   - **a)** Communicate about the status of their credentialing request.
   - **b)** Have the opportunity to correct incomplete, inaccurate, or conflicting credentialing information.
   - **c)** Understand that updated information does not prevent CMHA from considering the additions or corrections in the credentialing process and submitting to the Senior Clinical staff person and/or the Credentialing Committee even if after correction of the application, it appears to be a clean application.

3. If during the review of an application, issues of quality of care emerge, such as missing or inconsistent information, training requirements or consumer safety or malpractice issues, the Senior Clinical staff person will schedule a meeting with the Credentialing Committee.
   - **a)** The Credentialing Committee will document their investigation of those issues.
   - **b)** The Credentialing Committee will make a decision as to whether to approve with (1) no conditions (other than usual probationary period); (2) require a plan of correction along with probation; or (3) deny the request for credentialing.

4. Upon approval of the provider's initial credentialing/application, the provider will

be added to the list of providers for CMHA.

5. CMHA validates initially and annually, at the time of contract renewal, that the organizational provider is licensed or certified as necessary to operate in the State and has not been excluded from Medicaid or Medicare participation relating to procurement and health care issues.

6. CMHA ensures that the contract with the organizational provider requires the organizational provider to credential and re-credential their directly employed and subcontracted direct service providers in accordance with CMHA's credentialing/ re-credentialing policies and procedures that are consistent with NorthCare Network and MDHHS's credentialing process.

7. At a minimum, every two years, CMHA conducts a credentialing audit of contracted facilities or other organizational providers that includes a review of credentialing policies and procedures to assure compliance with CMHA policies; the security and confidentiality of credentialing records and an audit of credentialing files. The sample size of credentialing files should be a minimum of 10% of such files, but no more than 30 files.

8. Written notification of Credentialing/Recredentialing Determination within 10 days:

a) CMHA will issue written notice to all applicants within 10 days of the Senior Clinical staff person's and/or the Credentialing Committee's decision as to their initial application. Providers will be considered as re-credentialed unless otherwise notified in writing.

b) For any adverse determinations made by the Committee, the Provider shall be informed of the reasons for the adverse credentialing decision in writing.

c) If an organizational provider disagrees with a determination in the application process or during review of a provider's status and wishes to have the matter reviewed at a higher level, the provider may do so by submitting a written request to the CEO or designee within 30 calendar days of disposition. The request must include the following (via NorthCare's Provider Appeal Request Form): (1) reason for dispute and (2) documentation to support the appeal.

G. Deemed Status: Individual practitioners or organizational providers may deliver healthcare services to more than one NorthCare Network Provider. CMHA may recognize and accept credentialing activities conducted by any other NorthCare Network Provider in lieu of completing their own credentialing activities but must verify completeness of the requirements outlined. In those instances, where CMHA chooses to accept the credentialing decision of another NorthCare Network Provider, CMHA must maintain copies of the credentialing Provider's decision in their administrative records.

H. Provider Directory

1. CMHA maintains a Provider Directory that includes a listing of all providers, both organizations and practitioners, that CMHA has contracts with or employs.

a) CMHA updates the Provider Directory as soon as a provider or organization is

credentialed, or changes are made regarding any listed provider (no more than 30 days from the date of review by Senior Clinical staff person or the Credentialing Committee).

b) Within five business days of the determination of any participating provider not being re-credentialed for any reason or they no longer meet the credentialing requirements in CMHA's credentialing program, the provider is removed from the online Provider Directory.

2. CMHA updates NorthCare Network's Provider Staff Change Form on a monthly basis. This form identifies actions taken by the organization regarding credentialed staff such as new hires, terminations, and suspensions, to assist with ongoing monitoring by NorthCare.

3. Copies of Provider Directories must be retained for a minimum of three years.

I. Reporting Requirements

1. CMHA shall report any known improper conduct of any credentialed provider that results in suspension or termination as a provider for CMHA to proper authorities (i.e., DHHS, licensing, the Attorney General, etc.), as consistent with current Federal and State requirements, including those specified in the DHHS Medicaid Managed Specialty Supports and Services Contract.

2. After hire, it is the responsibility of the provider to notify CMHA in a timely manner of any adverse change in licensure or certification status. As soon as the provider is aware or should have been aware of the change, the employer must be notified. Acknowledgement of this responsibility is to be documented in the annual performance evaluation of the provider.

J. Removal as a Provider

1. Exclusions/Sanctioned Providers: If CMHA has actual notice that an employed staff or contracted provider has become an Excluded Party or Sanctioned Provider, CMHA will terminate employment or the contract with the staff or the provider and notify NorthCare of the exclusion in a timely manner.

Additionally, CMHA may not have any of the following relationships with an individual who is excluded from participating in Federal health care programs:

a) Excluded individuals cannot be a director, officer, or partner of CMHA (this includes members of the governing board);

b) Excluded individuals cannot have a beneficial ownership of five percent or more of CMHA's equity; and

c) Excluded individuals cannot have an employment, consulting, or other arrangement with CMHA for the provision of items or services that are significant and material to CMHA's obligation under its contract with the State/PIHP.

CMHA will notify NorthCare's CEO and/or Compliance Officer immediately if search results indicate that any of their network's providers, provider entities, or individuals or entities with ownership or control interests in CMHA are on the

Office of Inspector General (OIG) exclusions database.

2. Reporting Criminal Convictions: CMHA will notify NorthCare Network when disclosures are made by providers with regard to those offenses as detailed in sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the act. NorthCare Network will notify MDHHS Behavioral Health and Developmental Disabilities Administration Division of Program Development, Consultation and Contracts within two business days of receiving the disclosure.

3. Expiration of Licenses: Any provider with an expired license will be removed from practice at CMHA until the license can be verified. Any provider who has not renewed his/her license or certification within the applicable grace periods (per licensing) of its expiration will be terminated as a provider for CMHA. Providers who are terminated for lapsed licensure or certification may reapply for participation as a provider for CMHA at the discretion of CMHA's Senior Clinical staff person once licensure or certification is renewed.

4. Other Identified Credentialing Issues: Examples of other credentialing issues are if a provider ceases to comply with credentialing criteria as determined through the processes of continuous compliance monitoring or recredentialing and if the provider is not recredentialed within the time frame required by CMHA. All other identified credentialing issues will be reported to CMHA's management and will be resolved through CMHA's corrective action policy.

If a CMHA participating provider is listed on an ongoing disciplinary action report or other information source that determines lack of compliance to established practice standards, CMHA will reassess the provider's ability to perform the services that he/she is under contract to provide. In such situations, CMHA's Credentialing Committee will assess the information and will take action as deemed necessary. The Credentialing Committee may determine that no action is justified; issue a letter of guidance, warning or reprimand; impose conditions for continued practice in the network; impose a requirement for monitoring or consultation; recommend additional training or education; or, determine that the provider should be terminated for cause (as in the case of a loss of license).

K. Appeal Process: Note: This appeals process does not apply to medical necessity appeals or conditions that result in immediate termination such as provider loss of required certification or licensure; listing of the provider by a state department or agency as being suspended from service participation in the Michigan Medicaid and/or Medicare programs; and/or the provider being listed by a State department or agency in its registry for unfair labor practices.

If an organizational provider, group, or individually licensed provider disagrees with a determination by CMHA in the application process or during review of a provider's status, and wishes to have the matter reviewed at a higher level:

1. The provider may submit a written request and supporting documentation to

CMHA's CEO or designee within 30 calendar days of disposition. The request must include the reason for the appeal and the documentation to support the appeal.

2. An appeal review will be conducted within 20 calendar days of receipt of the provider request by a panel of at least three qualified individuals not involved in previous decisions relating to this appeal. At least one member will be a participating provider not involved in the day-to-day operations of network management and who is a clinical peer of the participating provider that filed the dispute. Members of CMHA's Credentialing Committee may be used for this level review.

3. After formal review of the dispute, a written summary of the outcome will be given to the provider, within 14 calendar days of completion.

4. The decision of the appeal panel will be the final decision regarding the dispute.

5. In the event of an emergent non-compliance dispute, the appeal process will be initiated and completed within five working days.

VI. REFERENCES AND LEGAL AUTHORITY: Michigan Public Acts 299, 268, and 368 as amended; DHHS/CMHSP Managed Specialty Supports and Services Contract-QAPIP Standards; CARF Behavioral Health Standards; NorthCare Provider Network Management Policies

VII. EXHIBITS: NorthCare Network Individual Practitioner/Individual Contract Provider Credentialing & Recredentialing Application; NorthCare Provider Panel & Credentialing Application; NorthCare Organization Re-credentialing Attestation form; Provider Appeal Request Form; Employee and Individual Contract Provider Routing Form; Credentialing Process; Recredentialing Process