Document Type:[1] __X__ Policy & Procedure ___ Process Guideline _____ Plan ___ System Description

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Document Scope: (applies to Policy & Procedure only)

X The requirements herein apply only to the GCBH Central Office and its functions.

– The requirements herein apply, verbatim, to GCBH and its network providers[2].

– The requirements herein apply to both GCBH and its network providers[2]. Additionally, network providers must have internal documents outlining their processes for implementing the requirements, insofar as they relate to actions for which network providers are responsible.

PURPOSE: Organizational Providers are credentialed prior to inclusion in the network and are re-credentialed every 36 months to assure that they remain in good standing with regulatory and accrediting bodies, continue to maintain the appropriate level of malpractice insurance, and are free from sanctions or ethical violations which indicate a problem with the quality of service delivery.

DEFINITIONS

I. Organizational Providers: Include, but are not limited to, facilities providing mental health and substance abuse services in ambulatory, residential, or inpatient settings. They may include acute inpatient psychiatric facilities, chemical dependence treatment or detox facilities, behavioral health partial hospitalization intensive outpatient, and residential programs.

II. Designated Crisis Responder (DCR): A behavioral health professional who is designated by the county or other authority authorized in rule, to perform civil commitment duties such as determining if a person in crisis presents a harm to self/others/property, or is gravely disabled and is at imminent risk, or if there is a non-emergent risk due to a substance use or mental disorder, or is in need of assisted outpatient behavioral health treatment as described in RCW 71.05 and 71.34. Within the GCBH BH-ASO, the Credentials Committee oversees approvals of DCR appointments.

POLICY

1. Credentialing activities shall verify that all Subcontractors meet the licensure and certification requirements as established by state and federal statute, administrative code, or as directed in BH-ASO-Provider Agency Contract.

2. Credentialing procedures and expectations are compliant with all applicable State requirements, which are in accordance with standards defined by the NCQA, related to the credentialing and re-credentialing of Health Care Professionals who have signed contracts or participation agreements with Greater Columbia Behavioral Health (Chapter 246-12 WAC).

[1]See definitions of document types in AD100, "Development, Approval & Review of Formal GCBH BH-ASO Documents"
[2]"Network Provider" – An organization with which GCBH BH-ASO is contracted for the provision of direct services.

3. The Greater Columbia Medical Director has direct responsibility for and participates in the credentialing process.
4. The Greater Columbia Behavioral Health Credentialing Committee oversees the credentialing process:
    a. Maintains a heterogeneous membership and requires those responsible for credentialing decisions to sign a Code of Conduct affirming non-discrimination and privacy.
    b. Meets quarterly, at minimum, for review of new files and monitoring of active credential entities/Individual practitioners.
    c. Reviews all requests for credentialing and provides a written decision within 60 days of application.
    d. Provides annual reviews of practitioner complaints for evidence of alleged discrimination.
    e. Provides an annual review of the processes used for credentialing (including those for primary source verification and security of credentialing related information).
        i. This review will identify any modifications to credentialing and re-credentialing information that did not meet the organization's policies and procedures for modifications.
        ii. Analyze all instances of modifications that did not meet the organization's policies and procedures for modifications
5. This review is reported to the GCBH BH-ASO Quality Management Oversight Committee (QMOC) which has responsibility for assuring adherence to policy, implementing interventions and monitoring quarterly until it demonstrates improvement in the finding over three consecutive quarters. Greater Columbia Behavioral Health does not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification.
    a. Greater Columbia Behavioral Health does not contract with individual or groups of providers in its provider network.

PROCEDURE

A. Organizational Providers must complete an initial application documenting their business and clinical structure. The application includes an attestation signed by a duly authorized representative of the facility. The following information must be included with the application:
    a. State Business License
    b. State Behavioral Health Agency License for each location providing contracted services.
    c. A completed W-9
    d. Disclosure of Ownership Form (DOO) – Verified, signed, and dated

e. Agency Organizational Chart

f. Copies of documents demonstrating that the Provider has a process ensuring that they credential their employees. These may include (but are not limited to) copies of their:

   i. Credentialing Policy and Procedure (current)

   ii. Medical Staff Executive Committee Membership

g. Copies of documents that indicate the Organizational Provider has been accredited by:

   i. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

   ii. Commission on Accreditation of Rehabilitation Facilities (CARF)

   iii. Council on Accreditation (COA)

   iv. Community Health Accreditation Program (CHAP)

   v. American Association for Ambulatory Health Care (AAAHC)

   vi. Critical Access Hospitals (CAH)

   vii. Healthcare Facilities Accreditation Program (HFAP, through AOA)

   viii. National Integrated Accreditation for Healthcare Organizations (NIAHO, through DNV Healthcare)

   ix. ACHC (Accreditation Commissions for Healthcare) and/or American Osteopathic Association (AOA)

An attestation from a provider regarding their accreditation status is not acceptable

h. If a recognized accrediting body does not approve the Organizational Provider, a Facility Site Audit is conducted to determine the quality of programming, types of staff providing service, staff competencies, quality of treatment record documentation, and physical environment to ensure access, safety, and satisfaction for our members. The Greater Columbia Behavioral Health audit tool based on NCQA/Health Plan standards:

   i. This audit is conducted as part of the credentialing activity and Organizations that fail to meet these standards are not approved for participation in the network.

   ii. In lieu of a Greater Columbia Behavioral Health site visit, the organization must provide documentation of Centers for Medicare & Medicaid Services (CMS) or the WA Department of Health (DOH) review/recertification within the past 36 months. Documentation must include the full review, outcomes, corrective action plans, and approved completion of corrective actions.

      1. The State Agency requirements are reviewed to determine if they meet Greater Columbia Behavioral Health facility site requirements.

i. Face Sheet of Commercial Liability Policy or ACCORD Certificate (Greater Columbia Behavioral Health must be named in the policy)

i. Greater Columbia requires its acute care settings to maintain professional and general liability insurance (malpractice) of $5 million/occurrence and $5 million/aggregate and $1 million/occurrence and $3 million/aggregate for non-acute care settings.

1. Acute care is defined as any facility duly licensed and offering inpatient mental health and/or substance abuse health care services.

ii. Greater Columbia Behavioral Health does accept umbrellas policy amounts to supplement professional liability insurance coverage.

j. An attestation regarding current or recent legal or liability issues that involve the Provider.

k. An attestation as to the accuracy of the material submitted for Credentialing review.

B. The Credentialing Committee obtains information from organizational providers so that prior to the credentialing/re-credentialing decision date they can:

a. Verify the licensure directly from the state agency and confirms that the facility holds valid current licenses in the applicable state/s where contracting for Greater Columbia Behavioral Health.

b. Verify the accreditation certificate or report from the entity or verification directly from the accreditation organization. If non-accredited, confirmation that the site audit visit was completed or copy of the state/CMS audit results are in the file if they are being accepted in lieu of a Greater Columbia Behavioral Health site visit.

c. Assure that the Provider does not have an Exclusion on the Office of Inspector General (OIG) and List of Excluded Individuals and Entities (LEIE) query.

d. Assure that the Provider does not have any sanctions by the Excluded Parties List System (EPLS) on the Systems for Awards Management (SAM) site.

e. Verify the National Plan Identifier (NPI) on the National Plan & Provider Enumeration System (NPPES).

f. Verify that the Provider is not identified on the Washington State Medicaid Exclusions sites.

g. Verification that DCRs are authorized as such by the county authorities or the ASO Credentialing Committee.

C. Primary Source Verification is completed by the GCBH BH-ASO Compliance Officer (or designee) and its maintained in a secure file that with limited access (restricted to only the Compliance Officer or designee). Once verification information is obtained it is not modified other than for affixing the date and initials (signature) of the person completing the verification. To prevent an unauthorized modification of verification documents, GCBH BH-ASO utilizes PDF software that records the identity of the person modifying the submitted documents and the date/time of the modification.

D. Organizational Provider documents must be current and verified within 180 days of the Credentialing Committee decision. If documents have expired, the Credentialing Committee designee will contact the facility to obtain updated document copies. If documents with current dates are not available (e.g. licensing board has not issued updated certificate), the Credentialing Committee designee contacts the licensing board to confirm status.

E. All Organizational Provider files are reviewed to ensure they meet Greater Columbia Behavioral Health credentialing criteria. If the Organizational Provider does not meet Greater Columbia Behavioral Health's credentialing criteria, the file will be presented to the Credentialing Committee as an exception or "Further Review File" to the Credentialing Committee.

    a. The provider is notified of the issue(s) within 30 days and given 30 days from that notice to provide information to address the issue(s). If not received within this timeframe, the Credentialing Application will be denied.

F. If the Credentialing Committee determines that their findings differ from the materials submitted than the Provider's submitted materials, they will contact the Provider an inform them of their rights to:

    a. Review materials.

    b. Correct incorrect or erroneous information.

    c. Be informed of their credentialing status.

    d. Appeal a decision in writing within 60 days from the date the decision is communicated.

G. The Organizational Provider contract with Greater Columbia Behavioral Health is not considered fully executed without Credentialing Committee approval.

H. The Greater Columbia Behavioral Health Credentialing Committee may grant Provisional Status, if indicated to meet a need for providing continuity or quality of care. The Provisional process includes:

    a. A guideline that the Provider may not be held in a provisional status for more than sixty (60) calendar days;

    b. The requirement that provisional status will only be granted one time and only for providers applying for credentialing the first time.

    c. A process that includes:

        i. Primary source verification of a current, valid license to practice;

        ii. Primary source verification of the past five (5) years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Databank query; and

        iii. A current signed application with attestation.

I. Organizational Provider credentialing files are confidential and are scanned into a secure imaging system. This document retrieval system is protected by user ID and password to prevent unauthorized access. These files are protected from discovery and may not be reproduced or distributed, except for confidential peer review and credentialing purposes consistent with state laws.

J. When Greater Columbia Behavioral Health has reached a credentialing decision, the Organizational Provider will be notified, in writing, within 15 calendar days of the decision date.

K. Organizational Provider re-credentialing is performed every 36 months. Re-credentialing activities are compliant with all applicable state and federal regulatory requirements.

L. If an Organizational Provider loses their accreditation or licenses prior to the re-credentialing period, they must notify Greater Columbia Behavioral Health in writing within 15 calendar days.

M. If the Credentialing Committee determines that is not providing approval to a request for Credentialing the Provider may appeal in writing (for quality reasons and/or for reporting of quality issues) as outlined in their contract with Greater Columbia Behavioral Health.

Designated Crisis Responder (DCR) Requirements:

N. In order for GCBH to approve of the appointment of a DCR for the GCBH BH-ASO region, the following are required:
   a. Letter from the requesting Network Provider, identifying the staff member seeking designation, to include the staff member's:
      i. Full name
      ii. Date of birth
      iii. Titles
      iv. Location(s) they provide services
   b. Completed DCR training certificate
   c. A copy of the staff member's license
   d. GCBH's DCR application form and attachments

O. Subsequent to receiving the above, the information is reviewed by the GCBH Credentials Committee within 30 days.
   a. The Committee (or designee) verifies eligibility based on information provided.
   b. Each designee and the affiliated agency will receive a written letter of designation for the GCBH BH-ASO region upon completion of document review.

P. If the Committee is unable to reach a decision or determines that the individual does not meet criteria for approval, the affiliated agency will be notified and provided an opportunity to either correct the submission or withdraw it.

Q. If a County chooses to retain appointment responsibilities they can appoint solely for their own county, and their processes and documentation will be audited for adherence to the ASO expectations on an annual basis.
   a. The affiliated agency will notify the ASO of those individuals that they have been approved so that the ASO can maintain a master list of all approved DCRs in the region.

This policy and procedure will be reviewed every year and revisions and updates will be made as needed.

APPROVAL

Sindi Saunders 7/17/2024

Karen Richardson or Sindi Saunders, Co-Directors Date

Greater Columbia Behavioral Health Administrative Services Organization

PROVIDER FACILITY APPLICATION

☐Initial or ☐Recredential

I. INSTRUCTIONS AND CHECKLIST

This form should be typed or legibly printed in ink. Copies of all documents must be current. If more space is needed than provided, attach additional sheets and reference the questions being answered.

Current copies of the following documents must be submitted with this application as is applicable:

☐State Business License

☐ State Behavioral Health Agency License for each location providing contracted services.

☐A completed W-9

☐ Evidence of current National Accreditation OR Results of the most recent DOH Audit/Survey within 36 months (if not available, then GCBH BH-ASO will complete a site survey prior to credentialing being completed)

☐Face Sheet of Commercial Liability Policy or ACCORD Certificate (GCBH BH-ASO must be named in the policy)

☐Disclosure of Ownership Form (DOO) – Verified, signed, and dated

https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/27-094.pdf

☐Proof of Exclusions/Debarment verifications for each individual listed on DOO (initialed and dated within one (1) week of application submission (to include OIG, SAM, and Washington State exclusion checks for HCA and DSHS)

☐Agency Organizational Chart

☐Credentialing Policy and Procedure (current)

☐ Evidence that the facility maintains individual provider DEA numbers within their current Credentialing file (may be a redacted example copy of a current DEA registration, a redacted spreadsheet or an attestation by the individual responsible for maintaining that information).

☐Medical Staff Executive Committee Membership (Inpatient only)

☐ Evidence that the facility maintains an on call or coverage system for patient care (could include a sample on-call calendar, policy indicating how patient care is covered when a provider is absent or an after-hours on call list).

II. FACILITY INFORMATION

Legal Business Name: (As listed on W9)	
Doing Business As: (if applicable)	
Contact Person:	Email:
Tax ID(s):	

III. PRIMARY SERVICE ADDRESS

Facility Location Name:

Address Line 1:			
Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:		Primary Contact:

Does this location meet ADA accessibility requirements? ☐ Yes ☐ No

Check all that apply:

Handicap Accessible: ☐ Building ☐ Parking ☐ Restroom

Services for Disabled: ☐ Text Telephone ☐ American Sign Language ☐ Mental/Physical Impairment

Accessible by Public Transportation: ☐ Yes ☐ No

IV. SECONDARY SERVICE ADDRESS (Attach separate sheet for additional Facility locations)

Facility Location Name:			
Address Line 1:			
Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:		Primary Contact:

Does this office meet ADA accessibility requirements? ☐ Yes ☐ No

Check all that apply:

Handicap Accessible: ☐ Building ☐ Parking ☐ Restroom

Services for Disabled: ☐ Text Telephone ☐ American Sign Language ☐ Mental/Physical Impairment

Accessible by Public Transportation: ☐ Yes ☐ No

V. NATIONAL PROVIDER IDENTIFIER (NPI) (Attach a separate sheet for multiple NPIs)

Name:	
Service Address:	
Tax ID/EIN:	NPI#:
Taxonomy Code(s):	
Federal DEA Number(s) if applicable:	

VI. LICENSURE (Attach a separate sheet for additional licensure information, if applicable)

State:	Issue Date:	License Number:	Expiration Date:
State:	Issue Date:	License Number:	Expiration Date:
State:	Issue Date:	License Number:	Expiration Date:

State:	Issue Date:	License Number:	Expiration Date:
State:	Issue Date:	License Number:	Expiration Date:
State:	Issue Date:	License Number:	Expiration Date:

VII. GENERAL AND PROFESSIONAL LIABILITY INSURANCE

General Liability Coverage	
Current Carrier Name:	
Policy Number:	Coverage Type: ☐ Occurrence Based ☐ Claims Based
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $
Professional Liability Coverage	
Current Carrier Name:	
Policy Number:	Coverage Type: ☐ Occurrence Based ☐ Claims Based
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $

VIII. ATTESTATION QUESTIONS

If your answer is "yes" to any of the following questions, please provide complete details and any pertinent documents on a separate sheet of paper. Be sure to include dates and status or outcome of each action. Please provide the specific nature of allegations/events that led to an affirmative response to the below questions.

Has your organization ever been disciplined by any state licensing or other authorizing agency, or by any Professional Conduct Board, or has it been reprimanded, or fined by a state agency that oversees your specific provider type?	☐ Yes ☐ No
Has your organization ever been reprimanded, censured, excluded, suspended, or disqualified by the Medicare or Medicaid program?	☐ Yes ☐ No
Are there any malpractice suits, arbitration, or other legal proceedings that involved your organization (including all entities/individuals listed in the DOO) that were instituted, remain active, or have been settled within the past 3 years?	☐ Yes ☐ No

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omission from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

I certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service. I certify that the appropriate state license or certification source is checked at least annually for existing and contracted service providers in order to ensure that every licensed individual providing services as a representative of the applicant holds a current license or certification to provide services. I certify that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. I certify the applicant does not employ or contract with any individual convicted of a felony for a health-care related crime, including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance.

I certify that the on-line exclusion lists for the Health and Human Services Office of Inspector General (OIG) (http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp), the System for Award Management (SAM) (https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf), and the Washington State Health Care Authority (HCA) Provider Terminations (https://www.hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/provider-termination-and-exclusion-list) are checked for all new employees and contracted service providers prior to the first provision of service. I certify that the on-line exclusion lists for the OIG, SAM, and Washington State Exclusion checks (both HCA and DSHS) are checked on a monthly basis for all existing employees and contracted service providers to ensure that no state or federally or Washington State excluded individuals perform any function related to any State or federal health care program. I certify that I will remove any employee or contracted service provider found on one of the above referenced exclusion lists from any functions related to a State or federal health care program.

The individual executing this attestation has the proper authority and authorization and does so with the intent to fully bind the applicant to the truthfulness of its answers.

Organization

Printed Name

Title

Signature (Stamp not acceptable)

Date

GCBH Personnel Only:
Received Date and Initials:

Additional Pages

ADDITIONAL SERVICE ADDRESS (Attach separate sheet for additional Facility			
Facility Location Name:			
Address Line 1:			
Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:		Primary Contact:
Does this office meet ADA accessibility requirements? ☐ Yes ☐ No			
Check all that apply: Handicap Accessible: ☐ Building ☐ Parking ☐ Restroom Services for Disabled: ☐ Text Telephone ☐ American Sign Language ☐ Mental/Physical Impairment			