CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Delegation of Credentialing Primary Source Verification	Number:	80.308.3
	Page:	1 of 8
REFERENCE: CAMHD Credentialing Policies and Procedures for Licensed and Unlicensed Providers; NCQA, BBA	**APPROVED:** Chief	4/9/06 Eff. Date

PURPOSE

To provide guidelines and timelines for the delegation of credentialing activities by CAMHD to CAMHD contracted provider agencies (Agency/ies) providing mental health services. The policy also provides guidelines for monitoring the delegated activities of the CAMHD Agencies.

DEFINITIONS

See Glossary of Credentialing Terms **(See Attachment A)**

POLICY

1. The CAMHD is responsible and will be held accountable to ensure that all delegated credentialing functions and activities are performed in accordance with the specifications outlined in this policy.
2. The CAMHD shall evaluate a prospective delegate's ability to provide the intended delegated credentialing functions.
3. The CAMHD shall review and approve all descriptions of delegated credentialing activities prior to the approval of a delegation agreement.
4. The CAMHD shall monitor delegated activities regularly using the formal, systematic processes outlined within this policy to assess the delegate's compliance.

PROCEDURE

PRE-DELEGATION ASSESSMENT

1. Prior to the delegation of credentialing activities and functions the CAMHD will pre-assess an Agency or credentials verification service contractor to determine its ability to perform the activities and functions as outlined in the "CAMHD Pre-Delegation Assessment Tool." **(See Attachment B)**
2. The results of the pre-assessment audit will be reported to the CAMHD Credentialing Committee for review and decision.

RESPONSIBILITIES AND ACCOUNTABILITY OF THE DELEGATE

1. Initial Credentialing:

A. The CAMHD Agency or credentials verification service contractor shall obtain initial credentialing primary source verifications using methodology and times frames as outlined in the "*CAMHD Licensed Provider Initial Credentialing Checklist*" **(See Attachment C)**, the "*CAMHD MHP and Paraprofessional Initial Background Verification Checklist*" **(See Attachment D)**

B. The CAMHD Agency will obtain credentialing and background verification approval for all practitioner (licensed or unlicensed) from CAMHD prior to serving CAMHD consumers. Services provided prior to this CAMHD approval will not be reimbursed.

1. The CAMHD Agency credentialing specialist or a primary source verification service representative must do the following:

   a. Obtain a completed credentialing application form from the practitioner;

   b. Create an agency credentialing file for each provider applicant;

   c. Obtain necessary consents to conduct credentialing primary source verifications;

   d. Conduct primary source verifications as outlined in the "CAMHD Licensed Provider Initial Credentialing Checklist" and "CAMHD MHP and Paraprofessional Initial Background Verification Checklist";

   e. Conduct a pre-audit of primary source verified documents to ensure they meet CAMHD requirements – using the "CAMHD Licensed Provider Initial Credentialing Checklist" and the "CAMHD MHP and Paraprofessional Initial Background Verification Checklist" as guides;

   f. Maintain the original primary source verification documents in the practitioner's file at the CAMHD Agency. Existence of the originals will be verified during delegation onsite audit visits;

   g. Create a duplicate credentialing file for the applicant with all the primary source verification;

   h. Tab primary source verifications with numbers to match the numbers on the "Licensed Provider Initial Credentialing Checklist and the MHP and Paraprofessional Initial Background Verification Checklists";

i. Send a duplicate file to the CAMHD Credentialing department; and

j. Keep current in the file all documents that have expiration dates such as licenses and malpractice insurance.

2. **Re-credentialing:**

A. The CAMHD Agency will conduct the re-credentialing primary source verifications as outlined in the "*CAMHD Licensed Provider Re-credentialing Checklist*" **(See Attachment E)** and the "*CAMHD MHP and Paraprofessional Background Re-verification Checklist.*" **(See Attachment F)** The primary source verification requirements must follow primary source verification methodology and time frames as outlined in the "*CAMHD Licensed Provider Re-credentialing Policies and Procedures*" and the "*CAMHD MHP and Paraprofessional Background Re-verification Policies and Procedures.*"

B. The CAMHD Agency will obtain re-credentialing and background re-verification approval for all practitioners (licensed or unlicensed) from CAMHD ***prior*** to expiration of original credentialing dates. ***Services provided in the time period between the end of the original credentialing end date and the start of the re-credentialing period will not be reimbursed.***

C. The CAMHD Agency credentialing specialist or a primary source verification service representative must do the following:

1) Obtain a completed credentialing re-application or background re-verification form from the practitioner;

2) Obtain necessary consents to conduct re-credentialing or background re-verification primary source verifications;

3) Obtain primary source as outlined in the "CAMHD Licensed Provider Initial Re-recredentialing Checklist" and the "CAMHD MHP and Paraprofessional Background Re-verification Checklist";

4) Conduct a pre-audit of obtained primary source documents to ensure they meet CAMHD requirements – use the "CAMHD Licensed Provider Re-credentialing Checklist" and the "CAMHD MHP and Paraprofessional Background Re-verification Checklist" as guides;

5) Maintain original primary source re-verifications in the clinician file at the CAMHD Agency. Existence of the originals will be verified during delegation onsite audit visits;

6) Create a duplicate file for the applicant with all the primary source re-verifications;

7) Tab primary source re-verifications with numbers to match the numbers on the "CAMHD Licensed Provider Re-credentialing Checklist" and the "CAMHD MHP and Paraprofessional Background Re-verification Checklist";

8) Send a duplicate file to the CAMHD Credentialing Department; and

9) Keep current in the file all documents that expire such as licenses and malpractice insurance.

3. **Operational Requirements:**

A. The CAMHD Agency shall ensure that the CAMHD requirements as outlined in *the "CAMHD Contracted Agency Credentialing Systems Audit Tool"* are in place. **(See Attachment G)**

B. The CAMHD Agency shall have documented processes in place to monitor the activities of their credentialing department. The supervisor for their credentialing specialist must have knowledge of the current CAMHD credentialing requirements in order for them to efficiently implement them and monitor the performance of their staff. A yearly evaluation of CAMHD Credentialing Staff must be conducted in order for CAMHD Agency management to be fully aware of performance issues that may hinder its ability to perform CAMHD delegated functions. Other operational requirements are outlined in the *"CAMHD Contracted Agency Credentialing Systems Audit Tool"* must be followed.

4. **Delegate's Accountability to CAMHD**

The delegate is accountable to ensure that all activities set forth in this delegation policy and procedures and in the delegation agreement are completed in accordance with CAMHD requirements within the specified timelines.

TIMEFRAME OF DELEGATED ACTIVITIES

The delegated activities and functions described in this policy will be effective as of the date of signature of the CAMHD delegation agreement with the delegate.

MONITORING OF DELEGATED ACTIVITIES

1. **Schedule and Location:**

Onsite monitoring of delegated activities and credentialing operations/systems will be conducted at least annually at the CAMHD Agency office where the credentialing files

are kept. CAMHD has the right to conduct additional on-site visits as indicated by program quality issues that may arise.

2. **Audit Tools and Thresholds:**

   A. The tool to be used will be the "Licensed Provider CAMHD Contracted Agency Credential File Audit Form" **(See Attachment H)** and / or the "MHP and Paraprofessional CAMHD Contracted Agency Credential File Audit Form." **(See Attachment I)** The existence of the originals of previously submitted primary source verifications will be checked. The date of primary source verifications that were originally submitted to CAMHD for review will be pre-listed on these tools.

   B. The CAMHD Agency must provide original documents for the audit. Absent original documents will be noted as such if they cannot be found by the conclusion of the on-site audit. The CAMHD Agency must complete, at a minimum, 85% of the requirement listed in the tool to demonstrate substantial compliance with this activity.

   C. The "CAMHD Contracted Agency Credentialing Systems Audit" tool will be used to evaluate other delegated credentialing functions and requirements. The threshold score of 85% is required to demonstrate substantial compliance. See Delegate Evaluation Scoring Compliance Scale **(See Attachment J)**

3. **Sample Size:**

   A. The sample Agency credential files that will be audited is selected through random sampling from the CAMHD Contracted Agencies' monthly report of employees and subcontractors. Names listed on the licensed and unlicensed monthly reports are arranged alphabetically. Each year a number is chosen. For example, the number five (5) is chosen and then every 5th name on the lists will be selected for the sample until 25% or 20 files, whichever is lesser, is selected.

   B. CAMHD will provide the CAMHD Agency with the sample for the agency credential files audit no later than two (2) days before the audit.

   C. The sample size will be at least 25% or twenty (20) files, whichever is lesser, for each category (licensed and unlicensed) of the clinician files inclusive of all psychiatrists.

4. **Technical Assistance / Additional Training:**

   A. Technical assistance is provided by the CAMHD Credentialing Specialist to all agencies on areas that they have not scored 100%. This includes reviewing the agencies' current credentialing processes.

   B. A suggestion on how activities could be improved in order for agency to achieve 100% performance on all aspects of credentialing.

C. Agencies that have managed to show improvement in their credentialing processes including aspects that are not technically part of the delegated activities, such as human resource functions, are recognized for their efforts and are encouraged to partner with other CAMHD Credentialing Specialist who continue to struggle in order to promote mentoring as part of the overall plan to create a successful delegation program.

REPORTING OF ONSITE AUDIT FINDINGS AND CORRECTIVE ACTION REQUESTS AND RESPONSES

1. **Reporting of Findings to the Delegate**

A. At the close of the visit the CAMHD auditor will conduct an exit interview with the CAMHD Agency credentialing specialist and any other pertinent personnel. The CAMHD auditor will go over findings and items that would be requested in a corrective action plan, if any.

B. A copy of the following will be provided to the agency staff at the completion of the audit to allow delegate ample time to submit any corrective actions:

- Licensed Provider CAMHD Contracted Agency Credential File Audit Form
- MHP and Paraprofessional CAMHD Contracted Agency Credential File Audit Form
- CAMHD Contracted Agency Credentialing Systems Audit Tool
- The Delegation Audit Corrective Action Form
- The CAMHD Contract Agencies' Specialists will be asked to acknowledge receipts of audit results by signing the Agency Receipt of Delegated Corrective Action Plan.

2. **Reporting of Findings to the CAMHD Credentialing Committee**

A. A copy of the Delegation Audit Corrective Action Form will be presented to the CAMHD Credentialing Committee at the meeting following the completion of the onsite visit. The Credentialing Committee will review the results and make additional recommendations for CAP that they feel should be included in the final corrective action report sent to the CAMHD Agency.

B. The CAMHD Credentialing Committee will report these findings to the CAMHD Performance Improvement Steering Committee for review and recommendations as applicable.

3. **Corrective Action Activities**

The CAMHD Agency' corrective action plans and any supporting documents must be submitted to the CAMHD Credentialing Specialist no later than thirty (30) days from the CAMHD Agency's receipt of the onsite audit report (the date of the actual onsite audit). CAMHD shall respond as appropriate.

4. **Follow-up On-site Visit**

CAMHD reserves the right to conduct a follow up on-site visit to ensure corrective activities stated in the corrective action plan are in fact being implemented by the agency, with a one-week notice prior to the visit provided to the agency.

SUSPENSION OR REVOCATION OF DELEGATION

CAMHD retains the authority to suspend or revoke delegated activities upon the CAMHD Agency's continued inability to implement corrective action activities resulting in a score lower than the established threshold of 85% in any of the evaluated sections after the third on-site visit or at any time the delegate fails to fulfill its delegated obligations.

RESPONSIBILITIES OF CAMHD

A. CAMHD will review submitted files and either approve or disapprove the files within thirty (30) working days of receipt of file.

B. In the event that a file is not approved, CAMHD will notify the CAMHD Agency via telephone or electronic mail of the deficiencies. The agency will be advised that the file will be kept in the CAMHD Credentialing office for thirty (30) days.

C. Files that are not presented to the CAMHD Credentialing Committee after thirty (30) days of deficiency notification will be returned to the CAMHD Agency.

D. CAMHD retains the authority to conduct monitoring reviews as described above to ensure that delegated credentialing functions and operational systems are being performed in accordance to CAMHD standards and expectations.

E. CAMHD retains the right to suspend or revoke delegated activities as described the in the "Suspension or Revocation" section of this policy.

ATTACHMENTS:

A. Glossary of Credentialing Terms

B. CAMHD Pre-Delegation Assessment Tool, Version:

C. CAMHD Licensed Provider Initial Credentialing Checklist, Revised:

D. CAMHD MHP and Paraprofessional Initial Background Verification Checklist, Version: 3-06

E. CAMHD Licensed Provider Recredentialing Checklist, Revised: 3-06

F. CAMHD MHP and Paraprofessional Background Re-Verification Checklist, Revised: 3-06

G. CAMHD Contracted Agency Credentialing Systems Audit. Version: 10/1/04

H. CAMHD Contracted Agency Licensed Providers Credential File Audit Form, Version: 3-06

I. CAMHD Contract Agency MHP and Paraprofessional Credential File Audit Form, Version: 3-06

J. Delegate Evaluation Scoring Compliance Scale

Glossary of Credentialing Terms

Applicant: Any practitioner applying for credential approval with CAMHD.

Attestation Letter – A letter from a representative of the Agency attesting that they have obtained primary source verification documents from the primary source and that originals of these documents are maintained in the Agency credential file.

BBA - Balanced Budget Act, 42 CFR.

Client- Youth with emotional and/or behavioral challenges receiving intensive mental health services from CAMHD.

Contracted Provider Agency - Agency under contract with CAMHD to provide mental health services to CAMHD clients.

Credentialing The systematic process of assessing the qualifications of CAMHD and CAMHD Agencies' qualified licensed mental health professional (QMHP), direct care personnel and clinical supervisors. The credentialing process ensures that staff has the required primary source verified credentials, licenses, certificates, malpractice coverage and other pertinent background to provide services to the consumers of CAMHD.

Credentialing Committee - standing The Credentialing Committee is a standing Child and Adolescent Mental Health Division (CAMHD) committee is designated to provide oversight over CAMHD's credentialing processes in accordance with the Credentialing Committee Policy and Procedures. Membership shall be representative of various disciplines from CAMHD's various sections with preference given, but not limited to licensed professionals.

Delegation- Authority assigned by the CAMHD to another / other organization to conduct functions and activities in CAMHD's behalf according to CAMHD expectations and standards in such a manner that benefits CAMHD. The organization is identified as a "*delegate*".

DCCA - Department of Commerce and Consumer Affairs, professional and vocational licensing division of the State of Hawaii

ECMFG: The Educational Commission for Foreign Medical Graduates that evaluates foreign medical graduates' medical school curriculum to ensure that it is in alignment with the United States' medical school standards.

NCQA - National Commission of Quality Assurance

PISC - Performance Improvement and Steering Committee, standing CAMHD committee

Primary Source Verification - The process of verifying an individual professional's verbal or documented claims of professional and legal standing through direct contact with officials at the primary sources of education, licensing, prior employment, insurance carriers, etc.

Practitioner: Any QMHP.

Qualified Mental Health Professional (QMHP): The following State of Hawaii Licensed clinicians fall under this category: Medical Doctor (M.D.) Licensed Social Worker (LSW), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist (Ph.D or Psy.D); Advanced Practice Registered Nurse (APRN) and Osteopathic Doctor (D.O.)

Recredentialing A re-verification process of primary source information that may have changed since last reviewed, such as licenses and malpractice claims information

Termination: Voluntary or involuntary end of contract or employment with CAMHD or a CAMHD Contracted Provider Agency.

CAMHD Pre-Delegation Assessment Tool
Part 1

AGENCY NAME: _____

DATE AUDITED: _____

AUDITOR'S NAME: _____

REQUIRED ELEMENTS	PRESENT	
	YES	NO
CREDENTIALING POLICIES AND PROCEDURES		
• Required primary source verifications clearly listed		
• Clearly states that clinician is not allowed to treat CAMHD clients prior to being approved by the CAMHD Credentialing Committee		
• Clearly states the clinician is not allowed to provide supervision to another credentialed clinician prior to being approved by the CAMHD Credentialing Committee		
• States the methodology of submitting copies of primary source verification documents to CAMHD		
• A statement ensuring confidentiality of all information gathered during the credentialing process		
• A statement to maintain current all documents that expire such as license and malpractice insurance.		
• A statement assuring CAMHD that the agency will have a trained Credentialing Specialist back-up		
• A statement outlining the communication process between the Contracted Provider Agency Credentialing Specialist and the Billing Specialist		
HUMAN RESOURCES PROCEDURES		
• Mechanism in place to verify at least 2 employment references conducted prior to start date of clinician; as applicable		
VERIFICATION OF EXPIRED DOCUMENTS		
• Tracking system that would allow tracking of malpractice insurance expiration dates		
• Tracking system that would allow tracking of licenses		

CAMHD Pre-Delegation Assessment Tool
Part 1

Continuation

REQUIRED ELEMENTS	PRESENT	
	YES	NO
AGENCY CREDENTIALING SPECIALIST		
• Credentialing Specialist on staff		
• Trained Credentialing back - up		
• Presence of email address for Credentialing Specialist		
• Telephone number for Credentialing Specialist		
INFORMATION SYSTEMS		
• Credentialing Tracking Database		
• Ability to query expiration dates documents & produce reports		
BILLING SYSTEMS		
• Written communication system between the Credentialing Department and the Billing Department		
• Written billing rejection troubleshooting manual		
REPORTING REQUIREMENTS		
• Monthly report templates on computer		
CREDENTIALING STAFF REVIEWS		
• Established processes for Evaluation of Credentialing Specialist Performance yearly		

CAMHD Pre-Delegation Assessment Tool
Part 2
MHP and Paraprofessional
Credential File Set Up

AGENCY NAME: _____

DATE AUDITED: _____

AUDITOR'S NAME: _____

PRIMARY SOURCE DOCUMENTS	TABS FOR THESE REQUIREMENTS PRESENT IN THE CHART?	
	YES	NO
Copy of Attestation letter sent to CAMHD on file		
Original Background Verification Application on file		
Original Transcript or Education Verification on file		
Original Hawaii Justice Center Check printout or letter on file		
Original CAN check results on file		
TOTAL SCORE		

CAMHD Pre-Delegation Assessment Tool
Part 3
Licensed Providers Credential File Set Up

PROVIDER NAME: _____

DATE AUDITED: _____

AUDITOR'S NAME: _____

PRIMARY SOURCE DOCUMENTS	TABS FOR THESE REQUIREMENTS PRESENT IN THE CHART?	
	YES	NO
Copy of Attestation letter sent to CAMHD on file		
Original Credentialing Application		
Original Dated Resume		
Original Transcript / or letter verifying education		
Original Residency Verification or Original Internship Verification or Original Fellowship Verification		
Original ECMFG Verification; as applicable		
Copy of submitted DEA certificate		
Copy of submitted State certificate		
Original current malpractice coverage verification		
Original prior malpractice coverage No Claims verification		
Original DCCA license verification		
Original other state license verification		
Original Medicare / Medicaid Sanction verification		
Original Hawaii Justice Center Check		
Original NPDB verification *(for MDs, PHDs, PsyDs, Dos and APRNs)*		
Original CAN check results		
Original Board Verification		
Original letter of good standing from hospital		
TOTAL SCORE		

CAMHD LICENSED PROVIDER
INITIAL CREDENTIALING CHECKLIST

PROVIDER NAME: _____

PROVIDER AGENCY NAME: _____

PROVIDER I.D. _____

SPECIFIC JOB FUNCTION:
(Be very specific and do not use generic names such as counselor, therapist, etc.) _____

_____

SERVICE SITE ADDRESS:
(List all possible service sites under the direct control of the provider or agency) _____

_____

_____

LEVELS OF CARE: _____

1	**ATTESTATION** ☐ Attestation by Agency Credentialing Specialist that originals of primary source verifications are kept in the Agency Credentialing File ☐ Date: _____ ☐ Within 180 days of CAMHD review and approval
2	**STATE OF HAWAII LICENSE VERIFICATION** ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Expiration date: _____ ☐ Name and dated signature of person conducting the query
3	**CAMHD CREDENTIALING APPLICATION** ☐ Date of Affirmation signature: _____ ☐ Signature within 180 days of CAMHD review and approval

(Continued on next page)

	PHYSICAL / MENTAL HEALTH STATEMENT: ☐ Health Status Question answered ☐ If negative answer, letter of explanation attached. ☐ If negative answer, letter from CAMHD Agency attached. SUBSTANCE ABUSE QUESTION: ☐ Substance Abuse Question answered ☐ If negative answer, letter of explanation from applicant attached. ☐ If negative answer, letter from CAMHD Agency attached. LOSS OF LICENSE / FELONY CONVICTION QUESTION: ☐ Loss of License / Felony Conviction Question answered ☐ If negative answer, letter of explanation from applicant attached. ☐ If negative answer, letter from CAMHD Agency attached. LOSS / LIMITATION OF PRIVILEGES QUESTION: ☐ Loss / Limitation of privileges question answered ☐ If negative answer, letter of explanation from applicant attached. ☐ If negative answer, letter from CAMHD Agency attached.

4	**RESUME** ☐ Date Prepared: _____ ☐ Within 180 days of CAMHD review and approval ☐ Gaps over 6 months within the past 5 years? State dates:_____ ☐ Letter of explanation attached
5	**EDUCATION** ☐ Date of Verification: _____ ☐ Within 180 days of CAMHD review and approval if using Board Verification as method of verification ☐ Received directly from the University or telephone verification – no time limit ☐ Highest Applicable Degree obtained: _____ ☐ Date conferred: _____
6	**ECFMG (If M.D., foreign graduate and licensed after 1986)** ☐ Date of Verification: _____ ☐ Within 180 days of CAMHD review and approval ☐ Received directly from ECFMG

~~CAMHD LICENSED PROVIDER~~
INITIAL CREDENTIALING CHECKLIST

7	**RESIDENCY, INTERNSHIP, FELLOWSHIP – Query Highest Completed** ☐ Date of Verification: _____ ☐ Within 180 days of CAMHD review and approval if using Board Verification as method of verification ☐ Received directly from the program - no time limit ☐ Using Board Certification in lieu of primary verification with program

8	**BOARD ELIGIBILITY / CERTIFICATION** **IF ALREADY BOARD CERTIFIED:** **ABPN Boards:** ☐ **Child / Adolescent Psychiatry** Date of Certification: _____ ☐ **Psychiatry** Date of Certification: _____ ☐ **Other:** _____ Date of Certification: _____ ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD approval ☐ Received directly from ABPN or ☐ AOA Physician Master File ☐ AMA Physician Master File ☐ ABMS Official Directory of Board Certified Medical Specialists through the ABMS CertiFACTS Online, the AMBS Certifax service and the online subscription service, www.boardcertifieddocs.com **IF RECENTLY COMPLETED ACGME TRAINING** ☐ Copy of Certification from ACGME
9	**CONTROLLED SUBSTANCE – STATE (For M.D.'s only)** ☐ Copy of current certificate attached ☐ Expiration Date: _____
10	**CONTROLLED SUBSTANCE – DEA (For M.D.'s only)** ☐ Copy of current certificate attached ☐ Expiration Date: _____

CAMHD LICENSED PROVIDER
INITIAL CREDENTIALING CHECKLIST

11	**CURRENT MALPRACTICE INSURANCE COVERAGE** **Insurance:** _____ **Policy #:** _____ ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Expiration Date: _____ ☐ Verification issued to agency ☐ Received directly from the insurer ☐ Provider name stated on letter ☐ 1 mil / 3 mil aggregate coverage

12	**MALPRACTICE NO CLAIMS VERIFICATION** **(Query ALL insurances within the past 10 years)** **For Current Insurance:** _____ **Policy #:** _____ ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Verification issued to agency ☐ Received directly from the insurer ☐ Provider name stated on letter ☐ NO CLAIMS verified **Prior Insurance:** _____ **Policy #:** _____ ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Verification issued to agency ☐ Received directly from the insurer ☐ Provider name stated on letter ☐ NO CLAIMS verified
13	**NPDB** (only for MDs. PHDs, PSYDs, DOs, APRNs) ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Received directly NPDB or verified with NPDB by a third party verification service such as HCVS ☐ No records found. If record found, do letters below ☐ Letters of explanation from employee and supervisor are present

14	**STATE OF HAWAII LICENSE SANCTIONS AND COMPLAINTS HISTORY** ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Prior complaints verified, printout present ☐ All pages contain name and dated signature of person conducting the query
15	**MEDICARE / MEDICAID SANCTION** ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review approval ☐ No records found ☐ Name and dated signature of person conducting the query
16	**OTHER STATE LICENSES VERIFICATION** ☐ Name of State: _____ ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Status: ____ Active ____ Inactive ☐ Expiration date: _____ ☐ Prior complaints verified, printout present ☐ All pages contain name and dated signature of person conducting the query

17	**LETTER OF GOOD STANDING FROM HOSPITALS WITH CURRENT PRIVILEGES** ☐ Name of Hospital: _____ ☐ Date of Verification: _____ ☐ Verification within 180 days months of CAMHD approval
18	**HAWAII JUSTICE CENTER CHECK** ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ No records found printout signed & dated by person conducting query ☐ If record found, a complete printout is present with each page signed & dated by person conducting query ☐ Letters of explanation from employee and supervisor are present

CAMHD LICENSED PROVIDER
INITIAL CREDENTIALING CHECKLIST

19	CHILD ABUSE & NEGLECT CHECKS ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD approval ☐ No records found ☐ If record found, letters of explanation from employee and supervisor are present ☐ Consent to release information from Child Protective Services submitted
20	**COMBINED SENTINEL, GRIEVANCE, CAMHD QUESTIONABLE PROVIDERS, AND MEDICAID DATABASE CHECK** for reported incidents, complaints, performance issues, child abuse case, and Medicaid sanction – **(For CAMHD to complete)** ☐ Database checked for a name match ☐ Date checked: _____ ☐ No name match found. ☐ If name match found, copy of report attached for committee review
21	**INITIAL ONSITE AUDIT (to be completed by CAMHD)** ☐ Date Conducted: _____ ☐ Within 1 year of CAMHD review and approval ☐ Score of 80 or higher? _____

The undersigned credentialing staff has reviewed all of the submitted copies of primary source documents to ensure that they are in accordance to the established CAMHD Licensed Provider Credentialing Requirements. This file is found to be in compliance with the requirements and is recommended for presentation to the CAMHD Credentialing Committee on _____.

_____ _____

CAMHD CREDENTIALING STAFF **DATE**

BASED ON THE ABOVE PRIMARY SOURCE VERIFICATIONS THE COMMITTEE HAS GRANTED THE FOLLOWING DECISION:

- ☐ **APPROVED FULL CREDENTIAL STATUS from _____ to _____.**
  See Official letter.
- ☐ **DEFERRED – see letter requesting additional information.**
- ☐ **DENIED – see letter stating reason for denial.**

_____ _____

CAMHD CREDENTIALING CMTE. CHAIR **DATE**

CAMHD MHP & PARAPROFESSIONAL
INITIAL BACKGROUND VERIFICATION CHECKLIST

PROVIDER NAME: _____

PROVIDER AGENCY NAME: _____

PROVIDER I.D. _____

LEVELS OF CARE: _____

1	**ATTESTATION** ☐ Attestation by Agency Credentialing Specialist that originals of primary source verifications are kept in the Agency Credentialing File ☐ Date: _____ ☐ Signature within 180 days of CAMHD review and approval.
2	**BACKGROUND VERIFICATION APPLICATION** ☐ Date of Affirmation signature: _____ ☐ Signature within 180 days of CAMHD review and approval ☐ Restrictive Action Questions answered ☐ If negative answer, letter of explanation attached. ☐ Health Status Question answered ☐ If negative answer, letter of explanation attached. ☐ Work Experience completed & Resume attached
3	**EDUCATION** ☐ Date of Verification: _____ ☐ Received directly from the University or telephone verification – no time limit ☐ Highest Applicable Degree obtained: _____ ☐ Date conferred: _____
4	**LICENSE VERIFICATION** * Submit a copy of any license the applicant has (ex. RN, LPN, LSW, etc…) relative to their position/job.
5	**HAWAII JUSTICE CENTER CHECK** ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ No records found printout signed & dated by person conducting query ☐ If record found , a complete printout, signed & dated is present ☐ Letters of explanation from employee and supervisor are present

CAMHD MHP & PARAPROFESSIONAL
INITIAL BACKGROUND VERIFICATION CHECKLIST

6	CHILD ABUSE & NEGLECT CHECKS ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD approval ☐ No records found ☐ If record found, letters of explanation from employee and supervisor are present ☐ Consent to release information from Child Protective Services submitted
7	COMBINED SENTINEL, GRIEVANCE, CAMHD QUESTIONABLE PROVIDERS, AND MEDICAID DATABASE CHECK for reported **incidents, complaints, performance issues, child abuse case, and Medicaid sanction – for CAMHD to complete** ☐ Database checked for a name match ☐ Date checked: _____ ☐ No name match found. ☐ If name match found, copy of report attached for committee review

The undersigned credentialing staff has reviewed all of the submitted copies of primary source documents to ensure that they are in accordance to the established CAMHD MHP and Paraprofessional Background Verification Requirements. This file is found to be in compliance with the requirements and is recommended for presentation to the CAMHD Credentialing Committee on _____.

_____ _____
CAMHD CREDENTIALING STAFF **DATE**

BASED ON THE ABOVE PRIMARY SOURCE VERIFICATIONS THE COMMITTEE HAS GRANTED THE FOLLOWING DECISION:

- ☐ **APPROVED FULL APPROVAL STATUS from _____ to _____.**
  See Official letter.
- ☐ **DEFERRED – see letter requesting additional information.**
- ☐ **DENIED – see letter stating reason for denial.**

_____ _____
CAMHD CREDENTIALING CMTE. CHAIR **DATE**

CAMHD LICENSED PROVIDER
RE-CREDENTIALING CHECKLIST

PROVIDER NAME: _____

PROVIDER AGENCY NAME: _____

PROVIDER I.D. _____

SPECIFIC JOB FUNCTION: _____
(Be very specific and do not use generic names such as counselor, therapist, etc.) _____

SERVICE SITE ADDRESS: _____
(List all possible service sites under the direct control of the provider or agency) _____

_____

LEVELS OF CARE: _____

1	**ATTESTATION** ☐ Attestation by Agency Credentialing Specialist that originals of primary source verifications are kept in the Agency Credentialing File ☐ Date: _____ ☐ Within 180 days of CAMHD review and approval
2	**STATE OF HAWAII LICENSE VERIFICATION** ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Expiration date: _____ ☐ Name and dated signature of person conducting the query
3	**CAMHD CREDENTIALING APPLICATION** ☐ Date of Affirmation signature: _____ ☐ Signature within 180 days of CAMHD review and approval

(Continued on next page)

CAMHD LICENSED PROVIDER
RE-CREDENTIALING CHECKLIST

	PHYSICAL / MENTAL HEALTH STATEMENT: ☐ Health Status Question answered ☐ If negative answer, letter of explanation attached. ☐ If negative answer, letter from CAMHD Agency attached. SUBSTANCE ABUSE QUESTION: ☐ Substance Abuse Question answered ☐ If negative answer, letter of explanation from applicant attached. ☐ If negative answer, letter from CAMHD Agency attached. LOSS OF LICENSE / FELONY CONVICTION QUESTION: ☐ Loss of License / Felony Conviction Question answered ☐ If negative answer, letter of explanation from applicant attached. ☐ If negative answer, letter from CAMHD Agency attached. LOSS / LIMITATION OF PRIVILEGES QUESTION: ☐ Loss / Limitation of privileges question answered ☐ If negative answer, letter of explanation from applicant attached. ☐ If negative answer, letter from CAMHD Agency attached.

4	**RESUME** ☐ Date Prepared: _____ ☐ Within 180 days of CAMHD review and approval ☐ Gaps over 6 months with past 5 years? State dates:_____ ☐ Letter of explanation attached
5	**EDUCATION (if obtained higher education than previously credentialed)** ☐ Date of Verification: _____ ☐ Within 180 days of CAMHD review and approval if using Board Verification as method of verification ☐ Received directly from the University or telephone verification – no time limit ☐ Highest Applicable Degree obtained: _____ ☐ Date conferred: _____

6	**BOARD ELIGIBILITY / CERTIFICATION** **IF ALREADY BOARD CERTIFIED:** **ABPN Boards:** ☐ **Child / Adolescent Psychiatry** Date of Certification: _____ ☐ **Psychiatry** Date of Certification: _____ ☐ **Other:** _____ Date of Certification: _____ ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD approval ☐ Received directly from ABPN or ☐ AOA Physician Master File ☐ AMA Physician Master File ☐ ABMS Official Directory of Board Certified Medical Specialists through the ABMS CertiFACTS Online, the AMBS Certifax service and the online subscription service, www.boardcertifieddocs.com **IF RECENTLY COMPLETED ACGME TRAINING:** ☐ Copy of Certification from ACGME
7	**CONTROLLED SUBSTANCE – STATE (For M.D.'s only)** ☐ Copy of current certificate attached ☐ Expiration Date:
8	**CONTROLLED SUBSTANCE – DEA (For M.D.'s only)** ☐ Copy of current certificate attached ☐ Expiration Date:
9	**CURRENT MALPRACTICE INSURANCE COVERAGE** **Insurance:** _____ **Policy #:** _____ ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Expiration Date: _____ ☐ Verification issued to agency ☐ Received directly from the insurer ☐ Provider name stated on letter ☐ 1 mil / 3 mil aggregate coverage

CAMHD LICENSED PROVIDER
RE-CREDENTIALING CHECKLIST

10	MALPRACTICE NO CLAIMS VERIFICATION **(Query ALL insurances within the past 10 years)** **For Current Insurance:** _____ **Policy #:** _____ ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Verification issued to agency ☐ Received directly from the insurer ☐ Provider name stated on letter ☐ NO CLAIMS verified **(Query ALL other insurances held since last credentialed)** **Other Insurance:** _____ **Policy #:** _____ ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Verification issued to agency ☐ Received directly from the insurer ☐ Provider name stated on letter ☐ NO CLAIMS verified
11	**NPDB** (only for MDs. PHDs, PSYDs, DOs, APRNs) ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Received directly NPDB or verified with NPDB by a third party verification service such as HCVS ☐ No records found. If record found, do letters below ☐ Letters of explanation from employee and supervisor are present
12	**STATE OF HAWAII LICENSE SANCTIONS AND COMPLAINTS HISTORY** ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Prior complaints verified, printout present ☐ All pages contain name and dated signature of person conducting the query

13	**MEDICARE / MEDICAID SANCTION** ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review approval ☐ No records found ☐ Name and dated signature of person conducting the query
14	**OTHER STATE LICENSES VERIFICATION** ☐ Name of State: _____ ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ Status: ____ Active ____ Inactive ☐ Expiration date: _____ ☐ Prior complaints verified, printout present ☐ All pages contain name and dated signature of person conducting the query

15	**LETTER OF GOOD STANDING FROM HOSPITALS WITH CURRENT PRIVILEGES** ☐ Name of Hospital: _____ ☐ Date of Verification: _____ ☐ Verification within 180 days months of CAMHD approval
16	**HAWAII JUSTICE CENTER CHECK** ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ No records found printout signed &dated by person conducting query ☐ If record found, a complete printout, with each page signed & dated is present ☐ Letters of explanation from employee and supervisor are present
17	**CHILD ABUSE & NEGLECT CHECKS** ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD approval ☐ No records found ☐ If record found, letters of explanation from employee and supervisor are present ☐ Consent to release information from Child Protective Services submitted

CAMHD LICENSED PROVIDER
RE-CREDENTIALING CHECKLIST

18	COMBINED SENTINEL, GRIEVANCE, CAMHD QUESTIONABLE PROVIDERS, AND MEDICAID DATABASE CHECK for reported incidents, complaints, performance issues, child abuse case, and Medicaid sanction – **(For CAMHD to complete)** ☐ Database checked for a name match ☐ Date checked: _____ ☐ No name match found. ☐ If name match found, copy of report attached for committee review
19	INITIAL ONSITE AUDIT (to be completed by CAMHD) ☐ Date Conducted: _____ ☐ Within 1 year of CAMHD review and approval ☐ Score of 80 or higher? _____

The undersigned credentialing staff has reviewed all of the submitted copies of primary source documents to ensure that they are in accordance to the established CAMHD Licensed Provider Credentialing Requirements. This file is found to be in compliance with the requirements and is recommended for presentation to the CAMHD Credentialing Committee on _____.

_____ _____
CAMHD CREDENTIALING STAFF **DATE**

BASED ON THE ABOVE PRIMARY SOURCE VERIFICATIONS THE COMMITTEE HAS GRANTED THE FOLLOWING DECISION:

☐ **APPROVED FULL CREDENTIAL STATUS from _____ to _____.**
See Official letter.
☐ **DEFERRED – see letter requesting additional information.**
☐ **DENIED – see letter stating reason for denial.**

_____ _____
CAMHD CREDENTIALING CMTE. CHAIR **DATE**

CAMHD MHP & PARAPROFESSIONAL
BACKGROUND REVERIFICATION CHECKLIST

PROVIDER NAME: _____

PROVIDER AGENCY NAME: _____

PROVIDER I.D. _____

LEVELS OF CARE: _____

1	**ATTESTATION** ☐ Attestation by Agency Credentialing Specialist that originals of primary source verifications are kept in the Agency Credentialing File ☐ Date: _____ ☐ Signature within 180 days of CAMHD review and approval.
2	**BACKGROUND VERIFICATION APPLICATION** ☐ Date of Affirmation signature: _____ ☐ Signature within 180 days of CAMHD review and approval ☐ Restrictive Action Questions answered ☐ If negative answer, letter of explanation attached. ☐ Health Status Question answered ☐ If negative answer, letter of explanation attached. ☐ Updated Resume/work experience
3	**EDUCATION** ***(If obtained higher education than previously verified)*** ☐ Date of Verification: _____ ☐ Received directly from the University or telephone verification ☐ Highest Applicable Degree obtained: _____ ☐ Date conferred: _____
4	**LICENSE VERIFICATION** * Submit a copy of any license the applicant has (ex. RN, LPN, LSW, etc…) relative to their position/job.
5	**HAWAII JUSTICE CENTER CHECK** ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD review and approval ☐ No records found printout signed & dated by person conducting query ☐ If record found, a complete printout, each page signed & dated is present ☐ Letters of explanation from employee and supervisor are present

CAMHD MHP & PARAPROFESSIONAL
BACKGROUND REVERIFICATION CHECKLIST

6	CHILD ABUSE & NEGLECT CHECKS ☐ Date of Verification: _____ ☐ Verification within 180 days of CAMHD approval ☐ No records found ☐ If record found, letters of explanation from employee and supervisor are present ☐ Consent to release information from Child Protective Services submitted
7	COMBINED SENTINEL, GRIEVANCE, CAMHD QUESTIONABLE PROVIDER, AND MEDICAID DATABASE CHECK (To be completed by CAMHD Credentialing Department) ☐ Database checked for a name match ☐ Date checked: _____ ☐ No name match found ☐ If name match found, copy of report attached for committee review

The undersigned credentialing staff has reviewed all of the submitted copies of primary source documents to ensure that they are in accordance to the established CAMHD MHP and Paraprofessional Background Verification Requirements. This file is found to be in compliance with the requirements and is recommended for presentation to the CAMHD Credentialing Committee on _____.

_____ _____

CAMHD CREDENTIALING STAFF **DATE**

BASED ON THE ABOVE PRIMARY SOURCE VERIFICATIONS THE COMMITTEE HAS GRANTED THE FOLLOWING DECISION:

☐ **APPROVED FULL APPROVAL STATUS from _____ to _____.**
See Official letter.

☐ **DEFERRED – see letter requesting additional information.**

☐ **DENIED – see letter stating reason for denial.**

_____ _____

CAMHD CREDENTIALING CMTE. CHAIR **DATE**

AGENCY NAME
2004 CAMHD DELEGATION AUDIT
AGENCY CREDENTIALING SYSTEM
DATE OF AUDIT

REQUIREMENT	POSSIBLE POINTS	AGENCY SCORE
Existence of an agency Delegation P&P that reflects the CAMHD Delegated Primary Source Verification P&P	2	
Existence of an agency Initial Credentialing of Licensed Healthcare Professionals P&P that reflects the CAMHD initial credentialing of licensed professional P&P	2	
Existence of an agency Re-Credentialing of Licensed Healthcare Professionals P&P that reflects the CAMHD re-credentialing of licensed professional P&P	2	
Existence of an agency Initial Background Verification and Re-Verification of Unlicensed Mental Health Professional and paraprofessional policy and procedure that reflects the CAMHD initial background verification and re-verification of unlicensed mental health professional and paraprofessional P&P.	2	
Required primary source verifications clearly listed in the 3 above policies	6	
The 3 Credentialing Policies clearly states that clinician is not allowed to treat CAMHD clients prior to being approved by the CAMHD Credentialing Committee	6	
The 3 Credentialing Policies clearly states the clinician is not allowed to provide supervision to another credentialed clinician prior to being approved by the CAMHD Credentialing Committee	6	
The 3 Credentialing Policies clearly states the methodology of submitting copies of primary source verification documents to CAMHD	6	
The 3 Credentialing Policies contains a statement ensuring confidentiality of all information gathered during the credentialing process	6	
Initial Licensed Credentialing P&P and Re-Credentialing P&P includes a statement to maintain current all documents that expire such as license and malpractice insurance.	2	
Credentialing Policies includes a statement assuring CAMHD that the agency will have a trained Credentialing Specialist back-up	2	
Credentialing Policies include a statement outlining the communication process between the Contracted Provider Agency Credentialing Specialist and the Agency Billing Specialist	2	

AGENCY NAME
2004 CAMHD DELEGATION AUDIT
AGENCY CREDENTIALING SYSTEM
DATE OF AUDIT

REQUIREMENT	POSSIBLE POINTS	AGENCY SCORE
The Credentialing P&Ps state that at least 2 employment references checks are conducted prior to start date of clinician; as applicable	2	
Credentialing P&Ps state that copy of current malpractice insurance (use the provider credential chart sample to check this) is maintained in the credentialing files	2	
Credentialing P&Ps state that copy of current license to practice – either printout from DCCA website or copy of actual license card - is maintained in the credentialing files.	2	
Agency has template used for CAMHD monthly reporting. All columns required for the monthly report are included in the template.	2	
Written communication system between the Credentialing Department and the Billing Department	3	
Written billing rejection troubleshooting manual	3	
Existence of a Credentialing Tracking Database	3	
Ability to query expiration dates documents & produce reports	3	
Submitted Monthly Reports By the 15th of the month (September 2003 to August 2004)	12	
Name of main Specialist:	3	
Trained back – up: NAME:	3	
Presence of email address for Credentialing Specialist	3	
Presence of email for back - up	3	
Telephone number for Credentialing Specialist	3	
Presence of telephone number for Back-up	3	
Methodology of evaluation of Credentialing Specialist Performance clearly outlined in the credentialing or HR policy and procedures.	3	
Credentialing Specialist Performance Evaluated since last Credentialing Audit (2003)	3	
TOTAL SCORES	100	
% OF COMPLIANCE WITH CREDENTIALING DELEGATION SYSTEM REQUIREMENTS	0.00%	

NAME OF AGENCY

2006 CAMHD DELEGATION AUDIT

FOR PRIMARY SOURCE VERIFICATION DOCUMENTS

LICENSED PRACTITIONERS

DATE OF AUDIT

FILE NUMBER	1		
FILE NAME			
REQUIREMENT	PSV Date	YES	NO
Copy of Attestation Letter			
Original Cred. App.			
Original Dated Resume			
Original Transcript / or letter verifying education			
Original Residency Verification or			
Original Internship Verification or			
Original Fellowship Verification			
Original ECMFG Verification; as applicable			
Copy of submitted DEA certificate			
Copy of submitted State certificate			
malpractice coverage verification			
Original prior malpractice coverage No Claims verification			
Original DCCA license verification			
Original other state license verification			
Original Medicare / Medicaid Sanction verification			
Original Hawaii Justice Center Check			
Original NPDB verification (for MDs, PHDs, PsyDs, Dos and APRNs)			
Original CAN check			
Original Board Verif			
Original letter of good standing from hospital			
If RE-CREDENTIALING, timely re-credentialed?			
		0	0

NAME OF AGENCY
2006 CAMHD DELEGATION AUDIT
FOR PRIMARY SOURCE VERIFICATION DOCUMENTS
UNLICENSED PRACTITIONERS
Date of Audit

FILE NUMBER	1			2		
FILE NAME						
REQUIREMENT	PSV Date	YES	NO	PSV Date	YES	NO
Copy of Attestation Letter						
Original Cred. Application						
Original Dated Resume						
Original Transcript / or letter verifying education						
Original Hawaii Justice Center Check						
Original CAN check						
If RE-CREDENTIALING, timely re-credentialed						
		0	0		0	0

Delegate Evaluation Scoring Compliance Scale

Full Compliance	The Delegate is 95% - 100% in compliance with the standards	• Delegation Agreement may be implemented • An annual performance evaluation will be performed in one year • A CAP may be suggested based on severity of recommendations.
Substantial Compliance	The Delegate is 85% - 94% in compliance with the standards	• Delegation Agreement may be implemented • An annual performance evaluation will be performed in on year. A corrective action plan will be implemented. • A focus performance evaluation may be performed within six (6) months of receiving the recommendations from CAMHD
Minimal Compliance	The Delegate is 70% - 84% in compliance with the standards	• A corrective action plan will be initiated by the delegate • An on-site and/or desk review focused performance evaluation may be performed within three (3) to six (6) months of prior performance evaluation. • The committee will determine the appropriate time frame for re-evaluation.
Non-Compliance	The Delegate is less than or equal to 69% in compliance with the standard	• The committee will be notified of score and non-compliance with standards • An on-site will be conducted within three (3) months of prior performance evaluation. • Committee will determine appropriate action
No Applicable	The standard does not apply to this Delegate at this time	• N/A