CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
POLICY AND PROCEDURE MANUAL

SUBJECT: Initial and Re-Credentialing of Licensed Qualified Mental Health Professionals	**Number:**	**80.308**
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REFERENCE: HRS; HI QUEST; QARI; HI State; Licensing Boards; CMSS; CAMHD QAIP; NCQA Standards for Credentialing & Re-credentialing: 42CFR; §438.12, § 438.200, § 438.204, § 438.206, § 438.214, §438.224; HSAG Audit Tool; HAR, Title 11, Department of Health, Chapter 98, Special Treatment Facilities	**APPROVED:**
	Signature on File 8/23/11
	Administrator Eff. Date

PURPOSE

The purpose of this policy is to assure that qualified mental health professionals through established minimum qualifications render services to CAMHD youth.

DEFINITIONS

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

POLICY

1. The CAMHD ensures a systematic credentialing process of assessing the qualifications of CAMHD and CAMHD contracted Provider Agencies' licensed, Qualified Mental Health Professionals (QMHP), direct care personnel and clinical supervisors. This process ensures that any Hawaii licensed practitioner providing mental health services to youth served by the CAMHD, who either:

   A. Is an independent contractor with CAMHD; or

   B. Is employed with CAMHD; or

   C. Is employed or subcontracted by a CAMHD contracted Provider Agency, hereafter referred to as the Provider Agency; and

   is credentialed *prior* to providing direct mental health services to youth.

2. The CAMHD Credentialing Committee, hereinafter referred to as the "Committee" meets monthly to make determination on all credentialing/re-credentialing applications. The Committee makes such determinations in accordance with this policy and the policy and procedures set forth in CAMHD P&P 80.508, "Credentialing Committee."

3. The CAMHD reserves the right to make the final determination about which practitioners may participate in its network and provide services to CAMHD registered youth. Practitioners shall meet all applicable standards to participate in the CAMHD's provider network.

   The CAMHD *will not pay* for services rendered if the provider is NOT credentialed.

4. The CAMHD credentials the following licensed practitioners as a QMHP:

   - Medical Doctor
   - Licensed Clinical Social Worker (LCSW)
   - Licensed Marriage and Family Therapist (LMFT)

- Licensed Psychologist (Ph.D. or Psy.D.);
- Advanced Practice Registered Nurse (APRN); and
- Osteopathic Doctor (D.O.)

5. The licensed practitioners who do not need to be credentialed/re-credentialed by CAMHD include:

   - Practitioners who practice exclusively within the inpatient setting and who do not provide mental health care for CAMHD youth who are admitted to a hospital or another inpatient setting. These practitioners need to be credentialed by the hospital or the inpatient setting they provide services.
   - Practitioners who do not provide care for CAMHD youth in a treatment setting (consultants).

6. The CAMHD will delegate to the Hospital-based Residential Programs the credentialing of QMHPs only.

7. **Applications.** The CAMHD Credentialing Section reviews all credentialing and re-credentialing applications. All applications shall include all required documents and verifications that will be presented to the Committee for review and approval. *(See **Attachment B, CAMHD Licensed Provider Initial Credentialing Application Form)*** A completed application shall include or meet the following requirements:

   A. All blanks on the application form are filled in and necessary additional explanations provided;

   B. All requested attachments and information have been submitted;

   C. Verification of the information is complete and done through primary sources when required; and

   D. All information necessary to properly evaluate the applicant's qualifications has been received and is consistent with the information provided in the application.

8. **Primary Source Verifications.** The CAMHD delegates primary source verification to the Provider Agencies for their employees and/or subcontractors. The CAMHD delegates the primary source verification to a contracted credentialing verification service for CAMHD employees. Required primary source verifications are outlined in ***Attachment C, CAMHD Licensed Provider Checklist (LPC)***, and include verification timeline requirements, and methods of accepted primary source verification.

   A. Practitioners shall be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs (DCCA), Professional and Vocational Licensing Division at http://pvl.ehawaii.gov/pvlsearch/app to verify Hawaii licensure.

   B. The credentials of practitioners shall be evaluated against pre-determined criteria in conjunction with the National Committee of Quality Assurance (NCQA) and state licensing requirements.

C. Practitioners will be notified in writing via regular mail of any information obtained during the credentialing process that varies substantially from the information provided to the CAMHD and/or the Provider Agency.

9. **Timeframes.** To prevent the Committee from considering a provider whose credentials may have changed since they were verified, primary source verification should be no more than one hundred eighty (180) days old (unless otherwise stated) at the time of the credentialing committee decision.

A. **Written verifications.** The one hundred eighty (180) days time limit begins with the date that the credentials were verified (the date on the letter or the signature date) and not when CAMHD or the Provider Agency received the information. Written documentation shall be complete using indelible ink.

B. **Oral verifications.** Oral verifications require a written statement to the CAMHD stating the verification date, the name of the primary source person who verified the information, the name and dated signature of the CAMHD or Provider Agency staff that conducted the query.

C. **Internet website verifications.** Internet verifications require the dated signature of the CAMHD or Provider Agency staff that conducted the query on all printed pages. Electronic signatures are allowed provided the signatures are password protected. The Provider Agencies and other agencies designated as primary source verifiers shall send a written report to the CAMHD of their electronic signature password protection policies.

10. **Credentialing Cycle.** Once a practitioner is credentialed, he/she is able to carry the full credential status for two (2)-years with the specified agency he/she is credentialed under. Upon approval, the Credentialing Section shall submit the practitioner's credentialing information to the CAMHD's Management Information System (MIS) Section for entry into the information/billing system.

A. The credentialing cycle begins with the date of the initial Committee decision to approve the credentialing application and ends two (2) years later. For example, if the Committee approved the practitioner's credentialing application on December 1, 2011, the practitioner's credentialing period would begin on December 1, 2011 and end on December 1, 2013.

B. Practitioners are considered credentialed/re-credentialed upon notification from the Credentialing Section after the Committee has rendered its decision.

11. **Confidentiality Policy**. The CAMHD holds all practitioner data and information obtained through the credentialing/re-credentialing process in strict confidence.

12. **Non-discrimination Policy.** The Committee does not make credentialing/re-credentialing decisions based solely on the applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients the practitioner (e.g., Medicaid) specializes in.

13. **Practitioner Rights.** The CAMHD shall provide all contracted agencies and CAMHD employees of their practitioner rights in the credentialing/re-credentialing process. Rights include but are not limited to:

    A. A review of submitted information in support of their credentialing/re-credentialing applications;

    B. The right to correct erroneous information; and

    C. The right to appeal any credentialing/re-credentialing decisions that limit, suspend or terminate a practitioner's credentialing/re-credentialing status.

PROCEDURES

1. **Credentialing Section Responsibilities:** The Credentialing Section staff, under the oversight of the Performance Manager, will:

    A. Inform the Provider Agencies of CAMHD's credentialing policies and procedures, providing them with a copy of each of CAMHD credentialing policies and procedures. The Provider Agencies are required to have similar policies and procedures to follow within their own agencies that comply with the CAMHD's credentialing policies and procedures.

    B. Provide training to the Provider Agencies on the credentialing/re-credentialing operational processes and requirements.

    C. Perform the following prior to the Committee's review of credentialing/re-credentialing applications:

        1) Receive and process all credentialing/re-credentialing applications prior to Committee review;

        2) Process all applications and conduct preliminary reviews of each practitioner's credentials in accordance with the LPC to ensure all primary source verifications being submitted meet the CAMHD's established criteria;

        3) Maintain and have available for review by the Committee the practitioner files that meet established criteria prior to the scheduled Committee meetings;

        4) Present a list of the names of all practitioners who meet the established criteria to the Committee for review and final approval;

        5) Present to the Committee all applicant files that do not meet all established criteria with all documentation necessary for the Committee to review and render appropriate determinations; and

        6) Provide the CAMHD's MIS Section with a list of credentialed practitioners following approval from the Credentialing Committee.

    Credentialing/Re-credentialing Documents and Primary Source Verification Requirements. The Credentialing Section staff will ensure that all credentialing/re-credentialing documentation and verification requirements are met. Primary source verification should be no more than one hundred eighty (180) days old (unless otherwise stated) at the time

of the Committee's decision. Staff will use the LPC that outlines the CAMHD required primary source verifications, verification timeline requirements, and methods of accepted primary source verification. All boxes of the LPC must be checked off with verifying documents attached. The LPC includes the following criteria items:

D. Attestation: ***(See Attachment D, Attestation Letter)***. The Provider Agency or CAMHD's designated primary source verification agency representative shall complete the "*CAMHD Attestation Letter*" and submit the signed original letter to the Credentialing Section.

E. Background Verification Application. The *Background Verification Form for Qualified Mental Health Professionals* (Application Form). Applicants ***shall complete all areas*** of the application form including:

1) Identifying Information
2) Educational Information
3) Health status: In the event an applicant answers "Yes", a letter of explanation must accompany the application. The Committee shall review the letter of explanation and weigh the implications of any health conditions stated as it pertains to the applicant's ability to perform the functions of the position for which the provider is being credentialed. The Committee may consider approval of the applicant with or without restrictions.
4) Restrictive Actions: In the event an applicant answers "Yes", a letter of explanation must accompany the application. The explanation shall be for each occurrence with dates, parties involved, circumstances surrounding the situation and the outcomes. The CAMHD shall review the application and letter of explanation from applicant with restrictive actions and a letter of support from the agency addressing the specific restrictive action. Restrictive actions include any of the following below:
    a. Loss, denial, limitation of privileges or disciplinary activity
    b. Voluntary relinquishing of privileges or license
    c. Denial of certification
    d. Malpractice issues
    e. Criminal convictions
    f. Illegal Drug Use
    g. History of loss or limitation of privileges or disciplinary activity
5) Relevant Work/Volunteer/Intern Experience
6) Release of Information Authorizations: Dated signature required
7) Affirmation: Dated signature required
8) Release and Immunity: Dated signature required
9) Provider Rights

10) Attestation as to the correctness and completeness of the application. The applicant must sign and date the attestation statement in the application.

F. Resume: The CAMHD does not require primary source verification of relevant work history to be submitted as part of the credentialing/re-credentialing requirement but defers employment verification activities as part of the intra agency human resource functions performed by the CAMHD or Provider Agencies in the case of CAMHD personnel.

For the work history requirement, a minimum of five (5) years of relevant work history must be obtained through the practitioner's resume. If it is obtained from the resume, the resume must state *a date of preparation* so that the Committee is able to determine the one hundred eighty (180)-day time limit for this criterion. The applicant must submit a written explanation of any gaps over six (6) months.

G. Education: The CAMHD or the Provider Agency must verify only the highest level of credentials attained. If a physician is board certified, verification of that board certification fully meets this element because specialty boards verify education and training. For practitioners who are not board certified, verification of completion of residency fully meets this requirement. For those who have not completed a residency program, verification of graduation from medical school meets this standard. Old verifications would be acceptable provided it verifies the education that is applicable to the licensure for which the applicant is being credentialed.

1) Education and training including board certification if the practitioner states on the application that he/she is board certified.

2) Education Verification Requirements for Different Specialties:

a. *For Board Certified Physicians:*

Verification of board certification fully meets education verification requirements because medical boards already verify education and training. Separate verification of education and residency training is not required for board certified medical doctors.

b. *For Non-Board Certified Physicians:*

Verification requirements of the completion of residency training or graduation from medical school can be met by the one of the following:

- Confirmation from the medical school
- Entry in the American Medical Association (AMA) Physician Master File
- Entry in the American Osteopathic Association (AOA) Physician Master File
- Confirmation from the Educational Commission for Foreign Medical Graduates (ECMFG) for international medical graduates after 1986

c. *Non-Physician Behavioral Healthcare Professionals*

Confirmation from the university specifically stating name of applicant, degree and date conferred. Written verifications must be received directly from the university attended. Telephone verifications are acceptable provided the name of the person verifying the information; the date of verification and the person's name at the primary source is identified in a memo.

H. Board certification, if designated by the practitioner on the application. ***Verification Time Limit:*** *Any NCQA recognized source is valid up to one (1) year but if it is a document source (e.g. American Board of Medical Specialties (ABMS) Compendium), verification must also be based on the most current edition*

If an applicant states in their application form that they are board-certified, the board certification must be queried. Acceptable methods of verification include any of the following:

1) *Physicians*

Completion of one of these:

- Entry in the ABMS Compendium.
- Entry in the American Osteopathic Association (AOA) Physician Master File.
- Entry in the AOA Directory of Osteopathic Physicians.
- Entry in the American Medical Association (AMA) Master File.
- Confirmation from the specialty board

2) *Non-Physician Behavioral Healthcare Professionals*

Confirmation from the specialty board

3) *Foreign Trained Physicians*

Foreign trained physicians that graduated and obtained licensed after 1986 must submit a copy of their ECFMG certificate.

I. State of Hawaii License Verification. ***Verification time limit: 180 days***

Applicant shall possess a current license to practice in the State of Hawaii.

The Provider Agency shall confirm that the applicant holds a valid, current State of Hawaii license to practice. The license must be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and Vocational Licensing Division at http://pvl.ehawaii.gov/pvlsearch/app. A copy of the license shall be printed and the person conducting the query shall date and sign all pages of the printout results.

J. Controlled Substance – State and Federal. ***Verification time limit: Certificate must be effective at the time of the credentialing/re-credentialing committee decision***. If the applicant is a medical doctor, a copy of the current Drug Enforcement Agency (DEA)

and state Narcotics Enforcement Division (NED) certificate must be present at the time of credentialing/re-credentialing approval.

A practitioner with a pending DEA application may be credentialed provided that another practitioner with a valid DEA certificate write all prescriptions requiring a DEA number for the practitioner until the practitioner has a valid DEA certificate. The name of the practitioner with the valid DEA number shall be noted clearly on the credentialing/re-credentialing file of the provider without a DEA number.

K. Malpractice Insurance: ***Verification time limit: Coverage must be effective at the time of the credentialing/re-credentialing decision.***

The Provider Agency shall obtain a letter confirming current malpractice coverage from the insurer. The letter shall state the name of the provider, policy number, dates of coverage, and 1 million / 3 million aggregate of coverage. Copies of face sheets from the practitioner will not satisfy this requirement unless it has been received from the insurer.

History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner. ***Verification time limit: 180 days***

The Provider Agency shall obtain written confirmation of malpractice settlements from the current malpractice carrier and for all malpractice carriers in the past seven (7) years. These years may include residency years. In some instances, practitioners may have been covered by a hospital insurance policy during residency. In these cases, CAMHD or its Agency does not need to obtain confirmation from the carrier.

L. National Practitioner Data Bank Query. ***Verification time limit: 180 days***

The National Practitioner Data Bank (NPDB) shall be queried for previous malpractice claims history and/or state licensure sanctions. The CAMHD, Provider Agencies or their primary source verification contractor must become registered users of the NPDB to be able to request verifications. The query results must indicate “no records” query result. In the event that there is a record on file, the applicant must provide a letter of explanation of the record including a printout of the results from the NPDB. The committee will review the implications of the record as it pertains to the applicant’s ability to provide quality services to CAMHD youth.

M. National Provider Identification: ***Verification time limit: 180 days***

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI shall be used in lieu of legacy provider identifiers in the HIPAA standards transactions. As outlined in the Federal

Regulation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

The CAMHD requires an NPI for all QMHPs and MHPs, and all paraprofessionals providing and billing for Intensive In-Home Therapy services.

N. State of Hawaii License Sanctions and Complaints History. ***Verification time limit: 180 days***

The practitioner's license limitations and restrictions must be primary source verified with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and Vocational Licensing Division at http://pvl.ehawaii.gov/pvlsearch/app. The results of the complaints history query shall be printed and the person conducting the query shall date and sign all the pages of the printout results.

O. Medicare/Medicaid Sanctions. ***Verification time limit: 180 days***

The Office of the Inspector General at http://exclusions.oig.hhs.gov/search.html must be queried for the existence of any Medicare/Medicaid sanctions against the applicant. The results of the sanctions query should be printed and the person conducting the query shall date and sign all pages of the printout results. The query results must indicate "no records" query result. In the event that there is a record on file, the applicant shall provide a letter of explanation of the record. The committee will review the implications of the record as it pertains to the applicant's ability to provide quality services to CAMHD youth.

P. Other State License Verification. ***Verification time limit: 180 days***
The Provider Agency shall query an applicant that possesses a current or expired license in another state.

For active licenses, the Provider Agency shall confirm that the applicant's license is valid and current in the state reported. This query must be primary-source-verified with that state's licensing board. The person conducting the query must date and sign all the pages of the printout results.

If the license has expired, the Provider Agency shall query the prior complaints history on such license. (See below.)

State sanctions, restrictions on licensure and/or limitation on scope of practice – for both active and expired out of state licenses:

The practitioner's license limitations and restrictions must be primary source verified with the other state's licensing board. The person conducting the query shall date and sign all the pages of the complaints history printout results.

Q. Letters of Good Standing from Hospitals with Current Privileges. ***Verification time limit: 180 days.***

CAMHD must obtain a letter from any and all hospitals with which the practitioner has current privileges.

R. Hawaii Justice Center Data Bank Verification: ***Verification time limit: 180 days***

The CAMHD or Provider Agency shall query the Hawaii Justice Center Data Bank for any criminal record. The query results must indicate "no records found". In the event that a record is found within the past ten (10) years, the applicant shall provide a written explanation of the record. Rehabilitative or self-improvement programs attended to help improve whatever issues there may be at the time of offense shall be listed. In addition, the Provider Agency shall also submit to CAMHD a written supervision plan that outlines the position and overall function of the applicant, supervision structure, and any other mechanisms in place to prevent similar offenses from occurring while the applicant is employed with the Provider Agency or around CAMHD youth.

S. Child and Abuse Neglect (CAN) Verification. ***Verification time limit: 180 days***

The Department of Human Services Child Protective Services Database must be queried for child abuse and neglect records. The ***" CAMHD CAN Request Form" (See Attachment E)*** and ***"CAMHD CAN Authorization Form" (See Attachment F) s***hall be completed. The query results must indicate "no records found". In the event that a positive CAN record is found, the Provider Agency shall notify the CAMHD Credentialing Section of the record within twenty-four hours (24) by telephone and provide the hardcopy of the positive CAN record within three (3) business days by fax.

The applicant through the Provider Agency shall submit a letter of explanation regarding the positive CAN results to the Credentialing Committee.

Once the applicant is credentialed and a CAN report is received with positive results, the Provider Agency shall suspend the practitioner from providing direct care services to CAMHD youth until the Committee has made a decision.

T. Central Database Check for Sentinel Events, Grievance, and Medicare/Medicaid Exclusion. ***Verification time limit: 180 days.***

The CAMHD Credentialing Section shall check its central database to determine if the provider applicant has had previous reports pertaining to Sentinel Events or Grievances or has been excluded from participating in Medicare programs.

2. **Credentialing Committee Decisions.** The Committee shall review the complete application packets presented by the Credentialing Section prior to rendering any determinations. The CAMHD has the right to make the final determination about which practitioners participate within its network.

3. **Notification of Credentialing Adverse Determinations.** The Provider Agency or CAMHD practitioner will be informed in writing of any adverse credentialing/re-credentialing decision(s) from the Chair of the Credentialing Committee.

A. The decision letter shall be sent to the Provider Agency within fifteen (15) calendar days of the decision. The letter will include the reconsideration and appeal process.

B. Upon receipt of an appeal, the CAMHD has thirty (30) calendar days from the date of receipt of the letter of explanation to review documents and render a decision.

C. The practitioner has the option to request a hearing and/or be represented by another person of the practitioner's choice.

4. **Practitioner Suspension of Participation**. The Committee has the authority to suspend a practitioner's participation in providing services to CAMHD youth. When there is immediate risk to a youth, the CAMHD shall suspend a practitioner's credentials while an investigation is conducted by the CAMHD.

A. The suspension process is initiated when a report is made or an investigation occurs in cases where it is determined that potential risks or harm may exist to CAMHD youth and presented to the Committee for review and decision. These preliminary investigative reports to the Committee may be from any of the following:

- Sentinel Events Unit
- Grievance Office
- Performance Monitoring
- Facility Certification Unit
- Possible abuse as indicated in the Child Abuse and Neglect Screening (CANS) Check Results

B. The Credentialing Section or Performance Management Office shall notify the Provider Agency verbally of the practitioner suspension within twenty-four (24) hours of the identified risk. The Provider Agency shall be notified in writing within seven (7) calendar days of the decision to suspend the practitioner's credentials. During the suspension of credentials, the practitioner may not work directly with CAMHD youth.

5. **Practitioner Restriction or Limitation of Participation.** The Committee has the authority to restrict or limit a practitioner's participation in the CAMHD Provider Network. Restriction or limitation may be considered in any of the following cases:

A. Previous Grievance, Sentinel Events, or Performance Monitoring report(s) involving any of the events while previously employed with another Provider Agency.

B. Previous criminal record within the past ten (10) years.

C. Reported prior termination due to poor performance.

D. Prior malpractice claims within the past ten (10) years.

E. Positive CAN check results within the past ten (10) years.

F. Prior drug abuse record within the past ten (10) years.

6. **Practitioner Termination.** The Committee has the authority to terminate a practitioner's participation in the CAMHD Provider Network. Termination may be considered in any of the following cases:

   - Loss of License
   - Exclusion from the Medicare/Medicaid program
   - Misrepresentation of credentials and/or other pertinent information (i.e. restrictive action questions)
   - Involvement in a malpractice claim that involves client safety
   - Criminal indictment of any type
   - Failure to adhere to what is established in the practitioner suspension, restriction or limitation of participation investigations (as described previously in the policy)
   - Findings of fraud and abuse in billing

7. **Practitioner Reinstatement.** If a CAMHD or Provider Agency practitioner is voluntarily or involuntarily terminated by the CAMHD or the Provider Agency and the practitioner wishes to be reinstated:

   A. In the case of voluntary termination the practitioner must again be initially credentialed if the break in service is *thirty (30) calendar days* or more.

   B. In the case of involuntary termination, after all requests for consideration and Grievance & Appeals has been exhausted and Credentialing not approved, the practitioner shall wait one (1) year from the date of termination before submitting a new application for initial credentialing.

   C. The CAMHD and/or the Provider Agency shall re-verify credential factors that are no longer within the credentialing/re-credentialing time limits.

   D. The Committee shall review all credentials and make the final determination prior to the practitioner's re-entry into the organization. A decision letter shall be processed to the applicant within fifteen (15) calendar days of its decision. The decision letter includes the reconsideration and appeal process stated in the *"Request for Reconsideration & Appeal Process"* section of this policy.

8. **Practitioner Agency Transfer.** Credentialing approval is specific to the Provider Agency making the application for credentialing and is non-transferable. Practitioners wanting to be credentialed at multiple agencies shall submit initial credentialing packet to the Credentialing Section to process for each of the multiple agency.

9. **Initial Credentialing Site Visits.**

   A. Onsite visits shall be conducted on an annual basis for all practitioner sites. These sites shall include treatment offices located within the CAMHD including Family Guidance Centers, or the Provider Agency Administrative Office, community treatment offices, residential facilities, and any other locations as reported by the practitioner applicant.

B. The *CAMHD Treatment Office Site Visit Tool* shall be used for these treatment office site visits. ***(See Attachment G, CAMHD Treatment Office Site Visit Tool).*** A designated Performance Management staff shall conduct the reviews. The reviews shall include the following:

1) Treatment Office Evaluation

A minimum score of 90% for the office site section is required. For practitioners providing services in a special treatment facility (STF) or therapeutic group home (TGH), the license to operate issued to the agency by the Office of Health Care Administration (OHCA) will be accepted as verification that the facility is in compliant with all state laws pertaining to the type of service.

2) Treatment Record-keeping Practices

A minimum score of 90% for the office site section is required.

3) Availability of Emergency Equipment

A minimum score of 90% for the office site section is required.

C. Relocations and Additional Sites

When notified upon any agency's application to open a new site, the CAMHD Credentialing Specialist or designated CAMHD staff shall conduct a readiness site visit. Instances when CAMHD shall visit new sites include, but are not limited to when a practitioner opens an additional office or moves to offices from one location to another.

10. **Follow-up Actions for Initial Onsite Visit Findings/Deficiencies**

A. Reporting of Initial Onsite Audit Deficiencies and Corrective Action Activities

1) If the provider scores lower than the minimum score allowed on any of the criteria in the "Treatment Office Visit Tool" during the initial visit, a request for a corrective action plan from the practitioner shall be made during the exit interview.

2) A written notification of the request for the corrective action shall be sent to the practitioner through the Provider Agency via regular mail or electronic mail.

B. Credentialing/re-credentialing of the practitioner shall be deferred until all deficiencies in the onsite visit are addressed and a score higher than the minimum scored required is obtained.

C. Corrective action plans or other required documents shall be submitted to the CAMHD Credentialing Specialist no later than thirty (30) days from the date of onsite visit. The CAMHD shall review the corrective action plan and submitted documents. All primary source verifications in the deferred file would have to be within acceptable timelines at the time of review and approval by the Committee.

D. Follow-up Onsite Visit. The CAMHD reserves the right to conduct a follow up onsite visit prior to approving the practitioner to ensure that initial deficiencies noted are now within acceptable thresholds.

11. **Ongoing Monitoring of Sanctions and Complaints**

A. State sanctions or limitations on licensure. On a yearly basis, the Provider Agency shall verify the status of practitioner's State of Hawaii licensure, sanctions, or limitations with the State of Hawaii Department of Commerce and Consumer Affairs, Professional and Vocational Licensing Division at http://pvl.ehawaii.gov/pvlsearch/app.

B. In addition, the CAMHD compiles all listing of Medicaid suspended or terminated practitioner letters from the Med-Quest Division. In the event that the name being reported by Medicaid is a current member of the CAMHD provider network, the issue shall be brought to the Committee within **twenty-four (**24**)** hours of receipt to conduct an emergency meeting to formalize the suspension or termination of the practitioner from the network.

C. The decision letter shall be issued within fifteen (15) calendar days and include the reconsideration and appeal process stated in the *"Request for Reconsideration & Appeal Process"* section of this policy.

12. **Notification to Authorities**

The CAMHD reserves the right to rescind the full credentialing/re-credentialing status of any practitioner that does not comply with State Ethics Standards, CAMHD standards, and State and Federal laws range of actions.

A. If the CAMHD discovers any misrepresentation of credentials or other illegal activities, the Committee shall review and make appropriate decisions. Results of the review may warrant reporting the practitioner's name and situation to the CAMHD Compliance Committee, Professional Activities Review Committee (PARC), and/or any other appropriate authority for investigation, with a copy to the Provider Relations Liaison. If warranted, the CAMHD shall refer the licensed practitioner's name to the designated Medicaid Investigator. The CAMHD reserves the right to retain, suspend, or terminate any practitioner that has misrepresented his or her credentials.

B. The CAMHD Fraud and Abuse Program describe the CAMHD's procedures for reporting serious quality deficiencies that could result in a provider's suspension or termination to the Medicaid Fraud Investigator as well as other appropriate authorities.

13. **Credentialing Reports**

A. The Provider Agencies are required to submit electronic quarterly reports of their current credentialed licensed staff in the format required by CAMHD.

B. If a practitioner is terminated, the Provider Agency is required to submit the terminated practitioner's name and termination code immediately to the CAMHD Credentialing Section via email.

ATTACHMENTS:

A. CAMHD Glossary of Credentialing Terms, Rev. July 15, 2009

B. CAMHD Licensed Provider Initial Credentialing Application Form, Rev. July 15, 2009

C. CAMHD Licensed Provider Initial Credentialing Checklist, Rev. May 19, 2011

D. CAMHD Attestation Letter, Rev. July 15, 2009

E. CAMHD Child Abuse and Neglect Disclosure Statement, Rev. 3/2006

F. CAMHD Child Abuse and Neglect Consent to Release Information, Rev. 02/2006

G. CAMHD Treatment Office Site Visit Tool; Rev. July 15, 2009

Glossary of Credentialing Terms

Alias: An assumed or additional name.

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.

Complete Application: All blanks on the application form are filled in and necessary additional explanations provided; 2) All requested attachments and information have been submitted; 3) Verification of the information is complete and was done through primary sources when required; 4) All information necessary to properly evaluate the applicant's qualifications has been received and is consistent with the information provided in the application.

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*".

Department of Commerce and Consumer Affairs (DCCA): Professional and vocational licensing division of the State of Hawaii

The Educational Commission for Foreign Medical Graduates (***ECFMG)***: Evaluates foreign medical graduates' medical school curriculum to ensure that it is in alignment with the United States' medical school standards.

Mental Health Professional (MHP): Unlicensed, Board Ineligible Psychiatrist; Psychiatric Resident; Unlicensed, Ph.D or Psychologist (Psy D); Registered Public Nurse (RPN), Licensed with Masters Degree; Unlicensed, Masters Psychology; Licensed, Masters Social Work; Unlicensed Masters Social Work (MSW); Unlicensed Marriage & Family Therapist (MFT); Unlicensed, Masters Certified Counselor; Unlicensed, Masters Degree.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions. As outlined in the Federal Regulation, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes. CAMHD requires an NPI for all QMHPs and MHPs, and all paraprofessionals providing and billing for 13101 (Intensive In-Home therapy) services.

National Commission of Quality Assurance (***NCQA)*** is an independent 501(c)(3) non-profit organization in the United States designed to improve health care quality. NCQA manages voluntary accreditation programs for individual physicians and medical groups. Health plans seeking accreditation measure performance through the Healthcare Effectiveness Data and Information Set (HEDIS).

Paraprofessional (PARA): Certified Substance Abuse Counselor (CSAC); Registered Public Nurse (RPN) Bachelors, Licensed; RPN Associate, Licensed; Licensed Practical Nurse (LPN); Bachelors, Psychology; Bachelors, Social Work; Bachelors, Counseling; Bachelors, Other; Associates, Other; High School Graduate or GED.

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, MHP or Paraprofessional.

Qualified Mental Health Professional (QMHP)*:* 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 Licensed Provider
Credentialing Application Form

This is an application for credential approval with the Child and Adolescent Mental Health Division (CAMHD). If more space is needed than provided on this original, please attach additional sheets and reference the questions being asked. **If a question is not applicable to you please mark N/A in the space.**

IDENTIFYING INFORMATION:

Applicant's Full (Legal) Name: _____

Any alias, maiden, or previous name(s)_____

SSN# Date of Birth NPI# Citizenship

Home Address City State Zip

Office Address City State Zip

Home Phone No. Office Phone No. Cell Phone No.

Home Fax No. Office Fax No. Pager/E-Mail Address

PRE-PROFESSIONAL INFORMATION:

Undergraduate College or University

Mailing Address City State Zip

Degree Received Date of Graduation (month & year)

PROFESSIONAL INFORMATION:

Graduate College or University

Mailing Address City State Zip

Degree Received Date of Graduation (month / year)

Dates attended school (From-To) Telephone Number

FOREIGN MEDICAL GRADUATES - Attach a photocopy of your ECFMG Certificate

INTERNSHIP:

Hospital

Mailing Address City State Zip

Specialty Date of Completion (month / year)

Dates of Internship (From-To) Telephone Number

- Did you successfully complete the program? ☐ Yes ☐ No (If no, give a brief narration)
- If you participated or were a part of any other internships, please note on a separate sheet of paper

RESIDENCIES:

Institution

Mailing Address City State Zip

Specialty Date of Completion (month / year)

Dates of Internship (From-To) Telephone Number

- Did you successfully complete the program? ☐ Yes ☐ No (If no, give a brief narration)
- If you participated or were a part of any other residencies, please note on a separate sheet of paper

FELLOWSHIPS:

Hospital

Mailing Address City State Zip

Specialty Date of Completion (month / year)

Dates of Internship (From-To) Telephone Number

- Did you successfully complete the program? ☐ Yes ☐ No (If no, give a brief narration)
- If you participated or were a part of any other fellowships, please note on a separate sheet of paper

SPECIALTY AND BOARD CERTIFICATION:

Please list those specialties with American Boards by where you were/are certified, if any:

Board Name:

Specialty: Sub-Specialty:

Certificate #: Expiration Date, if any:

Re-certification date, if any:

WORK HISTORY / AFFILIATIONS:

List all present and previous hospital, agency, and clinic affiliations for the past five years in chronological order:

1) Name of Organization			Dates (From – To)
Mailing Address	City	State	Zip Code
2) Name of Organization			Dates (From – To)
Mailing Address	City	State	Zip Code
3) Name of Organization			Dates (From – To)
Mailing Address	City	State	Zip Code

- If you were affiliated with more than three health care organizations, please list them on a separate sheet of paper with the mailing address and the dates you were affiliated.
- Please provide, on a separate sheet of paper, a chronological listing of all previous experiences including military service, private practice, and teaching. Also, please provide a narration of any breaks in experience.

LICENSURE:

Please list all active and inactive professional licenses you now hold or previously held - attach a clear photocopy of all current license(s).

State	License Type & Number	Expiration Date
State	License Type & Number	Expiration Date

IF AN M.D., please attach clear photocopies of your current certification of Federal Controlled Substance Registration Certificate (DEA) and the State of Hawaii's Certificate of Registration for Controlled Substances (CDS). If there are any restrictions on either of these certificates, please list them on a separate sheet of paper.

Federal DEA Registration No. Expiration Date Any Restrictions?

State CDS Registration No. Expiration Date Any Restrictions?

MALPRACTICE INSURANCE INFORMATION:

Please list all the names and complete addresses of current and past liability insurance coverage carriers covering the last 7 years. Attach additional sheets if necessary.

1. **CURRENT INSURANCE** Company Policy #

Mailing Address City State Zip Code

Coverage Amount: Per Claim Per Aggregate Effective Date Expiration Date

Please include any limitations / exclusions information.

2. **PREVIOUS** Insurance Company Policy #

Mailing Address City State Zip Code

Coverage Amount: Per Claim Per Aggregate Effective Date Expiration Date

Please include any limitations / exclusions information.

3. **PREVIOUS** Insurance Company Policy #

Mailing Address City State Zip Code

Coverage Amount: Per Claim Per Aggregate Effective Date Expiration Date

Please include any limitations / exclusions information.

HEALTH STATUS:

Health status is defined as including the physical and mental condition of the applicant as it relates to the individuals ability to exercise those clinical privileges requested.

Do you have any physical and/or mental condition which would interfere with the performance of those privileges which you are requesting and/or the essential functions of the contractual arrangement for which you are applying, with our without accommodation? No Yes (give narration)

RESTRICTIVE ACTIONS:

If you answer yes to any of the questions below, please attach an explanation of each occurrence to include the date, parties involved, circumstances surrounding the situation, and outcome.

1. Has your license to practice medicine, nursing, social work, marriage & family therapy, State and/or Federal Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have been fined or received a letter of reprimand – or is such action pending? No Yes (give narration)

2. Have you ever been denied, for possible incompetence or improper professional conduct, clinical privileges, membership, contractual participation or employment by any agency/organization that provides mental health services or any medical organization (i.e. hospital medical staff, health plan, health maintenance organization (HMO), professional association, medical school faculty position, or other health delivery entity or system). Or have your clinical privileges, membership, participation, or employment at any such agency/organization ever been suspended, restricted, revoke, or not renewed – or is any such action pending? No Yes (give narration)

3. Have you ever voluntarily relinquished privileges or a license anywhere at any time? No Yes (give narration)

4. Have you ever been denied certification/recertification, or has your eligibility status changed with respect to certification/recertification by a specialty board? Not Applicable No Yes (give narration)

5. Have there been, or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional practice? No Yes (give narration)

6. Have you ever been denied professional liability insurance or has your coverage ever been cancelled? No Yes (give narration)

7. Have you ever been convicted of a crime, pled guilty or "no contest" to a crime, or are you currently under indictment for an alleged crime?
 No Yes (give narration)

8. Do you presently or have you used any illegal drugs in the past two years?
 No Yes (give narration)

AFFIRMATION:

I represent that information provided in or attached to this credentialing application form is accurate. I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and may result in the denial of appointment and clinical privileges. In the event of my termination for this reason, I will not be entitled to any hearing, appeal, or other due process rights. Upon subsequent discovery of such misrepresentation, misstatement, or omission, the _____ may immediately terminate my appointment.

PRINT NAME OF APPLICANT: _____

SIGNATURE OF APPLICANT: _____

DATE OF SIGNATURE: _____

LEVELS OF CARE FORM

Applicant's Name:	

Please list the levels of care you would provide to our clients.

Services provided (Level of Care)

Agency

AUTHORIZATION FOR RELEASE OF INFORMATION

I, hereby authorize representatives of _____and Child and Adolescent Mental Health Division (hereafter referred to as CAHMD) to consult with representatives of other hospitals, institutions, government agencies, previous employers, and other persons or entities (hereafter collectively referred to as "persons" or "entities") to obtain and verify information concerning my professional qualifications, competence, moral character, ethical qualifications, and physical and mental condition and to conduct criminal background checks and Child Abuse and Neglect checks.

I consent to release by any and all hospitals, institutions, government agencies, previous employers, and other persons or entities to _____ and CAMHD all information and documents that may be relevant to an evaluation of my professional qualifications, competence, moral character, ethical qualifications and physical and mental condition.

I hereby release all representatives of _____, CAMHD, and all such persons or entities from any and all liability for their acts performed in good faith and without malice in giving, obtaining, and verifying such information in connection with evaluating my applications, my credentials, and my qualifications

I understand and agree that I, as an applicant, have the burden of producing adequate information to demonstrate to the satisfaction of _____ and/or CAMHD, my professional qualifications, clinical competence, moral character, ethical qualifications and physical and mental condition and for resolving doubts thereto. I further understand and agree that it is my responsibility to inform - _____ of any changes in the information provided through the application during the application period or at any subsequent time.

PRINT NAME OF APPLICANT: _____

SIGNATURE OF APPLICANT: _____

DATE OF SIGNATURE: _____

RELEASE AND IMMUNITY:

By applying for a position with _____, I accept the following condition regardless of whether or not I am granted the position, and intend to be legally bound thereby. These conditions shall remain in effect for the duration of my employment.

1. I authorize the release of all information necessary for an evaluation of my qualifications for initial appointment and or privileges;
2. I authorize _____ its staff and their representative to consult with any prior associate and others who may have information bearing on my professional competence, character, health status, ethical qualification, and ability to work cooperatively with others;
3. I agree to release from liability _____, the staff, or anyone acting by and/or for this agency, and its staff, who act without malice for any matter relating to this application for inclusion and referral, the evaluation of my qualifications or any matter related to appointment or clinical privileges; and
4. I release from liability _____ and staff for all matters relating to appointment and clinical privileges or qualifications for the same, if such acts are made without malice.

PRINT NAME OF APPLICANT: _____

SIGNATURE OF APPLICANT: _____

DATE OF SIGNATURE: _____

CAMHD PROVIDER RIGHTS

1. Process used to making credentialing and re-credentialing decisions.

The credentials of applicants are evaluated against pre-determined criteria in conjunction with NCQA and state licensing requirements. This policy outlines the criteria used to approve applicants. The "*CAMHD Licensed Provider Initial Credentialing Checklist"* and *"CAMHD Licensed Provider Re-credentialing Checklist"* were created to facilitate auditing of primary source verifications in the practitioner's credential chart. In addition, committee members are also required to use their professional and personal knowledge of the applicant's business practices, ethics, and ability to provide quality services to CAMHD clients in a safe treatment environment in the decision making process. All of these elements are taken into consideration during the credential approval decision-making process.

2. The process used to ensure that credentialing and re-credentialing are conducted in a non-discriminatory manner.

The CAMHD Credentialing Committee does not make credentialing decisions based solely on the applicant's race, ethnic / national identity, gender, age, sexual orientation, or the types of procedures or types of patients the practitioner (e.g., Medicaid) specializes in.

3. The process of notification to a practitioner of any information obtained during the credentialing process that varies substantially from the information provided to CAMHD and or the CAMHD Contracted Provider Agency by the provider:

CAMHD and or the CAMHD Contracted Provider agency must notify the applicant of any information obtained during the credentialing process that varies substantially from the information provided to them in writing via regular mail. The applicant must respond within 10 business days from the date of the notification letter with a letter of explanation for the varying information. Additional documents may be submitted to CAMHD and or the CAMHD Contracted Provider agency to substantiate or explain the variations. CAMHD has 30 days from the date of receipt of the letter of explanation to review documents and render a decision. The decision letter includes the reconsideration and appeal process stated below.

The Request for Reconsideration & Appeal Process

If the applicant does not agree with the CAMHD Credentialing Committee's decision, they have the right to request for reconsideration. Reconsideration requests must be submitted with additional documentation to support the request. These must be received at CAMHD within 10 business days from the decision letter, unless otherwise stated. The CAMHD Credentialing Committee will review the submitted documents and issue a reconsideration decision to the applicant or through the CAMHD Contracted Provider

agency via facsimile or mail within 30 days from the date of receipt of the reconsideration request. The applicant, either directly or through the CAMHD Contracted Provider Agency, has the option to file a formal complaint with CAMHD's Grievance and Appeal Office at 733-8495 in the event the CAMHD Credentialing Committee holds to its original decision.

4. The process to ensure that practitioners are notified of the credentialing or re-credentialing decision within 15 business days of the committee's decision.

A CAMHD Credentialing Committee letter is sent to the applicant through the CAMHD Contracted Provider Agency within 15 business days of the decision. If the applicant does not agree with the decision they are entitled to request for reconsideration through the "*Request for Reconsideration & Appeal Process*" outlined above.

5. The process used to ensure confidentiality of all information obtained in the credentialing process, except otherwise provided by law.

The CAMHD Credentialing Committee and CAMHD Contracted Provider Agencies' Credentialing Specialists and other personnel that have access to credential information must sign the "*CAMHD Credentialing Confidentiality Form*" to ensure confidentiality of all information gathered during the credentialing process, except otherwise provided by law, and are used for the sole purpose of credentials evaluation. In addition, any discussions held during the CAMHD Credentialing Committee must remain confidential except when otherwise provided by law.

6. The right of practitioner's right to review submitted information in support of their credentialing applications:

The applicant has the right to request and review primary source verifications obtained on their behalf. A written request must be sent to the CAMHD Credentialing Specialist, CAMHD Credentialing Department, 3627 Kilauea Avenue, Room 101, Honolulu, HI 96816. The CAMHD Credentialing Department has 30 days to forward copies of primary source documents to the applicant via regular mail. In the event that the primary source verification function has been delegated to the CAMHD Contracted Provider Agency, the written request must be sent to the attention of the CAMHD Contracted Provider Agency Credentialing Specialist. The CAMHD Contracted Provider Agency Credentialing Specialist has 30 days to forward the copies of the primary source documents to the applicant via regular mail.

Peer-review protected information, references, and letters or recommendations may not be reviewed by applicants.

7. The practitioner's right to correct erroneous information:

In the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner, CAMHD must notify the applicant in writing within 10 business days from date of discovery. Notification may be sent directly to the applicant or through the CAMHD Contracted Provider Agency Credentialing Specialist.

The applicant has the right to correct erroneous information by sending a letter directly to the CAMHD Credentialing Committee to the following address: CAMHD Credentialing Specialist, CAMHD Credentialing Department, 3627 Kilauea Avenue, Room 101, Honolulu, HI 96816 or through the CAMHD Contracted Provider Agency in writing within 10 business days from date of receipt of the notification letter from CAMHD. Additional documents may be submitted to CAMHD and or the CAMHD Contracted Provider agency to substantiate or explain the erroneous information. CAMHD has 30 days from the date of receipt of the letter of explanation to review documents and render a decision. The decision letter includes the reconsideration and appeal process stated in the "*Request for Reconsideration & Appeal Process*" section of the CAMHD Credentialing policy.

8. **The right of practitioners, upon request, to be informed of the status of their credentialing or re-credentialing application.**

The applicant has the right to request, in writing or through telephone, the status of their credentialing or re-credentialing application. CAMHD must respond to such inquiry within 10 business days either in writing or through telephone. In the event that the primary source verification function has been delegated to a CAMHD Contracted Provider Agency, the request must be directed to the CAMHD Contracted Provider Agency Credentialing Specialist. The CAMHD Contracted Provider Agency Credentialing Specialist should then contact the CAMHD Credentialing Specialist if unable to answer regarding the status of the applicant's application.

☐ **INITIAL**

CAMHD LICENSED PROVIDER CREDENTIALING CHECKLIST

☐ **RE-CREDENTIAL**

PROVIDER NAME: _____

PROVIDER AGENCY NAME: _____

PROVIDER I.D. _____

SPECIFIC JOB FUNCTION: _____

PROVIDER NPI NUMBER: _____

LEVELS OF CARE (list all): _____

1	**ATTESTATION** ☐ Attestation by Agency Credentialing Specialist that originals of primary source verifications are kept in the Agency Credentialing File ☐ Date: _____ and must be within 180 days of CAMHD review and approval
2	**BACKGROUND VERIFICATION APPLICATION** ☐ Date of Affirmation signature: _____ and must be 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. ☐ Letter(s) of support attached. ☐ All Levels of Care listed. ☐ Provider received "Provider Rights".
3	**RESUME** (Must be dated by the practitioner) ☐ Date Prepared: _____ and must be within 180 days of CAMHD review and approval. ☐ If there is any gap over 6 months in employment, letter of explanation attached
4	**EDUCATION** ☐ Date of Verification: _____ and must be 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: _____
5	**STATE OF HAWAII LICENSE VERIFICATION** ☐ Date of Verification: _____and must be within 180 days of CAMHD review and approval ☐ Expiration date: _____ ☐ Name and dated signature of person conducting the query
6	**CONTROLLED SUBSTANCE – STATE (For M.D.'s only)**

CAMHD LICENSED PROVIDER
CREDENTIALING CHECKLIST

	☐ Copy of current certificate attached ☐ Expiration Date: _____
7	**CONTROLLED SUBSTANCE – DEA (For M.D.'s only)** ☐ Copy of current certificate attached ☐ Expiration Date: _____
8	**RESIDENCY, INTERNSHIP, FELLOWSHIP – Query Highest Completed** (if applicable) ☐ Date of Verification: _____and must be 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
9	**ECFMG (If M.D., foreign graduate and licensed after 1986)** ☐ Date of Verification: _____and must be within 180 days of CAMHD review and approval. ☐ Received directly from ECFMG
10	**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: _____ and must be 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
11	**CURRENT MALPRACTICE INSURANCE COVERAGE** **Insurance: _____** **Policy #: _____** ☐ Date of Verification: _____and must be 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 7 years)** **For Current Insurance: _____** **Policy #: _____** ☐ Date of Verification: _____and must be 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: _____and must be 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	**National Practitioner Data Bank (NPDB) (**only for MDs. PHDs, PSYDs, DOs, APRNs) ☐ Date of Verification: _____and must be within 180 days of CAMHD review and approval. ☐ Received directly NPDB or verified with NPDB by a third party verification service such as HCVS ☐ Queried as a designated agent of CAMHD ☐ If record found, letters of explanation from employee and supervisor are present.
14	**STATE OF HAWAII LICENSE SANCTIONS AND COMPLAINTS HISTORY** ☐ Date of Verification: _____and must be 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: _____and must be within 180 days of CAMHD review approval. ☐ No records found. ☐ Name and dated signature of person conducting the query
16	**OTHER STATE LICENSES VERIFICATION** (if applicable) ☐ Name of State: _____ ☐ Date of Verification: _____and must be within 180 days of CAMHD review and approval. ☐ Status: ____ Active ____ Inactive

CAMHD LICENSED PROVIDER
CREDENTIALING CHECKLIST

	☐ 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** (if applicable) ☐ Name of Hospital: _____ ☐ Date of Verification: _____ and must be within 180 days months of CAMHD approval.
18	**NATIONAL PRACTITIONER INDENTIFIER (NPI)** ☐ NPPES Printout
19	**HAWAII JUSTICE CENTER CHECK** (Search for all names/aliases) ☐ Adult Criminal Convictions verification date: _____ and must be within 180 days of CAMHD review and approval. ☐ Sex Offender Search verification date: _____and must be 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
20	**CHILD ABUSE & NEGLECT CHECKS** ☐ Date of Verification: _____ and must be within 180 days of CAMHD approval. ☐ If record found, letters of explanation from employee and supervisor are present. ☐ Consent to release information from Child Protective Services submitted ☐ If Pending, CA/N Disclosure submittal date: _____
21	**COMBINED SENTINEL, GRIEVANCE, 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 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 LICENSED PROVIDER
CREDENTIALING CHECKLIST

_____ _____

CAMHD CREDENTIALING CMTE. CHAIR **DATE**

USE COMPANY LETTERHEAD

DATE:

CAMHD Credentialing Specialist
Credentialing Unit
Child and Adolescent Mental Health Division
3627 Kilauea Avenue, Room 101
Honolulu, HI 96816

Re: NAME OF PROVIDER:

Dear CAMHD Credentialing Specialist:

I attest that the attached is a complete application per *CAMHD P & P 80.308 or 80.308.1*. Attached please find the copies of primary source verifications for the above named provider. By way of this letter, I am attesting that we have the originals of all submitted primary source verifications and that we received this information directly from the primary source or through a primary source verification service contractor. The originals are maintained in a separate credentialing file for the above provider here at the agency.

I further attest that this application meets the [*Agency Name*] Human Resources and job requirements to fill the position of [*list position, such as Intensive In-Home Therapist*] and [*Agency Name*] is in good faith recommending him/her for work with CAMHD youth.

If you have any further questions or concerns, please feel free to call.

Sincerely,

AGENCY REPRESENTATIVE MUST SIGN THIS LETTER. OR THE CREDENTIALING FILE WILL BE CONSIDERED INCOMPLETE AND WILL NOT BE PRESENTED TO THE COMMITTEE UNTIL SIGNATURE IS OBTAINED.

USE COMPANY LETTERHEAD

DATE:

CAMHD Credentialing Specialist
Credentialing Unit
Child and Adolescent Mental Health Division
3627 Kilauea Avenue, Room 101
Honolulu, HI 96816

Re: NAME OF PROVIDER:

Dear CAMHD Credentialing Specialist:

I attest that the attached is a complete application per *CAMHD P & P 80.308 or 80.308.1*. Attached please find the copies of primary source verifications for the above named provider. By way of this letter, I am attesting that we have the originals of all submitted primary source verifications and that we received this information directly from the primary source or through a primary source verification service contractor. The originals are maintained in a separate credentialing file for the above provider here at the agency.

I further attest that this application meets the [*Agency Name*] Human Resources and job requirements to fill the position of [*list position, such as Intensive In-Home Therapist*] and [*Agency Name*] is in good faith recommending him/her for work with CAMHD youth.

If you have any further questions or concerns, please feel free to call.

Sincerely,

AGENCY REPRESENTATIVE MUST SIGN THIS LETTER. OR THE CREDENTIALING FILE WILL BE CONSIDERED INCOMPLETE AND WILL NOT BE PRESENTED TO THE COMMITTEE UNTIL SIGNATURE IS OBTAINED.

CHILD ABUSE/NEGLECT
Disclosure Statement

Be sure to complete this section completely & legibly.

NAME	
Any Alias(es), Former Name(s), Including Maiden & Married Name(s)	
DOB	
SSN	
AGENCY NAME	

Sign below to the statement A or B that you are declaring to be true.

A. FOR APPLICANTS WITH A POSSIBLE CHILD ABUSE/NEGLECT RECORD: I am aware, or suspect that there may be a Child Abuse and/or Neglect record concerning me and/or my family because of an investigation conducted by the Department of Human Services' Child Protective Services. I am disclosing the detailed circumstances in a written, dated, and signed statement attached to this document.

_____ _____

SIGNATURE DATE

B. FOR APPLICANTS ATTESTING THEY DO NOT HAVE A CHILD ABUSE/NEGLECT RECORD: This is to certify that I have not been an involved party to any investigation conducted by the Department of Human Services' Child Protective Services. Discovery to the contrary, of my involvement in an investigation may result in denial or revocation of my active CAMHD credential status.

_____ _____

SIGNATURE DATE

State of Hawaii
DEPARTMENT OF HUMAN SERVICES

Social Services Division
Child Welfare Services Branch

CONSENT TO RELEASE INFORMATION FROM THE Child Protective Services System Central Registry

I, _____ , hereby give my consent to have the Department of Human Services (DHS) conduct a child welfare services Child Protective Services System Central Registry check on me and to release the information to:

Name of Individual or Organizations: _____

Relationship: _____

Address: _____

This consent shall terminate a year from the date of my signature below. I understand that the information I provide about myself shall be used solely for the purpose of conducting the Child Protective Services System Central Registry check.

My Date of Birth: _____ **My Social Security Number:** _____

Any Alias, Former Name, Including Maiden Name: _____

_____

The information to be released shall be limited to the history of abuse or neglect in which I was identified as a perpetrator and as specified below:

Child Protective Services System Central Registry:

- Date of CONFIRMED incident (s) only
- Type of abuse for each incident

I understand that the release of t his information may be used as part of a background check for employment purposes and to comply with the requirements for various social services programs within the Department of Human Services, which may result in employment suspension or termination.

_____ _____

Signature Date

Mail the original consent form to: Department of Human Services, Child Welfare Services Branch, Statewide Child Welfare Services Section, 420 Waiakamilo Road, Suite 300A, Honolulu, Hawaii 96817. Faxes will not be accepted.

Department of Health
Child and Adolescent Mental Health Division

TREATMENT OFFICE VISIT

_____ Initial __XX__ **Annual Visit**

SITE NAME	
SITE ADDRESS	
DATE VISITED	
VISITED BY:	

	YES	NO	N/A	COMMENTS
COMPLIANCE WITH EXISTING STATE LAW				
HIPAA - Office meets req. (ie, computer, waiting area, meeting room, file storage)				
TOTAL SCORE FOR STATE LAW COMPLIANCE				
RECORD-KEEPING EVALUATION				
Paper or electronic records must contain the following:				
A. Patient Identification: Patient's name or ID number on each page				
B. Personal / biographical data: Birth Date, Sex, Address				
C. Dated Entries : All entries in the medical record are dated.				
D. Identification of provider: All entries are identified as to author.				
E. Legibility: Records must be legible				
F. Allergies: Any adverse drug reactions and / or medication allergies or absence of allergies (No known allergies – NKA) are posted in a prominent area in the medical record.				
G. Past Medical History: Record contains the patient's past medical history (for patients seen more than 3+ times) that is easily identifies and includes serious accidents, operations, illnesses. For children, past medical history relates to prenatal care and birth				
H. Immunizations: Pediatric (ages 12 and under) medical records include a completed immunization record or documentation that immunizations are up-to-date.				
I. Diagnostic Information: The medical record contained diagnostic information.				
J. Medication Information: The medical record contains medication information.				
K. Identification of Current Problems: The medical record contains information on current significant illnesses, medical conditions, and health maintenance concerns.				

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SITE NAME	
SITE ADDRESS	
DATE VISITED	
VISITED BY:	

	YES	NO	N/A	COMMENTS
L. Smoking/ETOH/ Substance Abuse: (For patients >12 years old and seen 3+ times) there is documentation in the medical records of cigarette and alcohol use and substance abuse. Abbreviations/ symbols may be appropriate.				
M. Consultations, Referrals, and Specialist Reports: There is documentation in the medical record of any referrals and results thereof.				
N. Emergency Care: Any emergency care rendered is noted in the medical record with physician follow-up noted.				
O. Hospital Discharge Summaries: The record must contain discharge summaries for hospital admissions that occur while the patient is seen by the provider and prior admissions as necessary.				
Patient Visit Data – Patient visits must include at a minimum adequate evidence of:				
A. History to include appropriate subjective and objective information for presenting complaints.				
B. Plan of treatment to include objective goals.				
C. Diagnostic tests.				
D. Treatments and other prescribed regimens				
E. Documentation concerning follow up care, call or visit is included in the medical record, when indicated. Specific time to return is also noted as weeks, days, months, or PRN. There is also documentation that unresolved concerns from previous visits are addressed in subsequent visits.				
F. There is documentation in the medical record of any referrals and results thereof. There is evidence that the ordering physician has reviewed consultation, lab, and x-ray reports files in the medical records, through physician initials or other documentation. Consultations, and significantly abnormal lab and imaging study results specifically notes physician follow up plans.				
G. All other aspects of patient care, including ancillary services are documented.				
TOTAL SCORE FOR RECORD-KEEPING EVALUATION				

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SITE NAME	
SITE ADDRESS	
DATE VISITED	
VISITED BY:	

	YES	NO	N/A	COMMENTS
TREATMENT OFFICE EVALUATION				
Physical Accessibility – For Ambulatory Care				
• Wheelchair accessible				
Physical Appearance				
The office is kept neat, clean, appears properly maintained.				
The office is has adequate lighting				
Adequacy of waiting and examining room				
There is a designated waiting room.				
There is a designated examining room.				
Availability of appointments				
Appointments are available within 24 hours of notification				
TOTAL SCORE FOR TREATMENT OFFICE EVALUATION				
EMERGENCY EQUIPMENT AVAILABILITY				
First Aid Kit				
TOTAL SCORE FOR EMERGENCY EQUIPMENT AVAILABILITY EVALUATION				

TREATMENT OFFICE VISIT

_____ Initial __XX__ **Annual Visit**

SITE NAME	
SITE ADDRESS	
DATE VISITED	
VISITED BY:	

SUMMARY OF FINDINGS:	**# OF YES**	**# OF POSSIBLE YES**	**THRESHOLD**	**SCORE**
COMPLIANCE WITH EXISTING STATE LAW		1	**90%**	
RECORD-KEEPING EVALUATION		22	**90%**	
TREATMENT OFFICE EVALUATION		6	**90%**	
EMERGENCY EQUIPMENT AVAILABILITY		1	**90%**	
TOTAL SCORE:		30	90%	