n05709

Clinician Data Maintenance and Credentialing Requirements

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

The purpose of this policy to ensure Clinician, Clinician groups, and facilities comply with current regulatory requirements related to the Centers for Medicare and Medicaid Services (CMS) Interoperability Rule which is a focus on driving interoperability and patient access to health information by liberating patient data using CMS authority to regulate Medicare Advantage (MA), Medicaid, CHIP, and Qualified Health Plan (QHP) issuers on the Federally-Facilitated Exchanges (FFEs). Sections of this rule will go into effect July 1, 2021. The No Surprises Act which was signed into law as part of the Consolidated Appropriations Act of 2021 (H.R. 133; Division BB – Private Health Insurance and Public Health Provisions) addresses surprise medical billing at the federal level. Most sections of this legislation go into effect on Jan. 1, 2022. Both of these rules will require your participation as a panel Clinician with Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC (NHP/NHIC/NH TPA/NHAS).

Policy Detail:

The purpose of this policy to ensure Clinician, Clinician groups, and facilities comply with current regulatory requirements related to the below defined requirements.

As of 2024, the Centers for Medicare and Medicaid Services (CMS) have established specific requirements for the Interoperability - Clinician Directory API (Application Programming Interface) as part of the efforts to promote interoperability and data sharing among healthcare providers. Requirements are as follows:

1. Data Accessibility: The clinician directory must provide a standardize way to access information about healthcare providers, including details on qualifications, availability, specialty, and practice locations.
2. Standardized formats: The information provided through the API should adhere to the standardized formats like Fast Healthcare Interoperability Resources (FHIR), ensuring that the data can be easily used and interpreted by different systems.
3. Real time availability: the API should support real-time updates so that the directory reflects up to date information on clinicians, including changes in practice status or location.
4. Security and privacy: The API must ensure compliance with patient privacy regulations, including the Health Insurance Portability and Accountability Act (HIPAA) to protect sensitive health information.
5. Provider identification: The API should include unique identifiers for each clinician to avoid duplication and to enable easy lookup and verification.

6. Integration with existing systems: The API is designed to integrate with existing health IT systems used by clinicians and healthcare organizations, facilitating seamless data exchange.
7. CMS-regulated payers are required by this rule to make Clinician directory information publicly available via a standards-based API. Making this information broadly available in this way will encourage innovation by allowing third-party application developers to access information so they can create services that help patients find Clinicians for care and treatment, as well as help clinicians find other Clinicians for care coordination, in the most user-friendly and intuitive ways possible. Making this information more widely accessible is also a driver for improving the quality, accuracy, and timeliness of this information. MA organizations, Medicaid, and CHIP FFS programs, Medicaid managed care plans, and CHIP managed care entities were required to implement the Clinician Directory API by January 1, 2021. QHP issuers on the FFEs are already required to make Clinician directory information available in a specified, machine-readable format.
8. No Surprise Act:
    A. Beginning for health plan years on or after Jan. 1, 2022, plans will be required to establish a verification process to ensure accurate Clinician directories, a response protocol for individuals inquiring about the network status of a Clinician, and a publicly accessible Clinician database. These Clinician directory requirements do not pre-empt existing state law, and patients that relied on inaccurate Clinician directory information would only be subject to the in-network cost sharing amounts. The law requires that health plans verify and update Clinician directory information no less than every 90 days (or within two days of receiving notice of a change), as well as establish a procedure for removal of Clinicians who are no longer in network. Plans are required to respond to individuals inquiring about the network status of a Clinician or facility within one business day of the inquiry and must retain records of the inquiry for two years. Plans must have a web-based Clinician directory that includes the Clinician and facility contact.
    B. Directory information includes; first name, last name, middle initial, title, NPI, gender, languages spoken (other than English) (providing language information is voluntary), primary specialty, secondary specialties, Medicaid accepted (Y/N), Group Name, Group Address including city state and zip, Group phone, Group fax, primary email address, PCP (Y/N), accepting new patients (Open/Closed), Board Certification board, Hospital Affiliations, ADA accessibility. Other areas collected: Language services available through the practice and volunteered race and ethnicity.
    C. Both of these rules will require your participation as a panel Clinician with Network Health Plan/Network Health Insurance Corporation/Network Health Third Party Administrator/Network Health Administrative Services, LLC (NHP/NHIC/NH TPA/NHAS).

Procedure Detail:

NPI Registry (per CMS requirement) and rosters must be updated quarterly.

A. The NPI Registry Public Search is a free directory of all active National Clinician Identifier (NPI) records. Healthcare Clinicians acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. CMS now requires all Clinicians to access the NPI registry and update their Clinician demographics on a quarterly basis. Network Health will access this database quarterly to use as a tool to aid the accuracy of provider data.

B. Rosters must be submitted on a quarterly basis to the provinfo@networkhealth.com. Clinicians/facilities must return rosters within 10 business days of receipt from Provider Informatics.
    1. If the roster is not returned within 90 days, Clinicians/Facilities will be removed of the directory.
    2. Terminations of Clinician or facilities must be submitted to Network Health at least 10 days prior to the termination date whenever possible.
    3. If there is a break in Credentialing that is thirty (30) days or greater, or if the Clinician leaves one contract and starts with another contracted group thirty (30) days or greater, the Clinician shall be required to begin the Credentialing process again.

C. All prospective plan practitioners must successfully complete the credentialing process before the contract is executed and a provider may see our members. NHP/NHIC/NH TPA/NHAS will not allow provisional or temporary credentialing of practitioners. Notification of new hires are to be submitted to Network Health as soon as possible. Clinicians that require credentialing cannot see Network Health members until they have passed credentialing, and the contract manager has informed them that they have been added to the contract. Should members be seen prior to credentialing, Clinician is responsible for costs incurred while seeing the member.
    1. Credentialing may take up to 90 days if a Clinician is timely with submitting all required information. NHP/NHIC/NH TPA/NHAS selects and directs its members to see a specific practitioner or group of practitioners. NHP/NHIC/NH TPA/NHAS will credential practitioners in the following settings:
        a. Practitioners are licensed, certified, or registered by the state to practice independently (without direction or supervision).
        b. Practitioners have an independent relationship with NHP/NHIC/NHAS. – An independent relationship exists when NHP/NHIC/NHAS directs members to see a specific practitioner or group of practitioners, including all practitioners' members can select as primary care practitioners.
        c. Practitioners provide care to members under NHP/NHIC/NHAS's medical benefits.
        d. Practitioners to which credentialing applies include:
            - Doctor of Medicine (M.D.); Doctor of Osteopathic Medicine (D.O.); Doctor of Dental Science (D.D.S.) who provide care under the medical benefit program; Oral Surgeons; Doctor of Podiatric Medicine (D.P.M.); Doctor of Chiropractic (D.C.); and Doctor of Optometry (O.D.).
            - Behavioral Health care practitioners to include Psychiatrists and Physicians who are certified in Addiction Medicine; doctoral and/or master's level Psychologists (PhD, PsyD) who are state certified or state licensed.
            - Master's level Clinical Social Workers who are state certified or state licensed.
            - Master's level Clinical Nurse Specialists or Psychiatric Nurse Practitioners who are nationally or state certified or state licensed.
            - Other Behavioral Health Care Specialists who are licensed, certified, or registered by the state to practice independently.
            - Speech, Language, Physical and Occupational Therapist working

in an autism in home service.
- Nurse Practitioners and Physicians Assistants, who provide direct patient care and make referrals to specialists or have prescriptive duties.
- APNP and Midwives, who are licensed, certified, or registered by the state to practice independently.
- Urgent care physicians and anesthesiologist who work outside the hospital setting.
- Genetic Counselors
- Audiologist
- Anesthesiologists with pain management
- Locum Tenens Provisional credentialing is required if these practitioners work less than 60 calendar days. – Full credentialing is required if these practitioners work 60 calendar days or more.
- Telemedicine providers
- Rental Networks that are part of NHP/NHIC/NHAS's primary network, and NHP/NHIC/NH TPA/NHAS has members who reside in the rental network area. – specifically, for out-of-area care, and members may see only those practitioners, or are given an incentive to see rental network practitioners
- PPO network: – If an organization contracts with a PPO network to provide health services to members who need care outside its service area, and if it encourages members to obtain care from that network, when they are outside the network, NCQA considers this to be an independent relationship if:
    - Information about the network is included in member materials or on an ID card that directs members to the network (e.g., network name, phone number, logo), or
- There are incentives for members to see the PPO's practitioners. In this type of contractual arrangement, NHP/NHIC/NHAS must credential the practitioners or delegate credentialing to the PPO networks.
- Acupuncturists

e. NHP/NHIC/NH TPA/NHAS credentialing does not apply to:

- Practitioners who practice exclusively in an inpatient setting and provide care for organization members only because members are directed to the hospital or another inpatient setting.
- Practitioners who practice exclusively in free-standing facilities and provide care for organization members only because members are directed to the facility.
- Pharmacists who work for a pharmacy benefits management (PBM) organization to which NHP/NHIC/NHAS delegates utilization management (UM) functions.
- Covering practitioners (e.g., locum tenens) who do not have an independent relationship with NHP/NHIC/NHAS are outside NCQA's scope of credentialing.
- Practitioners who do not provide care for members (e.g., board-certified consultants who may provide a professional opinion to the treating practitioner).

- Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

f. Practitioners to which credentialing does not apply includes:

- Anesthesiologists without Pain Management Practice
- Assistant Surgeon
- Athletic Trainers
- Critical Care
- Dieticians
- Emergency Medicine
- Hospital based urgent care
- Hospitalists
- Locum Tenens-If they serve in this capacity for less than ninety (90) calendar days
- Medical Toxicology
- Neonatologist
- Nuclear Medicine
- Nutritionist
- Occupational Therapists-except those working in an autism in home service
- Physical Therapists
- Speech/Language Therapists-except those working in an autism in home service
- Pathologists
- Radiologists
- Radiation-Oncology
- Radiology-Vascular interventional
- RN/Surgical Techs in specialty practices
- Para-Professional working in an autism in home service

Regulatory Citations:

42 C.F.R. 422.503
42 C.F.R. 422.504(h-i) 42 C.F.R. 423.504 42 C.F.R. 423.505(b) (10) (h-i) 45 C.F.R. 155.20 45 C.F.R. 156.340

Related Policies:

n00329Delegation Oversight Policy and Procedure Credentialing Process

Related Documents:

None

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