5160-1-42 **Provider credentialing.**

In accordance with the federal credentialing standards found in 42 CFR 422.204, "provider selection and credentialing" (as in effect on October 1, 2021), this rule details the credentialing and recredentialing process for medicaid providers.

(A) For purposes of this rule the following definitions apply.

(1) "Council for affordable quality healthcare (CAQH)" is a non-profit organization which created a process allowing ODM to use a single, uniform application for credentialing. This end-to-end process simplifies data collection, primary source verification, and sanctions monitoring, to support ODM's credentialing needs.

(2) "Credentialing" means an evaluation of the qualifications of health care providers that seek contracts or participation agreements with ODM.

(3) "Credentialing committee" means the group of individuals appointed by ODM for provider and facility review, as well as reconsidering providers and facilities initially denied by credentialing as described in paragraph (K) of this rule.

(4) "Delegate" means a hospital group or physician hospital organization formed by a hospital and group of physicians granted the authority by ODM to credential its health care providers who require credentialing.

(5) "Delegation" means the act of ODM granting another health care entity the authority to credential its health care providers who require credentialing.

(6) "Designee" means a third party with whom ODM has contracted to complete certain credentialing related administrative tasks and information gathering tasks required to fulfill credentialing and re-credentialing for those providers whose credentialing is not completed through the process of delegation; and

(7) "Eligible provider" has the same meaning as a person or entity who is an eligible provider as defined in rule 5160-1-17 of the Administrative Code who is enrolled with ODM.

(B) Credentialing by ODM is mandatory for the following practitioners:

(1) Physicians as defined in Chapter 4731. of the Revised Code;

(2) Psychologists as defined in Chapter 4732. of the Revised Code;

(3) Physician assistant as defined in Chapter 4730. of the Revised Code;

(4) Dentists as defined in Chapter 4715. of the Revised Code;

(5) Optometrists as defined in Chapter 4725. of the Revised Code;

(6) Pharmacists as defined in Chapter 4729. of the Revised Code;

(7) Chiropractors as defined in Chapter 4734. of the Revised Code;

(8) Acupuncturists as defined in Chapter 4762. of the Revised Code;

(9) Clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner as defined in Chapter 4723. of the Revised Code;

(10) Licensed independent social worker, licensed independent marriage and family therapist, or licensed professional clinical counselor as defined in Chapter 4757. of the Revised Code;

(11) Licensed independent chemical dependency counselor as defined in Chapter 4758. of the Revised Code;

(12) Certified Ohio behavior Analysts as defined in Chapter 4783. of the Revised Code;

(13) Audiologists as defined in Chapter 4753. of the Revised Code;

(14) Occupational therapist as defined in Chapter 4755. of the Revised Code;

(15) Physical therapist as defined in Chapter 4755. of the Revised Code;

(16) Speech-language pathologist as defined in Chapter 4753. of the Revised Code; and

(17) Dietitians as defined in Chapter 4759. of the Revised Code.

(C) Credentialing by ODM is mandatory for the following facilities:

(1) Nursing facilities as defined in Chapter 5165. of the Revised Code;

(2) Hospitals as defined in Chapter 3727. of the Revised Code;

(3) Hospice as defined in Chapter 3721. of the Revised Code;

(4) Home health agencies as defined in rule 3701-60-01 of the Administrative Code;

(5) Ambulatory surgical facilities as defined in section 3702.30 of the Revised Code;

(6) Community mental health services providers as defined in Chapter 5119. of the Revised Code;

(7) Community addiction services providers as defined in Chapter 5119. of the Revised Code;

(8) End stage renal disease (ESRD) Treatment Centers as described in rule 3701-83-23.1 of the Administrative Code;

(9) Radiology centers as described in rule 3701-83-51 of the Administrative Code; and

(10) Residential facility as defined in Chapter 5119. of the Revised Code.

(D) Credentialing by ODM is not mandatory for the following practitioners:

(1) Health care professionals who are permitted to provide services only under the direct supervision of an independently enrolled practitioner as defined in rule 5160-4-02 of the Administrative Code;

(2) Hospital-based health care professionals who provide services "incidental-to" a hospital service and are not independently enrolled;

(3) Health care professionals who are designated as current residents, interns, or fellows as defined in Chapter 5160-4 of the Administrative Code; and

(4) Moonlighting residents as defined in 42 CFR 415.208 (as in effect on October 1, 2021).

(E) Those providers listed in paragraph (B) of this rule will provide ODM or ODM's credentialing designee the following information for initial credentialing verification:

(1) Access to the standard provider credentialing application form used by the council for affordable quality healthcare (CAQH) in accordance with section 3963.05 of the Revised Code within one-hundred-eighty days prior to credentialing date;

(2) Active provider licensing information;

(3) Board certification, if applicable;

(4) Education;

(5) Clinical privileges, if applicable;

(6) Medical malpractice insurance;

(7) Drug enforcement administration (DEA) certification, if applicable;

(8) National practitioner data bank information regarding malpractice and clinical privilege actions;

(9) Sanctions or limitations on licensure;

(10) Eligibility for participation in medicare and medicaid, if applicable; and

(11) Minimum five-year work history. The five-year timeframe begins with date of initial licensure. If the provider has been licensed for less than five years, available work history should be provided.

(F) The facilities listed in paragraph (C) of this rule will provide ODM or ODM's credentialing designee access to the following information for initial credentialing verification:

(1) The Ohio department of insurance (ODI) form INS5036, revision date February of 2021, found at https://insurance.ohio.gov/static/Forms/Documents/INS5036.pdf;

(2) Active provider licensing information;

(3) Certification through an accrediting body or a site visit completed by a state designated agency;

(4) Eligibility for participation in medicare and medicaid, if applicable;

(5) Verification of good standing with applicable state and federal bodies; and

(6) Active malpractice insurance.

(G) Prerequisites for becoming a delegate as defined in paragraph (A)(4) of this rule are the following:

(1) Maintain an active, valid delegation contract approved by the credentialing committee;

(2) The delegate has to complete a pre-delegation audit prior to their becoming an active delegate;

(3) The delegate has to adhere to the standards set forth in the delegated contract, including the time frames and content for reporting, duties assigned, necessary processes and procedures, and collaborating of a yearly audit;

(4) The delegate has to have their own credentialing committee, with decision making capabilities, and delegation contract monitoring;

(5) The delegate has to report any additions, changes, and terminations in a timely manner including both credentialed and non-credentialed practitioners and facilities;

(6) Delegates will be audited by ODM every twelve months; and

(7) Practitioners with a delegated group understand they are still expected to update their information in the provider data system, and to revalidate according to their ODM determined schedule.

(H) Every thirty-six months, those providers listed in paragraph (B) of this rule will provide ODM or ODM's credentialing designee information listed in paragraphs (E)(1) to (E)(10) of this rule for recredentialing.

(I) Every thirty-six months, facilities listed in paragraph (C) of this rule will provide ODM or ODM's credentialing designee the information listed in paragraphs (F)(1) to (F)(6) of this rule for recredentialing verification.

(J) The following information may be requested by the state or its designee from providers or facilities as listed in paragraph (B) or (C) of this rule at any time during the credentialing or recredentialing process:

(1) Demographic information;

(2) Information missing in CAQH;

(3) Verification of certifying board names;

(4) Explanation for work history gaps;

(5) Updates regarding expired information;

(6) Verification of specialty information;

(7) Information regarding previous sanctions or affirmative responses to CAQH disclosure questions; and

(8) Continuing education (CE) prerequisites as required by the provider's state licensing board.

(K) ODM will establish and utilize a credentialing committee for provider and facility review and appeals when the credentialing prerequisites specified in paragraph (K)

(1) of this rule are under review. The credentialing committee will follow the process described below when a provider or facility is found to be non-compliant with the credentialing prerequisites.

(1) Providers or facilities that fail to meet the following prerequisites, have a discrepancy, or negative findings with the information provided in paragraphs (E) or (F) of this rule, are subject to review by the state established credentialing committee. Prerequisites are the following:

(a) Previous licensing board sanctions;

(b) Previous clinical actions taken by a medical group or hospital;

(c) Affirmative responses to CAQH disclosure questions, with the exception of the following CAQH questions:

(i) To your knowledge, has information pertaining to you ever been reported to the national practitioner data bank (NPDB) or healthcare integrity and protection data bank (HIPDB)?

(ii) Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past ten years? And if yes, provide information for each case.

(d) Excessive malpractice claims within the past ten years, as defined by the credentialing committee;

(e) Inappropriate training or education for disclosed provider specialty;

(f) Previous medicare or medicaid disbarments or actions;

(g) Site visit non-compliance;

(h) Previous DEA actions;

(i) Material misrepresentation or omission concerning professional credentials; and

(j) Prior criminal history in accordance with rule 5160-1-17.8 of the Administrative Code.

(2) The following individuals will participate in the ODM credentialing committee as determined by ODM. Voting members are expected to attend no less than

seventy-five per cent of all meetings held to maintain voting rights, and sign non-discrimination and conflict of interest forms.

(a) Committee chair;

(b) Community-based peers of providers requiring credentialing as defined in paragraph (B) of this rule;

(c) Managed care organization representatives;

(d) Medical directors; and

(e) Staff from ODM and ODM's designee.

(3) The credentialing committee members will carry out the following responsibilities:

(a) Review the credentials of practitioners;

(b) Review and approve sanctions monitoring;

(c) Review and approve delegated audits, contracts, and agreements; and

(d) Review and approve credentialing reports from ODM and ODM’s designee.

(4) When a provider or facility is denied by the credentialing committee, the following process will occur.

(a) The provider or facility is sent a denial letter by ODM outlining the unmet credentialing prerequisites or negative findings under review, and their appeal rights and instructions for proceeding;

(b) The provider or facility will have no more than thirty calendar days to appeal to the credentialing committee;

(c) The appellant provides the credentialing committee with supplemental information which supports its appeal of the decision;

(d) Appeal decision is rendered by the credentialing committee; and

(e) Credentialing committee decisions on appeals are final, and those providers and facilities denied by the credentialing committee are not subject to reconsideration as found in paragraph (D) of rule 5160-70-02 of the Administrative Code. The practitioners denied by the credentialing committee are denied ODM enrollment.

(L) Providers and facilities who do not have any negative findings regarding the information needed for initial credentialing verification or recredentialing listed in paragraph (E) or (F) of this rule and meet the prerequisites listed in paragraph (K)(1) of this rule are considered to have a clean file and have met the requirements for credentialing with ODM. Providers and facilities with clean files and no negative findings will not meet with the credentialing committee unless otherwise determined by ODM and ODM's designee. Clean files for initial credentialing and recredentialing will have a final review by ODM's medical director.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02; 5164.32
Rule Amplifies:	5162.03; 5164.02; 5164.32