

HB 125 Contracting and Credentialing FAQs
December 2, 2010

Definitions

- Q: Does the HB 125 apply to *free standing radiology centers*? What application would these organizations be required to use? These organizations are not specifically named in the provider definition.

A: An entity that is not included in either the “contracting entity” or “provider” definitions of HB 125 is not subject to the legislation and would not be required to use the credentialing forms prescribed by the Department for that purpose.

- Q: The definition of provider includes "*hearing aid dealer*" but not audiologists. Are *audiologists* included within the definition and therefore required to submit the CAQH application?

A: If an audiologist is acting as a hearing aid dealer they would be required to submit a CAQH application. If the audiologist is not acting as a hearing aid dealer, they are not included in the definition of provider and are not required to use the CAQH application.

- Q: What is the definition of “*third party*” as referenced in ORC 3963.02?

A: There is no statutory definition of the term “third party” in Chapter 3963 of the ORC. Therefore, the term “third party” must be given its plain meaning: a party that is neither the contracting entity nor the provider.

- Q: Do we have definitions for the manner of payment terms: *fee-for-service*, *capitation*, and *risk*, as identified in the required Summary Plan Disclosure?

A: The Department has not defined these terms. The Department expects contracting entities to use the terms as they are commonly defined.

- Q: What is the definition of “*hospital*” to be used for purposes of ORC 3963.01 under "Provider?"

A: The term “hospital” is not defined in HB 125. Consequently, the plain meaning of the term should be used to interpret this word.

- Q: Are ancillary provider types, such as DME vendors, infusion providers, home health care agencies and skilled nursing facilities, also required to use the CAQH form even though it is designed primarily for practitioners?

A: Individuals and entities included in the definition of “*provider*” in ORC 3963.01 (with the exception of hospitals) must use the CAQH form. Infusion providers, DME vendors (excluding orthotists and prosthetists) and skilled nursing facilities are not included in the “*provider*” definition; therefore, they are not required to use the CAQH form. Home health care agencies are required to use the CAQH form.

Health Care Contracting

Summary Disclosure Form

- Q: Is a summary disclosure form required for contracts that are in existence prior to June 25, 2008?

A: No. The requirement to provide a summary disclosure form with each health care contract is not retroactive, but applies to contracts entered into, materially amended or renewed on or after June 25, 2008. ("Material amendment" is a defined term which can be found in ORC 3901.01 (J).)

- Q: Are contracting entities required to provide a summary disclosure form with every version of the contract or just the final version that is signed by the provider?

A: When a contracting entity presents a health care contract to a provider it should contain a summary disclosure form. During the contracting process the summary disclosure form should be updated to reflect changes to the contract.

- Q: If the parties agree to amend a provision of a provider agreement existing prior to June 25, 2008 and they both sign an amendment, does the HIC have to include a summary disclosure form and/or amend the agreement to include any provisions of the law that conflict with or were not in the existing agreement - or is a mutual amendment not considered a "material amendment" as that term is defined?

A: The definition of material amendment in ORC 3963.01 (J)(6) specifically excludes changes to a health care contract described in ORC 3963.04(B). This section of the statute describes a situation in which a provider affirmatively accepts a material amendment in writing. Therefore, a mutually agreed upon amendment to a contract in which the provider accepts the amendment in writing is not considered to be a material amendment.

TPA's

- Q: Is a TPA that contracts with a contracting entity subject to all of the terms and conditions of the health care contract negotiated between the contracting entity and the provider?

A: Yes. ORC 3963.02(A)(2)(b) provides that a contracting entity must require a third party, in this instance a TPA, to comply with all of the applicable terms and conditions of the health care contract negotiated between the contracting entity and the provider.

- Q: Does ORC 3963.02(F)(1) subject TPAs to arbitration?

A: ORC 3963.02(F)(1) subjects contract disputes among "parties to a health care contract" to arbitration. If a TPA is a party to a "health care contract" as defined in ORC 3963.01(H), then the TPA would be subject to arbitration. A TPA that contracts with providers for the delivery of health care services would be considered a contracting entity, and if that contracting entity enters into a health care contract, then the TPA is subject to the provisions that apply to contracting entities, including arbitration.

- Q: Does ORC 3963.02(A)(2)(b) require TPAs contracting with contracting entities to maintain a web page containing a list of third parties with whom they are contracting?

A: ORC 3963.02(A)(2)(a) requires that a contracting entity that enters into the healthcare contract with a provider must maintain a web page or a toll-free telephone number. The statutory language does not obligate parties that contract with the contracting entity to maintain a web page or toll-free telephone number. The statute also does not prohibit the contracting entity from arranging for another party to set up the web site or toll-free telephone number on its' behalf.

- Q: Representatives in the credentialing department of a provider network are stating that it is not subject to HB 125 because it is not an insurance company. It represents a "network" of insurance companies. Is this a true statement? The representatives are requiring us to still complete their credentialing applications. They also are stating that it can take over 4 months for their credentialing process. Please advise.

A: HB 125 is not limited in its applicability to insurance companies. ORC 3901.01(C) defines the term "contracting entity" to include any person that has a primary business purpose of contracting with participating providers for the delivery of health care services. (The term "person" is defined in ORC 1.59 (C) to include corporations and other business entities.) A provider network that is a "contracting entity" would be subject to the credentialing requirements of HB 125. In response to your comment about the length of time allowed for completion of the credentialing process, ORC 3963.06 (C)(1) requires a contracting entity to complete the credentialing process within ninety days after it receives a credentialing form from a provider. If the contracting entity is a hospital, the ninety day time frame is not applicable pursuant to ORC 3963.06 (C)(3).

- Q: Are entities that contract with "contracting entities" exempt from the requirements of ORC 3963.03?

A: The contracting entity that signs a health care contract with the provider must include the items listed in ORC 3963.03. A party that enters into an agreement with a contracting entity to use the services of the provider must abide by the terms of the health care contract that the contracting entity has entered into with the provider. Parties that enter into agreements with contracting entities are therefore not exempt from the requirements of ORC 3963.03. These requirements should already be in the health care contract that the party will use.

Miscellaneous Health Care Contracting

- Q: Will HICs need to refile the provider contracts that are revised to comply with HB 125?

A: The Department does not require insurers or HICs to file provider contracts, other than upon initial licensure for HICs. The Department will not require provider contracts revised as a result of HB 125 to be filed.

- Q: Does HB 125 apply to our current contracts that are not up for renewal? Do they have to comply with all or any of the terms in HB 125?

A: Section 3 of HB 125 states that the act applies only to contracts that are delivered, issued for delivery, or renewed or materially amended in Ohio after June 25, 2008. Existing contracts do not need to comply with the provisions of HB 125 until they are renewed or materially amended.

- Q: ORC 3963.04(C) requires that existing agreements need to be re-negotiated to comply with the new legislation when materially amended or "renewed." If the HIC's provider agreements automatically renew at the end of every calendar year for successive one year terms with no new terms or conditions, is the HIC required to renegotiate all of its agreements at that time or is the intent of the term "renew" limited to instances where the HIC takes specific action on the agreement, such as modifying, amending or restating a term or condition of the agreement?

A: The term "renewed" is not defined in HB 125. ODI would consider the automatic renewal of a contract to be a renewal for purposes of ORC 3963.04 (C) in keeping with the plain meaning of the term "renewal."

Credentialing

Delegated Entities

- Q: HB 125 FAQs clarify that a delegated entity must follow the guidelines of ORC 3963.05 and ORC 3963.06; however, how does this apply to hospitals that are delegated entities? Must they also follow all of the provisions in these ORC guidelines including 90-day verification timeframe, communication regarding credentialing via fax, email, or certified mail--return receipt, and not requiring additional information in addition to what is required on the CAQH application. ORC 3963.06 states that the 90-day timeframe does not apply to credentialing hospitals; however, does this change if the hospital is a delegated entity?

A: Delegated entities are required to perform all of the duties of the delegator. When a hospital credentials on behalf of another contracting entity it must comply with all of the HB 125 requirements for that contracting entity

- Q: After 9/25/08, ORC 3963.05(C) will not allow a health plan or its delegated entity (for purposes of this question, a hospital) to ask for credentialing information from providers in addition to the information required by the applicable standardized credentialing form. However, hospitals are required by JCAHO standards to send out delineation of privilege forms, bylaws, etc. Does HB 125 allow hospitals, who are acting as delegated entities, to send out additional information that may be required to continue their accreditation with JCAHO?

A: Yes. The limitation in ORC 3963.05 (C) pertains exclusively to the information that a contracting entity may require from providers for the purpose of credentialing. ORC 3963.05 (C) does not impose any limitation on other types of information sent to providers for other purposes such as accreditation.

Use of Credentialing Form

- Q: Do the provisions of HB 125 apply to Ohio provider contracts regardless of whether the provider is Ohio-based? For example, if a contracting entity has an agreement with a national home health provider network that is based in Ohio, but has providers under contract in other states in addition to OH, would the contracting provisions of HB 125 apply to all of the network's providers (even those in other states), or just the OH home health providers? What if the contract

is with a provider whose main office is in a bordering state, but the provider also has offices that are in OH--would HB 125 apply to this contract?

A: You will need to consider the particular facts of the provider contract or contracts in question, including whether the contract were issued or delivered in Ohio. You should consult with your legal counsel about how Section 3 of HB 125 applies in the various scenarios outlined in your question.

- Q: We have received updated information, including disclosure forms, from only one insurance carrier since the passage of HB 125. How does notice of HB 125 reach credentialing staff for carriers that are based out of state? If we are credentialing new doctors in the near future, should we send notice of the passage of HB 125 along with the standardized CAQH form? Although insurance carriers are using CAQH online subscription for medical providers, it is not used for dental providers and we are still processing credentialing applications on paper.

A: HB 125 does not specify how information about the legislation must be circulated. Professional trade organizations generally provide education and legal updates on new legislation to their members. ODI has been providing information to the public and to professionals by giving presentations and through this web-site. Individual notices regarding the enactment of HB 125 are not being sent to providers.

- Q: There are two versions of the credentialing form available on the CAQH website; one with specialty updates (43 pages) and one without (18 pages). Are both acceptable? Will you please advise if we have a choice on which form or if one is mandated for dentists?

A: There is actually only one CAQH form and it is 18 pages. The CAQH website includes one link to the 18-page form and another link to a 43-page application kit. The application kit includes all of the information you might need to complete the form including a list of all the codes (e.g., provider types, license status, professional schools) used by CAQH. The application kit also includes supplemental pages that may be needed, such as extra pages for additional practice locations. Many providers will be able to provide all the required information on the 18-page form, but some will need to use the extra pages. ODI recommends that you access the application kit to ensure that you have all the information you need.

- Q: What if a provider does not have Internet access?

A: ODI will mail a paper copy of the appropriate credentialing form (CAQH or Part B) to a provider upon request. Contact the ODI Life and Health Division at 614-644-2644 to request one.

Methods of Providing Notice for Credentialing

- Q: Does ORC 3963.06(D) which states that “any communication between the provider and the contracting entity shall be electronically, by facsimile, or by certified mail, return receipt requested” apply to ALL credentialing and recredentialing communication with the exception of the initial request to a provider to complete the application/reapplication? Are these same methods of transmittal required to notify providers that their application to be recredentialed has been approved? In addition, could you please verify that ORC 3963(A) (the 21-day notification period to advise a provider of deficient credentialing forms) also applies to recredentialing.

A: Yes, the transmittal methods required by ORC 3963.06(D) apply to both credentialing and recredentialing communications because the statute makes no distinction between the two processes. As you point out, the statute pertains to "any" communication between a provider and contracting entity with the exception of the initial request of the provider. Therefore, the specified methods of transmittal must be used to notify a provider that their application for recredentialing has been approved. As for your last question, the 21 day notification period would appear to only be applicable when a provider initially submits a credentialing form upon the request of a contracting entity.

- Q: The statute states the provider must submit the credentialing form to the contracting entity electronically, by facsimile or by certified mail with return receipt. Is the provider permitted to submit his application via regular mail or return his/her application via courier to the requested entity?

A: No. The only permissible methods of transmission between contracting entities and providers are those specified in ORC 3963.06 (D).

- Q: Is the initial request to complete a credentialing or recredentialing form sent from the contracting entity to the provider required to be sent electronically, facsimile or certified mail?

A: ORC 3963.06(A) does not specify the particular method by which the contracting entity must make the initial request to a provider to complete credentialing or recredentialing forms, but both oral and written requests are recognized. ORC 3963.06 (A) requires that subsequent communications by the contracting entity for additional information from the provider must be made electronically, by facsimile, or by certified mail.

- Q: ORC 3963.06 (D) Any communication between the provider and the contracting entity shall be electronically, by facsimile, or by certified mail, return receipt requested. Clarification is needed, does this mean any communication from the contracting entity to the provider AND any communication from the provider to the contracting entity must be done electronically, by facsimile or by certified mail, return receipt requested?

A: Yes, ORC 3963.06(D) clearly states that any and all “communication between the provider and the contracting entity shall be electronically, by facsimile, or by certified mail, return receipt requested.” As such, any other method of communication is not acceptable under the law.

- Q: Does ORC 3963.06(D) apply to all communications or just those related to credentialing activities? For example, may a contracting entity continue to send provider newsletters by first class mail?

A: It would be a fair reading of ORC 3963.06(D) to assume it only applied to communications between providers and contracting entities concerning credentialing.

Timeframe for Provider Notification of Incomplete Credentialing Form

- Q: Please clarify the timeframes for following up inconsistent information found in a provider application. According to the statute, if provider submits an incomplete credentialing form, the contracting entity has 21 days after receipt of the form to request the information. If the contracting entity receives any information that is inconsistent with the information given by the provider on the credentialing form (for example, after performing primary source verification), the contracting entity can request clarification of the inconsistency - does the request for clarification also have to be done within 21 days of receipt of the application?

A: ORC 3963.06(B) does not include a time period for requesting clarification of inconsistencies. The 21 day time period applies only to notification to providers regarding incomplete forms.

- Q: ORC 3963.06(A) requires the HIC to notify a provider of a deficiency in the provider's credentialing application within 21 days of receipt. If the HIC participates with CAQH and obtains the provider's application electronically from the CAQH database using the number given by the provider, when is the application deemed "received"? Is the application deemed received when the HIC obtains the provider's number to access CAQH, when it accesses CAQH or when the provider's updated and complete application is made available on CAQH?

A: The application would be considered to be received when the provider's updated and completed application is made available by CAQH to the contracting entity.

- Q: Please clarify how the 21 day timeframe for following up with a provider/CAQH who submits an incomplete application, fits into the 90 day requirement to complete the credentialing process. Does the 90 day timeframe apply regardless of whether the CAQH form is received incomplete or not? The contracting entity has 21 days to request the completed information. The contracting entity would not have any control over the timeframe in which the provider responds with the completed information. Therefore, does that time period toll until the additional information is received? For example, contracting entity receives a credentialing application and it is in queue for 5 days. The contracting entity then sends a letter to provider requesting the incomplete information. Provider responds in 45 days with necessary information. Does 50 days count toward the 90 day requirement, or only the 5 that the contracting entity had the application on hand?

A: The 90 day timeframe would apply even if the credentialing form submitted is incomplete. HB 125 does not contain any provision which would "toll" the 90 time period. The time period commences when the credentialing form is *received* by the contracting entity and there is no additional time allotted for credentialing forms that are "in queue." In your example, the 50 days would "count" toward the 90 days.

- Q: ORC 3963.06(A) requires the HIC to notify a provider of a deficiency in the provider's credentialing application within 21 days of receipt. Is this 21 business days or calendar days?

A: Notification must be done within 21 calendar days. ORC 1.14 provides that "the time within which an act is required by law to be done shall be computed by excluding the first and including the last day; except that, when the last day falls on Sunday or a legal

holiday, the act may be done on the next succeeding day that is not Sunday or a legal holiday.” Therefore, the 21 day timeframe should be adjusted as necessary.

Timeframe for Completion of Credentialing Process

- Q: ORC 3963.06(C) requires the HIC to complete the credentialing process within 90 days of receipt. Although the application may not be "deficient", the HIC's credentialing committee or medical director may need additional information regarding certain information submitted by a provider, such as an adverse event reported to the NPDB or a previous license suspension. Is there any opportunity to "pend" the application beyond the initial 90 day period to allow the medical director to discuss certain aspects of a provider's application if directed by the credentialing committee? If not, and the application must still be processed within 90 days, does the Department offer any guidance on how such application should be handled?

A: HB 125 does not contain any exception which would permit an application to “pend” beyond the 90 day timeframe. Contracting entities are expected to complete their review of provider applications within the 90 day period using whatever internal procedures they deem necessary for compliance with ORC 3963.06(C) or be subject to the monetary liability described in the statute.

- Q: Does the 90 day timeframe include notification to the practitioner (i.e. the acceptance letter), or just mean that the practitioner has to be credentialed/processed and effective within 90 days? We were under the impression that we were able to send out the notification letter within 60 days of them being accepted.

A: The statute requires that the provider be credentialed within 90 days. The definition of credentialing does not include notification to the provider. However, the Department would expect notification to be provided on a timely basis. Excessive delays in notification that have an adverse effect on the provider may be considered an unfair practice.

- Q: ORC 3963.05(C)(1) states “...a contracting entity shall complete the credentialing process not later than ninety days after the contracting entity receives that credentialing form from the provider.” Because of the civil penalties involved I am under the impression that the individual who is credentialed needs to be able to see patients on the 90th day. However, what if the contract is not signed/dated (or back-dated) to be effective as of the 90th day, will we be out of compliance with this requirements?

A: It is the credentialing process which must be completed within 90 days. HB 125 is silent regarding the timeframe within which provider contracts must be executed.

- Q: In certain situations, a health insuring corporation (HIC) will have a Physician-Hospital Organization (PHO) act as a delegated credentialing agent for the HIC. While the PHO reviews credentialing applications, verifies essential information and submits applications to their internal credentialing committee for a recommendation on the application, the HIC retains the final authority to grant or deny the credentialing application. In this situation, is a PHO that is acting as a delegated credentialing agent for a HIC, subject to the 90-day credentialing time frame? If so, could the PHO as a delegated credentialing agent, be held responsible for the financial penalties outlined in 3963.06(C)(1) if the credentialing application is not approved or denied within the 90-day timeframe? Could the PHO be held financially responsible even if it has completed its

delegated responsibilities within 90 days but the HIC has not and the PHO is not the final arbiter of the application?

A: A PHO acting as a delegated credentialing agent for a HIC would be subject to the same credentialing timeframes as the HIC. The liability questions you raise concern the contractual relationship between the parties and are beyond the scope of HB 125.

- Q: I am just beginning a medical practice and intend to submit an application to several health plans in the area. Are health plans required to complete the credentialing process in connection with my application within 90 days?

A: No, ORC 3963.06(C)(1) provides that the credentialing process starts when the provider initially submits a credentialing form upon the oral or written request of a contracting entity. If a contracting entity has not requested the credentialing application from you, it is not required to complete the process within 90 days

- Q: If a provider's credentialing form is taken to the Credentialing Committee for approval on the 90th day from the date it was received by the contracting entity, would the provider need to be notified on that date to be in compliance with the provisions of HB 125? If so, does this apply to both initial credentialing and recredentialing?

A: ORC 3963.06 (C)(1) contains the only notification requirement with respect to credentialing and provides that a contracting entity which exceeds the 90 day period shall select the liability to which it is subject and shall inform the provider of that selection. The statute does not provide a timeframe within which this notification must be done. This section of the statute also provides that "the credentialing process starts when a provider initially submits a credentialing form upon the oral or written request of a contracting entity. The use of the phrase "initially submits" and the absence of any reference to "rec credentialing" support the conclusion that the 90 day timeframe is only applicable to the original credentialing process.

- Q: NCQA guidelines state that verifications and attestations can be within 180 days of the decision date. Although HB 125 states the application must be processed within 90 days of receipt of a completed application, can we still follow NCQA guidelines for verification and/or attestation dates?

A: Contracting entities may still follow NCQA guidelines for verification and/or attestation dates. The 180 day NCQA time period relates to the length of time that verifications or attestations are valid and does not extend the 90 day time period for the completion of the credentialing process.

- Q: I received a credentialing application by e-mail directly from the provider (.pdf format). The e-mail was sent on a Friday afternoon. I opened the e-mail and downloaded the application on Monday morning. When does the 90 day timeline begin - Friday or Monday? Also, the provider did not request an electronic return receipt. How can he document when the application was received?

A: The credentialing application should be considered to have been received on the date it became accessible on your computer. This conclusion is in keeping with the plain definition of the word "received." Your question regarding documentation of receipt of

an electronic transmission is not addressed in HB 125 and is a matter which you may wish to discuss with legal counsel.

- Q: How do you verify the date when the 90 days is to start in reference to the penalties of not credentialing? Should applications be sent certified mail to show proof of mailing and the date it was mailed?

A: HB 125 does not address verification specifically, however ORC 3963.06(D) prescribes that any communication between a contracting entity and a provider be transmitted electronically, by facsimile, or by certified mail, return receipt requested. Each of these methods is capable of documenting receipt. Keep in mind that it is the date of *receipt* which triggers the 90 day time period, not the date of transmittal.

- Q: ORC 3963.06 (C)(1) states: A contracting entity that does not complete the credentialing process within the ninety-day period specified in this division is liable for either a civil penalty payable to the provider in the amount of five hundred dollars per day, including weekend days, starting at the expiration of that ninety-day period until the provider's credentialing application is granted or denied or retroactive reimbursement to the provider according to the terms of the contract for any basic health care services, specialty health care services, or supplemental health care services the provider provided to enrollees starting at the expiration of that ninety-day period until the provider's credentialing application is granted or denied. Does this require that every credentialing application have a decision rendered regarding its acceptance even if the provider does not provide the information required for credentialing despite multiple requests? Can the health plan discontinue the application within the 90 days for non-response, or the inability to meet credentialing criteria?

A: Yes, every credentialing application must have a decision rendered within 90 days. The statute does not permit an option to pend or "discontinue" an application until additional information is received.

- Q: Is Ohio Medicaid required to comply with the 90 day credentialing time frame? This credentialing question is related to an OD not a MD - does that make a difference?

A: ORC 3963.10(A) states that Chapter 3963 (HB 125) does not apply to "[a] contract or provider agreement between a provider and the state or federal government, a state agency, or federal agency for health care services provided through a program for Medicaid or Medicare." As a consequence, the 90-day time frame would not apply to a contract between a provider and the Department of Job and Family Services for Medicaid services. By contrast, the 90-day time period would apply to a contract between a provider and a health insuring corporation that provides services to Medicaid beneficiaries.

- Q: Do the credentialing requirements and time frames apply to delegated entities as well as contracting entities?

A: Yes. ORC 3963.05 and 3963.06 require that contracting entities must use the standard credentialing forms and comply with the stated timeframes. Contracting entities that delegate the credentialing function to a third party continue to be responsible for the process used to credential their providers and retain the obligation to assure that credentialing is done pursuant to the requirements of ORC 3963.05 and 3963.06.

Restrictions on Requests for Additional Information

- Q: We are a Hospitalist Group, i.e., a group of doctors that practice only in the hospital but are not employed by the hospital. Are we exempt from using the CAQH Provider Application? In addition, since HB 125 mandates the use of the CAQH form, will the ODI Credentialing Form no longer be accepted?

A: Individual physicians who are in a hospitalist group are not exempt from the requirements of HB 125. Contracting entities are required to use the CAQH application form when credentialing “providers” and physicians fall within the provider definition. The required use of the CAQH form by contracting entities is not dependent upon how individual providers have organized themselves for business purposes, but rather whether or not the individual practitioners are “providers” for purposes of the credentialing statutes.

In response to your last question, the ODI Credentialing Form should no longer be accepted by any contracting entities.

- Q: Please confirm whether the law requires a hospital to utilize the CAQH and/or ODI credentialing application, or whether it is okay for the hospital to have their own application?

A: If a hospital is credentialing a provider, either on its own behalf or on behalf of another entity, the hospital is required to use the CAQH credentialing application.

- Q: My understanding is that payers/insurers/networks have to accept the CAQH standardized form for credentialing after May of 2008, but if the provider chooses, can the provider/facility opt to complete and submit the payer's proprietary credentialing app instead of using the CAQH?

A: Contracting entities are required to use the appropriate standardized credentialing form when credentialing providers. This means that the choice of form cannot be at the option of a provider.

- Q: Is the CAQH credentialing form to be used for Facility credentialing?

A: A “Part B” credentialing form to be used to credential defined institutional providers is available on the Department’s website.

- Q: Is the CAQH application the only acceptable application at this point? Are we still able to send or accept the ODI application?

A: The CAQH credentialing form is the only form that contracting entities may use to credential individual providers who are included in the HB 125 “provider” definition. A “Part B” credentialing form has been created by the Department to credential defined institutional providers.

- Q: For nurse practitioners applying to our health plan, we require a copy or proof of their collaborative agreement/standard care arrangement with a licensed physician who is participating

with us. Are we able to collect this information as part of the credentialing and recredentialing process since it is not a document collected as part of the CAQH application process?

A: You can collect this information directly from each practice site as a part of either the credentialing or recredentialing process.

Q: The statute states that health plans cannot ask for additional information outside of what the credentialing application itself requests from the practitioner. The ODI application has a checklist of supplemental documents required as part of the application (copy of DEA license, certificate of insurance, etc.). The CAQH form doesn't appear to ask for submission of any additional documents. What are we permitted to collect with the CAQH application?

A: Contracting entities may request documentation of applicable licenses, degrees, and certifications referenced in the CAQH application. The Department does not consider a request for documentation for verification purposes to be a request for additional information. CAQH also requests documentation of various items.

- Q: Many of the physicians are submitting to us the CAQH Summary vs. the CAQH long application when we are asking them to complete for re-credentialing. Are we allowed to accept this 'summary' version as a contracting entity, or must we notify them that only the long version is acceptable?

A: ORC 3963.05(B) specifies that contracting entities must use the CAQH credentialing application when initially credentialing and recredentialing individual providers. The summary is used for the physician's review prior to attestation. It is not to be submitted to a contracting entity as an alternative to the CAQH form.

Recredentialing

- Q: When recredentialing, we currently use a pre-populated form, containing pertinent information, which we ask the dentist to review, indicate any changes, sign and return. Will this still be permitted or will we be required to use the CAQH Provider Application for recredentialing?

A: ORC 3963.03(B) provides that contracting entities must use the CAQH form for credentialing and recredentialing providers. However, once the CAQH form has been completed, the contracting entity may ask the provider to review that pre-populated CAQH form and indicate any changes to the provider's responses.

- Q: Some of our providers who are up for re-credentialing are not with CAQH because they belong to large hospital groups. Does the use of the new CAQH provider application apply to re-credentialled physicians?

A: All contracting entities must use the CAQH form to credential and re-credential individual providers. The CAQH form must be used for recredentialing providers. ORC 3963.05(B) states: "No contracting entity shall fail to use the applicable standard credentialing form described in division (A) of this section when initially credentialing or recredentialing providers...."

- Q: Is there a way I can download the new Provider Application for my physician members who are not part of CAQH. As it is now, on Adobe - we cannot make changes and update this application on line.

A: Providers who are not affiliated with a CAQH member may now self-register with CAQH. They may request a provider ID from CAQH by contacting info@caqh.org. Once a provider receives their ID number, they will be able to complete the CAQH form online.

Miscellaneous Credentialing

- Q: My question concerns Ohio's Standardized Credentialing Form. I am the manager of a single-provider practice doing business as an LLC, as permitted by Ohio law. By HIPAA regulations, this makes us a group practice. As a result, we have both a Type 1 and Type 2 NPI number. The Type 1 # is for the rendering provider (CMS-1500 form box 24J), the Type 2 # is the billing entity (CMS-1500 form, box 33a). Since a significant number of healthcare providers are solo practitioners, it would seem to make sense for the Credentialing Form to incorporate an area to include Type 2 NPI numbers. It would also seem to make sense for the Form to also include an area whereby the solo provider could list the name of his/her business entity since few self-employed providers use just their name. (As an example, there is big difference between Sharon D. Brown, Psy.D. and Sharon, D. Brown, Psy.D., LLC.) I request that the Form's Section III Office/Practice Information be revised to provide a logical place for a provider to include both Type 1 and Type 2 NPI numbers as well as the name of the business entity the provider renders services through if self-employed.

A: CAQH has told the Department that Type 2 NPI may be collected in a future version of the application, but a timeline has not been established. Please contact CAQH for any additional information regarding this topic.

- Q: Does HB 125 override ORC 1753.06 concerning notification of a practitioner of the status of their application within 120 days?

A: Yes. ORC 1.52 provides, in pertinent part, that if two statutes are irreconcilable, the statute latest in date of enactment shall prevail. Therefore, ORC 1753.05 no longer applies if it conflicts with a provision in HB 125.