UnitedHealthcare®

North Carolina Community Plan Credentialing and Recredentialing		Policy Identifier/Number: 163	
Annual Review Completed Date: NEW April 20; rev. 11/14/19; rev. 2/13/2020; rev. 2/27/2020; rev. 3/6/2020			
Policy Category: Credentialing and Recredentialing	**Applicable Lines of Business:** Medicaid	**Entity/Plan:** Community Plan	**State:** North Carolina

Policy Statement and Purpose

The purpose of this policy is to comply with the credentialing and recredentialing requirements of applicable North Carolina regulatory and contractual standards and to include provider selection and nondiscrimination requirements (42 CFR § 438.214, 42 CFR § 438.206 (b) (6)), as well to meet standards established by the National Committee for Quality Assurance (NCQA) to ensure that all participating Providers are qualified and licensed.

Credentialing/recredentialing is a peer-review process designed to review certain information pertinent to a credentialing decision on whether to contract with a Provider (Licensed Independent Practitioner or Facility/Organizational), either initially or on an ongoing basis. Providers who meet the basic qualifications will be credentialed without regard to race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g., abortions) or patients (e.g., Medicaid) in which the Licensed Independent Practitioner or Facility/Organizational specializes. UnitedHealthcare will not discriminate in the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. Consistent with 42 CFR § 438.12, UnitedHealthcare will not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment. Requirements of this policy assess Provider's ability and professional principle to ensure the quality and safety of services provided to our members.

UnitedHealthcare will not employ or contract with Providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

Policy Definitions

1. "Department" means the North Carolina Department of Health and Human Services.

2. "Facility/Organizational" includes but is not limited to hospitals and ancillary providers such as home health agencies, skilled nursing facilities, and behavioral health centers providing mental health and substance abuse services (inpatient, residential and ambulatory), Federally Qualified Health Centers, Rural Health Centers, free-standing surgical centers.

3. "Licensed Independent Practitioner" or "LIP" means any health care professional who is permitted by law to practice independently within the scope of the individual's license or certification, and includes but is not limited to medical doctors (MD), doctors of osteopathy (DO), dentists (DDS or DMD),

chiropractors (DC), doctors of podiatric medicine (DPM), psychologists (PhD), social workers, certified registered nurse practitioners (CRNP), physician assistants (PA), certified nurse midwives (CNM), physical, speech, occupational therapists and all other non-physician practitioners who have an independent relationship with the Plan and provide care under a Benefit plan. Individual practitioners associated with outpatient primary, specialty care clinics are subject to credentialing. Credentialing is performed at the individual practitioner level and not required at the group level.

4. "Material Restriction" means a restriction that includes but is not limited to the following: a requirement to obtain a second opinion from another practitioner prior to patient diagnosis or treatment; a limitation on prescription drug writing; a limitation on providing examination, diagnosis or procedure without a second person present or approving the procedure; or restriction, suspension, or involuntary termination of hospital staff privileges if the LIP's specialty normally admits patients to a hospital; a restriction on or prohibition from performing a service procedure typically provided by other practitioners in the same or similar specialty.

5. "NCC" means the UnitedHealthcare National Credentialing Center.

6. "NCQA" means the National Committee for Quality Assurance.

7. "PDM/CVO" means Provider Data Management/Credential Verification Organization.

8. "Plan" means UnitedHealthcare Community Plan.

Scope

This Policy covers credentialing and recredentialing for both individual and organizational Providers as required by NCQA, including but not limited to acute, primary, behavioral health, substance use disorders, and long term services and support.

Policy Provisions

I. Procedure:

A. Initial CredentialingProcess

1. To join the UnitedHealthcare Community Plan network, Providers must register and be enrolled with the Department as a North Carolina Medicaid care provider, consistent with applicable provider disclosure, screening and enrollment requirements.

2. To help recognize the Department's aim of engaging and supporting providers, the Department has established a centralized credentialing process including a standardized provider enrollment application and qualification verification process. The Department will engage a Provider Data Management/Credential Verification Organization (PDM/CVO), where the CVO is certified by the National Committee on Quality Assurance (NCQA), to facilitate the enrollment process including the collection and verification of provider education, training, experience and competency.

MedicaidCredentialedProviderFile

a) The Provider credentialing and verified information on the Medicaid Credentialed ProviderFile shall be accepted and will be used for network contracting purposes.

b) No additional credentialing information shall be requested from the Provider without the Department's written prior approval.

c) The Plan is not prohibited from collecting other information from Providers necessary for the contracting process.

d) The Plan shall not solicit or accept provider credentialing or verified information from any source other than the Department, or designated Department vendor, except as expressly permitted by the Department.

3. Participation

a) UnitedHealthcare prohibits contracting with Providers who are not enrolled with the Department as North Carolina Medicaid providers consistent with screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B & E.

b) The Department will screen and enroll, and periodically revalidate all Plan Network Providers as Medicaid providers. 42 C.F.R. § 438.602(b) (1).

- The Plan may execute network Provider contract, pending the outcome of Department screening, enrollment, and revalidation, of up to one hundred twenty (120) days but must terminate a network Provider immediately upon notification from the state that the network Provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) day period without enrollment of the Provider, and notify affected Members. 42 C.F.R. § 438.602(b) (2).

c) The Plan shall load credentialed Providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a Member and billed to the health plan by the Provider:

- Newly credentialed Provider attached to a new contract within ten (10) business days after completing credentialing;
- Newly credentialed hospital or facility attached to a new contract within fifteen (15) business days after completing credentialing;
- Newly credentialed Provider attached to an existing contract within five (5) business days after completing credentialing;
- Changes for a re-credentialed Provider, hospital, or Facility attached to an existing contract within five (5) business days after completing re- credentialing;
- Change in existing contract terms within ten (10) business days of the effective date after the change; and
- Changes in provider service location or demographic data or other information related to Member's access to services must be updated no later than thirty (30) calendar days after the Plan receives updated provider information.

4. Contracting Information
   a) For new agreements, the following information will be requested in conjunction with the contracting process:
      - W-9
      - Billing Address, Phone, Fax
      - Service Location(s) – Practice Name, Address, Phone, Fax, Tax ID, Group NPI
      - Current Professional Roster / Attestation – see example below:

Provider represents that it has provided UnitedHealthcare with a Professional Roster that includes all of the following data elements for the LIPs on staff, as applicable:

- Name of Professional (first name, middle initial, last name)
- Degree (MD, DO, NP, PA, other)
- Gender (M/F)
- Provider Specialty(ies) (primary, secondary, additional specialties)
- Willing to be listed/assigned as a Primary Care Professional "PCP" (Y/N)
- State License Number and Type
- DEA or Coverage Arrangements
- Medicaid ID Number
- NPI Number
- Foreign Language(s)
- Admitting Hospital(s)

If any data element is not applicable to a specific professional, Provider will indicate "not applicable" in the appropriate field. Acceptable formats include in writing, electronically in Excel, ANSI, or text (comma delineated) formats.

B. Recredentialing

1. Providers are recredentialed in alignment with the Departmental requirements for recredentialing.

2. Medicaid Credentialed Provider File
   a) The provider credentialing and verified information on the Medicaid Credentialed Provider File shall be accepted..
   b) No additional credentialing information shall be requested from the provider without the Department's written prior approval.

c) The Plan shall not solicit or accept provider credentialing or verified information from any source other than the Department, or designated Department vendor, except as expressly permitted by the Department.

3. Payment Suspension at Recredentialing:

a) The Plan shall suspend claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that Provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise fail to meet Department requirements.

b) The Plan shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information within fifty (50) days of suspension, the Department will terminate the provider from UnitedHealthcare's Medicaid network.

c) The Plan shall not be liable for interests or penalties for payment suspension at re-credentialing.

C. Confidentiality

1. The credentialing/recredentialing process is a peer review activity and information obtained through that process is confidential. All individuals with file access are responsible to assure that all credentialing/recredentialing information remains confidential, except as otherwise provided by law.

2. The Plan is prohibited from using, disclosing or sharing provider credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of the provider and the Department.

D. Centralized Credentialing Process

1. The Department is establishing a centralized credentialing process including a standardized provider enrollment application and qualification verification process. The Department will engage a Provider Data Management/Credential Verification Organization (PDM/CVO), where the CVO is certified by the National Committee on Quality Assurance (NCQA), to facilitate the enrollment process including the collection and verification of provider education, training, experience and competency.

E. Ongoing Monitoring

1. Sanctions Monitoring

a) On-going monitoring is conducted on State and Federal reports in order to identify Participating Providers who have had OIG sanctions on Medicare or Medicaid participation, GSA debarments, or other sanctions against their license or certification. If identified of a professional license that is not valid, an OIG sanction on Medicare or Medicaid participation, GSA debarment, or other sanction against a license or certification, action shall be taken as outlined in the pertinent Participation Agreement.

2. Quality Monitoring

a) Participating Providers will be monitored for complaints, potential quality concerns or identified adverse events. Identified concerns will be identified, tracked and resolved.

F. During the Provider Credentialing Transition Period, the Plan shall apply the Objective Quality Standards most recently approved by the Department, or designated Department vendor, to contracted providers as the provider is re-enrolled in Medicaid.

G. The Plan shall submit any significant policy changes to Objective Quality Standards to the Department for review and approval at least sixty (60) calendar days prior to implementing such changes.

H. The Plan shall meet with the Department, or designated Department vendor, quarterly and as requested regarding the credentialing and network contracting process.

I. The approved Provider Credentialing and Re-credentialing Policy will be published on the Plan's website, including previous versions, and effective date of each Policy.

Audit

All procedures are reviewed at least annually and revised as necessary

Related Policies, Procedures & Materials

Attachments

N/A

Policy Owners/Questions

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Approval History

- Policy created and effective: 4/1/2019
- Revision: 2/13/2020
- Revision: 2/27/2020
- Revision: 3/6/2020