Maryland

INSURANCE ADMINISTRATION

PROVIDER PANELS: THE CREDENTIALING PROCESS--Basics of Maryland Law

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Life and Health Complaints

Agenda

- ✓ What is the Maryland Insurance Administration?
- ✓ Where to find the law
- ✓ Application and time frames
- ✓ Prohibited and permitted reasons for denial or termination
- ✓ Participating group practice with an employee who is not yet credentialed
- ✓ Special situations

What is the Maryland Insurance Administration?

- The MIA is an independent State agency that regulates Maryland’s insurance industry.
- The MIA implements and enforces laws enacted by the General Assembly that affect Maryland’s insurance industry.
- The MIA protects consumers and investigates/resolves complaints about insurers and insurance agents (producers) that conduct business in Maryland.
- The MIA investigates acts of insurance fraud.

Where to find the law

- Section 15-112 of the Insurance Article is the primary law on provider panels and establishes the minimum requirements for provider credentialing in Maryland.
- It applies to “carriers”. Carriers include insurers, health maintenance organizations, nonprofit health service plans, dental plan organizations, any other person that provides health benefit plans subject to regulation by the State, and an entity that arranges a provider panel for a carrier.

What types of providers are covered by the law?

- Section 15-112(a)(16) of the Insurance Article defines "provider" to mean a health care practitioner, or group of health care practitioners, who are licensed, certified, or otherwise authorized by law to provide health care services.
- Section 15-112(g) of the Insurance Article gives the requirements for the application process used by carriers to process an application by a provider (i.e. a practitioner) to participate on the carrier's provider panel.

What application form is required?

- Section 15-112.1 of the Insurance Article states that a carrier shall accept the uniform credentialing form as the sole application for a health care provider to become credentialled.
- The Maryland Insurance Administration issued Bulletin 09-25 to designate the CAQH's form as the uniform credentialing form.

Time Frames

- The carrier is required to provide an application to a provider on request.
- If a carrier receives an incomplete application, notice must be sent to the provider within 10 days indicating what additional information is needed.
- When a complete application is received, the carrier has 30 days to send the provider written notice of its intent to continue to process the application or to reject the provider for participation.
- If the carrier proceeds with credentialing, it has 120 days from the date of the notice to accept or reject the provider for participation, and to send written notice of the decision.

Prohibited reasons for denials and terminations

The law bars carriers from rejecting or terminating providers from their provider panels under certain conditions, including but not limited to:

- Gender, race, age, religion, national origin, or a protected category under the Americans with Disabilities Act.
- Number or type of appeals based on medical necessity filed by the provider.
- Appeals or complaints through an internal review process established by the carrier for that purpose.
- A carrier may not limit the number of behavioral health providers at a health care facility that may be credentialed.

Permitted denials

A carrier may deny participation due to:

- Having a sufficient number of similarly qualified providers on its panel already; or
- Any reason that is not prohibited.

Permitted terminations

A carrier may terminate participation due to:

- Having a sufficient number of similarly qualified providers on its panel already; or
- Any reason that is not prohibited, upon at least 90 days written notice; or
- Fraud, patient abuse, incompetence, or loss of licensure status immediately upon notice of termination.

What if a group practice hires a provider who is not credentialed?

Section 15-112(w) of the Insurance Article requires a carrier to reimburse a participating group practice at its participating rates for a provider who is not participating if the provider:

- is employed by, or a member of, the group practice;
- has applied for credentialing and the carrier intends to continue to process the application;
- has a valid license to practice in the State; and
- is currently credentialed by an accredited hospital or has professional liability insurance.

What if a group practice hires a provider who is not credentialed?

The carrier must reimburse the group practice at the participating rate from the date of written notice that the carrier will continue to process the provider's application until the date of notice of acceptance or rejection to participate on the provider panel.

The carrier's members may not be held liable for amounts other than the deductible, copayment, or coinsurance.

At the time of service, the group practice must give notice to the patient that:

- The treating provider is not participating;
- The treating provider has applied to become a participating provider;
- The carrier has not completed its assessment of the qualifications of the provider to participate; and
- Any covered services must be reimbursed at the participating provider rate.

What if a credentialed provider changes employers?

Section 15-112(j) of the Insurance Article prohibits a carrier from requiring a provider to be recredentialed:

- If a provider changes a federal tax identification number;
- If the provider's employer changes a federal tax identification number; or
- If the provider changes to a new employer and the new employer participates on the carrier's provider panel or is the employer of providers that participate on the carrier's provider panel.

What if a credentialed provider changes employers?

If a participating provider changes employers or tax identification numbers, they must send the carrier written notice at least 45 days before the effective date of the change. The provider contract will have the address to send notice to the carrier.

The notice must include:

- A statement of intent to continue to provide services in the same field of specialization;
- The effective date of the change in tax identification numbers;
- The new federal tax identification number and a copy of the form W-9;
- The new employer's name, the employer's contact person, and the address, telephone number, fax number, and email address for the contact person.

The carrier has 30 business days to acknowledge receipt, and if carrier deems necessary, to issue a new provider number.

Nonparticipating locations

Sometimes a provider participates on the carrier's provider panel, but only for specific offices.

If the provider participates through a group practice or health care facility, the carrier may not require the provider to be considered participating when:

- Providing services to a carrier's enrollee through an individual or group practice that does not have a contract with the carrier; and
- Billing for the services using a different federal tax identification number than that used by the participating group or health care facility.

The provider must notify the carrier's enrollee that the provider is not participating and what the anticipated total charges are.

Provider Directory Updates

Carriers are required to have accurate and up-to-date directories. You should promptly notify the carrier of any change in your address or other contact information, or if you are no longer accepting new patients. If you want to terminate your provider contract, you need to give at least 90 days notice.

Facilities

When credentialing a facility, a carrier is not subject to the requirements in § 15-112 of the Insurance Article because a facility does not fall under the definition of a “provider” in the statute.

Generally, a facility is credentialed to provide facility services. Practitioners are credentialed and bill separately. For example, a hospital may be participating for emergency room facility services, but the physicians in the emergency room may or may not participate, and will bill separately.

MIA Contact Information

- You can call the Life and Health Complaints unit to ask questions at 410-468-2224 or 1-800-492-6116.
- The MIA's website is www.insurance.maryland.gov.