Provider Credentialing & Payor Contracting Processes

Presented via Webinar to ACRO Members

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Questions?

Chat or Q&A during Webinar & also will cover at end
Disclaimer

This presentation was prepared as a tool to assist attendees in learning about provider credentialing and payor contracting processes. It is not intended to affect clinical treatment patterns. While reasonable efforts have been made to assure the accuracy of the information within these pages, the responsibility for correct provider credentialing and payor contracting lies with the provider of the services. The material provided is for informational purposes only.

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Expert Services Available

- Credentialing & Contracting
- Guidance & Education in Registration, Financial Counseling
- Coding & Compliance
- Interfacing & Claim Submission
- Payment Posting & Reconciliation
- Denial Management & Accounts Receivable
- Education & Support
Our Clients
Where Do We Start?

A Few Considerations:

• Revenue Cycle
• Place of Service
• Payment Remit Addresses
• Lock Box or Not
• Are you credentialed?
• What about your contracts?
• What services do you provide?
The Revenue Cycle

- What does this mean?
- Does it matter?
- Should you, as a provider, be concerned with all these details?
Credentialing/Contracting in the Revenue Cycle

Education & Support
Denial Management & Accounts Receivable
Payment Posting & Reconciliation
Interfacing & Claim Submission
Coding & Compliance
Registration & Financial Counseling
Credentialing & Contracting
Provider Credentialing & Payor Contracting

Before you sign......
Credentialing vs. Contracting

Credentialing

Different definitions of credentialing:

- When payors or other entities *review and verify* a provider’s credentials
- Completion of “credentialing applications” via paper or electronic application for payor participation (in-network)
Credentialing Verification Items Required *(Non-Expired)*

- Medical license(s) (actual license copy)
- Federal DEA (by state)
- State controlled substance certificate(s), if applicable
- Diploma(s)
- Education / training certificates
- ECFMG (Education Commission Foreign Medical Graduates)
- Board certifications
- Work history and specifics of any adverse actions
- Current CV
- Immunizations, TB testing records
Additional Payor Credentialing Items Required

- NPI # and username and password
- CAQH # and username and password
- CME certificate copies or specific list (prior 24 months)
- Malpractice insurance coverage (all)
- All malpractice or adverse claim-specific history, patient information, claim dates, settlement amounts, etc.
- All gaps of time greater than 60 days not work-related or education-related since your MD graduation date must have explanation
Credentialing Timeline

- Credentialing is required for payor participation
- Can take 60-180 days, or more, to complete
- Normally, process includes 20+ payors
- Process may include enrollment in PHO (Physicians Health Organization); IPA (Independent Physicians Association); ACO (Accountable Care Organization) and/or MCO (Managed Care Organization) entities
- Save valuable time, request contract at the same time credentialing application is requested
- Correct contract negotiation to include rates takes time
Federation Credentials Verification Service (FCVS) [http://www.fsmb.org/medical-professionals/fcvs/](http://www.fsmb.org/medical-professionals/fcvs/)

- Credentialing verification service available to obtain state licensure and other state certificates
- Many credentialing verification entities
- Benefits include expertise and sometimes licensure process can take less time
- Disadvantages include additional cost and lengthy process
Credentialing Costs?

- Credentialing Verification Process:
  - FCVS costs are listed in detail on these websites or by contacting these entities

- Payor Credentialing Process:
  - Hourly can range from $100.00 - $200.00
  - One time fee for # of payors, generally 20, $1,800.00
  - Maintenance of credentialing documents
    $65.00 - $90.00 per month
Contracting

Process of establishing a mutual agreement between the provider and payer for reimbursement

Negotiation of contract language along with rates are addressed during this phase

Will need to be performed for each and every payor individually
Contracting Process

Important points of payor contracting to review are:

1. Timely file limits
2. Overpayment terms
3. Contract terms, length; 1, 2, 3 (COLA) year, auto annual renewal, time required if termed, is contract FIXED or NON-FIXED
4. Reimbursement rates (on **TOP 20-25 utilized CPT® codes**)
5. Understanding contract rate exhibits to know whether rates offered are based on aggregate/average or same % on codes, current or prior year RBRVS, % of billed charges, etc.
6. CPT® codes and specialties to be outlined in rate exhibits
7. Entire contract review for any questionable language
Types of Contracts

Fixed (Static) Payor Contracts

- Rates are fixed for the duration of the contract excluding any new annual CPT® codes or when a new contract is agreed upon by both parties
- Benefits the provider

Non-Fixed Payor Contracts

- Most common type of contract
- Benefits the payor
- Fees can increase, decrease based on payor market fee schedule or CMS RBRVS’s
One of the most vital and important roles in the Credentialing & Contracting process is proper FOLLOW-UP!

Follow-up must be done in a TIMELY manner or a goal of participation within 120 days will not be achieved.

After contract has been submitted, appropriate follow-up would be at least one time per month.

Communication is via email whenever possible. This provides a trail of the steps/processes taken. Phone is not preferable. Try to avoid “snail” mail!
# Contract Allowable Spreadsheet - Top Utilized Codes by Practice

<table>
<thead>
<tr>
<th>Top Billed CPT Order</th>
<th>CPT</th>
<th>2016 Billed Charges</th>
<th>2016 Global Medicare Allowables</th>
<th>Contract Based on 2009 Cigna MFS at 120% / Fixed / Default 50% of *BC</th>
<th>% to 2016 MC</th>
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Default - 50% of Billed Charges

*AVG % to Medicare 2400%

*AVG denotes either an AVERAGE AGGREGATE on ALL code reimbursement fees analyzed together, or the individual reimbursement % on each CPT code.
Where are you?

Determining & knowing your correct place of service is 1 of the most VITAL steps in achieving proper payor contract related reimbursement.

Other elements that should be considered in payor contracting are internal contracts / ownership, transfer agreements, consolidated billing and patient status.
Place of Service Billing

Hospital Outpatient

Technical Services
UB04

Physician Services
(-26) CMS 1500
Place of Service Billing (Continued)

Freestanding Facility

Global Billing

Pro & Tech Services CMS 1500

Split Billing
(allowed under separate TAX IDs only)

Physician Services (-26) CMS 1500

Technical Services CMS 1500
Common Payor Lines of Business

Government Payors – Medicare, Medicaid, etc.

PPO – Preferred Provider Organization

POS – Point of Service (Type of HMO)

HMO – Health Maintenance Organization

EPO – Exclusive Provider Organization (Type of HMO)

PFFS – Private Fee for Service

Indemnity – Broader Access, Employer Based

ACA – Affordable Care Act EXCHANGE & Replacement Plans, Medi-Medi, all types
Contracting Specialty Services

- If your practice plans to perform any specialty services these services must be negotiated and specifically outlined during any contracting process or ‘no payment’ may result.
- Also note the Nuclear Regulatory Commission (NRC) requirements often go beyond requirements for Accreditation Council for Graduate Medical Education (ACGME) graduation.
- Just a few specialty services to mention; Brachytherapy, Gamma Knife, Iodine for thyroid cancer, parenteral administration (strontium, radium), Y-90, Xifigo.
Questions?