Provider Credentialing & Enrollment: The Basics

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NATIONAL ASSOCIATION MEDICAL STAFF SERVICES
NAMSS
ADVANCING THE DELIVERY OF QUALITY HEALTHCARE

Provider Enrollment

The Basics

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OBJECTIVES

- Understanding the different types of enrollments
- Review Provider Enrollment application elements and process.
- Special challenges
- Learn Enrollment success tips.

CREDENTIALING

Healthcare **credentialing** refers to the process of verifying education, training, and proven skills of healthcare practitioners.

The process can be very lengthy depending upon the specific items that need to be verified.

A credentialing process is utilized by healthcare facilities as part of its process to allow practitioners to provide services

CREDENTIALING

- Delegated Credentialing
  - Similar to "practitioner" credentialing
  - Control over process
  - NCQA
- Encompasses enrollment
  - Health Plans (contract)
  - Government Programs (non-contract)
- Impacts provider reimbursement
  - Potential to improve claims processing
  - Reduce Delays
  - Reduce Denials

ENROLLMENT

Enrollment is the process of applying to health insurance plans/networks for inclusion into provider panels to bill and be paid for services rendered.

The provider enrollment process involves requesting enrollment/contracting with a plan; completing the plans credentialing/enrollment application; submitting copies of licenses, insurance, and other documents; signing a contract; and any other steps that may be unique to a carrier.

Be sure document, document, document!

The provider enrollment processing time varies by payor.

CONTRACTING

Contracting is a business decision to enter into a legal arrangement with a practitioner (or group of practitioners) to supply certain services to the MCO's members.

INSTITUTIONAL PROVIDER

- Physicians
- Physician assistant
- Anesthesiology Assistant
- Audiologist
- Certified nurse midwife
- Certified registered nurse anesthetist
- Clinical nurse specialist
- Clinical social worker
- Nurse Practitioner
- Psychologist, Clinical
- Psychologist billing independently
- Registered Dietitian or Nutritional Professional
- Speech Language Pathologist
- Mass immunization roster biller
- Occupational therapist in private practice
- Physical therapist in private practice

GOVERNMENT ENROLLMENT

Application submitted to Medicare fee-for service contractor (also referred to as carrier, fiscal intermediary, Medicare Administrative Contractor, or the National Supplier Clearinghouse) serving your state or geographic location

ENROLLMENT

- Start early – months ahead of provider joining your practice or group
- Name = SSN recorded name
- Copies of documents
- Notarized documents
- "Wet" signature
- Health plan preferences

ENROLLMENT

- Application data entry: 15-30 minutes
- Confirmation on a "clean" application averages 3 months
- Medicare disclaimer "It can take up to 180-business days to process and application…"

CMS-PECOS

- Provider Enrollment, Chair and Ownership System (PECOS)
  - Internet-based
    - Enrollment
    - Updates/changes
    - View/check on status
  - Alternative to CMS-855 process (paper)

ACCESSING PECOS

User IDs and passwords are established when practitioners applied on-line to the National Plan and Provider Enumeration System (NPPES) for their National Provider Identifiers (NPIs).

ACCESSING PECOS

An individual who will use Internet-based PECOS **on behalf** of a provider or supplier organization will go to Internet-based PECOS at https://pecos.cms.hhs.gov to register in the PECOS Identification and Authentication system (PECOS I&A).

AUTHORIZED OFFICIAL

The AO will create a PECOS User ID and password as part of this registration process and facilitate the process through the CMS External User Services (EUS).

ENROLLMENT APPLICATIONS

- Applications are available in a fillable (PDF) format.
- Still needs to be printed, signed and mailed.
- Keep a copy of a clean, unsigned form and a signed form
- PECOS, while online still requires a mailing of a printed, signed Certification form

SUBMISSION OF APPLICATION

- For each enrollment application submitted you will receive a 2-page Certification Statement
- Mail the original signed Certification Statement and supporting documents within 7 days of the electronic submission
- Effective processing date is the date the Medicare contractor receives the signed and dated (blue ink recommended) Certification Statement.

ENROLLMENT RE-VALIDATIONS

- Required for:
  - All enrolled practitioners
- Re-Validation due:
  - Medicare – every 5 years or upon request
  - Medicaid – varies by state

DID YOU KNOW?

The Medicare Identification Number, often referred to as the Provider Transaction Access Number (PTAN) or Medicare Legacy Number, is a GENERIC term for any number OTHER THAN the NPI that is used to identify a Medicare supplier

COMMERCIAL ENROLLMENT

Relationships are key!

- Know the requirements and expectations of each payer
  - Non-delegated credentialing & contracting
  - Delegated credentialing
- Confirm if the plan uses CAQH
  - Re-attestation every 120 days
  - Keep documents current
- Establish a tracking system to check on status of application

COMMERCIAL ENROLLMENT

Relationships are key!

- Remember to ask what the providers "recredentialing cycle" is
  - If new to the plan it could be 36 months
  - If already credentialing and just "flipping" a TIN they cycle could be any time.
- Demographic changes
- Terminations

MANAGING THE PROCESS

- Software
- CAQH – ProView
- Spreadsheet tool – requirements, preferences & deadlines of:
  - Payor's
  - Hospitals
  - 3rd Party Vendors

THE PROCESS

Pre-Enrollment

- Step 1 – Determine Which Plans to Enroll.
- Step 2 - Collect Provider Info & Documents.
- Step 3 - Obtain, Complete & Submit Application.
- Step 4 – Follow up Until Determination is Made and Effective Dates Obtained.

THE PROCESS-STEP 1

Step 1 – Determine Which Plans to Enroll

- Pre-determined based on group/hospital etc.
- A good resources is the AIS Directory of US Health Plans).
- Go to payor's website, call Provider Enrollment for enrollment timeframe, any special requirements or forms, and preferred submission method/address.

THE PROCESS-STEP 2

Step 2 – Collect Provider Info & Documents

- Pre-application, CAQH, NPI registry, rosters.
- Review/QA for completeness/accuracy.
- Check addresses, zip codes and counties on USPS website.
- Check names/addresses/expiration dates on licensure and supporting documents.

THE PROCESS- STEP 3

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- **Step 3 - Obtain, Complete & Submit Application**
  - **Application Elements**
    - Instructions (Good ones heads off questions)
    - Provider Identifying Information, Education, Training
    - Provider Licensure, Certifications, Affiliations
    - Work History & Gap information
    - Practice Information/Description/Services
    - Professional Liability Insurance

THE PROCESS-STEP 3

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- **Step 3 - Obtain, Complete & Submit Application**
  - **Application Elements (Continued)**
    - Billing Info/Clearinghouse/3rd Party Administrator
    - Attestation Questions/Disclosures
    - Ownership/Controlled Interest Disclosure
    - Information Release/Acknowledgements
    - Provider Agreement(s)/ EFT Agreement
    - Checklist of Attachments

TYPICAL APPLICATION DOCUMENTS

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- All applicable Professional, Medical, Federal, State, & Local Licensure, Certifications, Registrations.
- IRS Issued CP575 & Signed/Dated IRS W9.
- Articles of Incorporation/Partnership Agreement, etc.
- Professional Degree, Fellowship, Residency
- Driver's License, Passport, Visa, as applicable

TYPICAL APPLICATION DOCUMENTS

- Professional & General Liability; Workers Comp (if applicable).
- Copy of Voided Check (for EFT agreement).
- Copy of Lease Agreement for Practice Location (CA).
- Application Fee (if applicable).
- Cover Letter (paper applications only).

THE PROCESS-STEP 4

- **Step 4 – Follow up Until Determination is Made**
  - **Communication, Communication!**
- Follow up with payor (email, phone, fax).
- Respond promptly to any requests for more info.
- Give updates to provider or supervisor/log into system.
- If approved, you may need to ask for an acceptance/welcome letter, or duplicate letter.
- If denied, ask why and when to re-apply.

POST-ENROLLMENT

Post-Enrollment

- Step 1 – Obtain Proof of Enrollment/Denial.
- Step 2 – Implement with Billing Department.
- Step 3 – Record/Load New Contract in Database.
- Step 4 – Maintenance for Continued Enrollment.

POST-ENROLLMENT STEPS

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- **Step 1 – Obtain Proof of Enrollment/Denial.**
- **Step 2 – Implement with Billing Department**
  - Assist with any applicable EFT, EDI, ERA paperwork.
- **Step 3 – Record/Load New Contract in Database**
  - Executed copies; welcome letter; ensure provider is loaded into payer network system.
- **Step 4 – Maintenance for Continued Enrollment**
  - Send any changes/updates/terms to payer; re-credentialing, re-validation, re-attestation.

SUCCESS POINTS

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- Begin the enrollment process immediately upon colleting provider's information/documentation.
- Automate the enrollment process to the greatest extent possible with credentialing software.
  - Lessens errors & omissions.
  - Minimize the use of paper forms whenever possible.
  - Expedites process with some payers.
- Respond to payor requests as soon as possible.
- Communicate proactively with providers!

RESOURCES

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Google.com

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html

https://mtaccesstohealth.acs-shc.com/mt/general/providerEnrollmentHome.do

http://www.cms.gov/Outreach-and-Education/Look-Up-Topics/Medicaid/Medicaid-page.html

RESOURCES

- www.cms.gov/medicare
- www.cms.gov/MedicareProviderSupEnroll/
- https://NPPES.cms.gov
- www.cms.gov/NationalProvIdentStand
- http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf

ENROLLMENT APPLICATIONS

- CMS 855A – for Institutional providers
- CMS 855B – for Clinics, Group Practices, and other certain suppliers
- CMS 855I – Physicians and Non-Physician Practitioners
- CMS 855R – Reassignment of Medicare Benefits
- CMS 855O – Eligible Ordering and Referring Physicians and Non-physician Practitioners
- CMS 855S – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Below is a list of terms commonly used in the Medicare enrollment process:

Accredited provider/supplier means a supplier that has been accredited by a CMS-designated accreditation organization.

Applicant means the individual (practitioner/supplier) or organization who is seeking enrollment into the Medicare program.

Approve/Approval means the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges.

Authorized official means an appointed official (e.g., chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

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Billing agency means an entity that furnishes billing and collection services on behalf of a provider or supplier. A billing agency is not enrolled in the Medicare program. A billing agency submits claims to Medicare in the name and billing number of the provider or supplier that furnished the service or services.

Deactivate means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information.

Delegated official means an individual who is delegated by the "Authorized Official" the authority to report changes and updates to the provider/supplier's enrollment record. The delegated official must be an individual with an ownership or control interest in (as that term is defined in section 1124(a) (3) of the Social Security Act), or be a W-2 managing employee of, the provider or supplier.

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Deny/Denial means the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges.

Enroll/Enrollment means the process that Medicare uses to grant Medicare billing privileges.

Enrollment application means a paper CMS-855 enrollment application or the equivalent electronic enrollment process approved by the Office of Management and Budget (OMB).

Final adverse action means one or more of the following actions: (i) A Medicare-imposed revocation of any Medicare billing privileges; (ii) Suspension or revocation of a license to provide health care by any State licensing authority; (iii) Revocation or suspension by an accreditation organization; (iv) A conviction of a Federal or State felony offense (as defined in §424.535(a) (3) (i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or (v) An exclusion or debarment from participation in a Federal or State health care program.

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Institutional provider means – for purposes of the Medicare application fee only - any provider or supplier that submits a paper Medicare enrollment application using the Form CMS–855A, Form CMS– 855B (not including physician and non-physician practitioner organizations), Form CMS–855S or associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment application.

Legal business name is the name that is reported to the Internal Revenue Service (IRS).

Managing employee means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier.

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Medicare identification number - For Part A providers, the Medicare Identification Number (MIN) is the CMS Certification Number (CCN). For Part B suppliers other than suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), the MIN is the Provider Identification Number (PIN). For DMEPOS suppliers, the MIN is the number issued to the supplier by the NSC. (Note that for Part B and DMEPOS suppliers, the Medicare Identification Number may sometimes be referred to as the Provider Transaction Access Number (PTAN).)

National Provider Identifier is the standard unique health identifier for health care providers (including Medicare suppliers) and is assigned by the National Plan and Provider Enumeration System (NPPES).

Owner means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of, the provider or supplier as defined in sections 1124 and 1124(A) of the Social Security Act.

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Physician means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, as defined in section 1861(r) of the Social Security Act.

Physician-owned hospital – under 42 CFR § 489.3 – means any participating hospital in which a physician, or an immediate family member of a physician, has a direct or indirect ownership or investment interest, regardless of the percentage of that interest.

Provider is defined at 42 CFR §400.202 and generally means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice, that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

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Reassignment means that an individual physician, non-physician practitioner, or other supplier has granted a Medicare-enrolled provider or supplier the right to receive payment for the physician's, non-physician practitioner's or other supplier's services. (For further information, see § 1842(b) (6) of the Social Security Act, the Medicare regulations at 42 CFR §§424.70 - 424.90, and CMS Publication 100- 04, chapter 1, sections 30.2 – 30.2.16.)

Reject/Rejected means that the provider or supplier's enrollment application was not processed due to incomplete information or that additional information or corrected information was not received from the provider or supplier in a timely manner.

Revoke/Revocation means that the provider or supplier's billing privileges are terminated.

Disclaimer: Key Definitions for Medicare Enrollment can be found in the Centers for Medicare and Medicaid Services (CMS) Internet Only Manual Publication 100-08 Medicare Program Integrity Manual Chapter 15, Section 15.1.1.