Commercial Payer Enrollment 101

COMMON TERMS & DEFINITIONS

Payer/payor – an insurance company providing health insurance and benefits to national, regional, or local populations.
Provider/practitioner – a licensed or certified professional who provides medical, dental or behavioral health services, e.g. MD/DO, DMD, DDS, APRN, PA, LMSW or other individual delivering billable services.
Provider institution/organization – an entity where medical services are rendered.
Network Management – ensures provider contracting is within the organization's service area to appropriately meet the needs of their insured members.
Linking - Refers to a credentialed provider who does not have an individual contract.

- Linked to a Tax ID with an existing contract
- Process happens after credentialing
- TAT is 30-45 days.

Load - Occurs after a provider has been linked to a Tax ID or a provider signed contract has been sent to the payer for counter signature.

- TAT to complete 30-45 days.
- At process completion, payer issues a "Welcome" letter or an email with the provider's effective date and provider ID number (if issued).
- Effective date required before billing and submitting claims.

Demographic updates – Differs from the payers standard credentialing process. Used to update the information for a credentialed provider or organization.

- TAT to complete is around 30 days - depends on the payer and their workload.

Retroactive Billing – depends on the situation and payer. Allows providers to hold claims and submit to the insurance company once payer participation is approved.

- *Important to collaborate with payer as retroactive billing is not as prevalent as it used to be.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Accreditation is a "Seal of Approval" for credentialing standards

- Nonprofit organization.
- Founded in 1990 to improve healthcare quality.
- Provides a framework to credential and recredential providers.
- Evaluates the credentialing conducted by organizations to determine compliance with their standards:
    - Time limits for verifying practitioners' credentials
    - Credential Committee reviews practitioner(s) files
    - Monitoring of practitioner sanctions
- Credentialing standards similar to CMS.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Agency of the U.S. Department of Health and Human Services

- Manages Medicare and Medicaid Enrollment
- CMS provides oversight while States administer the Medicaid program.
- *Electronic Code of Federal Regulations* for provider enrollment and credentialing criteria:
    - 42 CFR § 455.410 - Enrollment and screening of providers
    - 42 CFR § 455.450 - Screening levels for Medicaid providers
- Medicaid Provider Enrollment Compendium (MPEC):
    - https://www.medicaid.gov/affordable-careact/downloads/program-integrity/mpec-7242018.pdf
- Sets minimum standards (Conditions of Participation).
- Administers federally-funded programs:
    - Health Insurance Marketplace
    - Medicare
    - Medicaid
    - Children Health Insurance Program (CHIP)
    - Clinical Laboratory Improvement Amendments (CLIA)
- Grants "deeming authority" to health plans for Medicare/Medicaid reimbursement.

COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE

Referred to by its acronym CAQH

- Non-profit alliance of health plans and associations.
- CAQH ProViewTM
    - electronic universal credentialing data source
    - providers self-report data
    - used by health plans for credentialing and accepting providers into their networks
    - provider must grant permission for healthcare plans to access
    - providers must update/re-attest to their data at least every 120 days
        - Failing to re-attest can delay payer credentialing due to unavailable profile data
- Compliant with all state mandated applications.