Contracting and Credentialing: A Complex Obstacle to Navigate

MONTE SANDLER

The terms *contracting* and *credentialing* are often used interchangeably, but the processes involved in each, while interdependent, are very different and have different outcomes.

Contracting, in brief, is the process of creating a formal legal agreement between the payer (insurance company) and the provider (facility, physician, and/or physician extender). The contract outlines expectations and requirements of all parties. The effective date of the agreement, the reimbursement/fee schedule, place of service, termination clauses, services allowed and disallowed, etc. are all included in a typical contract.

Credentialing with payers is the process of vetting or screening the providers to ensure they meet the criteria to be an approved network provider. It is usually performed by a division of the revenue cycle management/billing team, internally, or through a vendor. The end result is the assignment of an in-network effective date with the payers.

Billing under a provider that did not provide the service can result in serious penalties. The only time this type of billing should occur is when it is explicitly allowed by the payer and supported by state and federal regulations around the scope of practice for the provider type involved. For example, payer ABC may say a physician assistant is allowed to bill under their supervising physician as long as all state and federal oversite regulations are followed. Payer XYZ may say all provider types must be credentialed regardless of more lenient state and federal clinical guidelines.

Credentialing criteria by the payer includes providers who are full time, part time, and sometimes. Payers do not differentiate by the number of hours or shifts a provider covers. Nor do they consider whether the provider is employed or contracted/1099. The only exceptions are payers who clearly state they allow "locum tenens" billing. Those are few and far between. Most commercial payer contracts include some type of government payer product, and therefore they defer to the CMS guidelines. CMS has renamed locums tenens as Fee-for-Time Compensation Arrangements, but the term *locum tenens* is still most commonly used. You can find CMS regulations at CMS.gov.

Monte Sandler is Executive Vice President, Revenue Cycle Management of Experity (formerly DocuTAP and Practice Velocity).

Consequences of Violating the False Claims Act

The False Claims Act is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal healthcare program; that includes any plan or program that provides health benefits, whether directly, through insurance or otherwise, and which is funded directly in whole or in part by the United States government or any state healthcare system. Financial penalties to the person or organization include recovery of three times the amount of the false claim(s), plus an additional penalty of $5,500 to $11,000 per claim. Violation of the False Claims Act constitutes a felony punishable by imprisonment, a fine of $50,000 or more, or both, for each violation. This is a lot more than a slap on the hand or a refund.

Prevention Is Better than Cure

The number-one way to avoid credentialing compliance issues is *education*.

- Staying up-to-date on credentialing requirements from each payer is critical.
  - Payers can change the requirements at any time and may not always adequately notify.
  - When contacting payers, be sure to ask for criteria specific to the contract you have with them. The best reference is the EIN/Tax Id associated with the contract.
  - Keep a record of how to contact payers in the event of a contact change within your organization.

– Identify recredentialing and reenrollment requirements by provider.
– Understand payers' policies on reporting any violation in credentialing.

The second most important step is to be *organized*.

- Develop a formal method to track credentialing criteria by payer by provider type.
- Include credentialing criteria in new provider onboarding processes.
- Keep all payers updated on internal or vendor contact information.
- To increase the chances of getting notification, keep payers up to date on how to contact you.
- Utilize software or another system to track credentialing status for each entity, location, and provider by payer.
- Make this available to your registration and billing teams so they are always up to date on the status of each provider.

The third step is to provide *resources* to this process.

- By all accounts, this is a time-consuming responsibility.
- Credentialing is an enormous and time-consuming responsibility; utilize resources that are equipped for this level of task.
- Assign the chore of staying current on payer policies and status of credentialing to someone reliable as one of their primary responsibilities—not as a task they do during "down time."
- If you find you are in violation, follow the steps provided to you by each payer. In most cases, a corrective action plan that will include regular follow-ups is required.

In closing, bear in mind that every organization needs to consider contracting and credentialing a vital part of their business. The days of "my mother's brother's cousin is doing my credentialing" are long past. It takes a professional team to stay current and to reduce your risk of contracting and credentialing compliance issues. ■