The Challenges of Billing Out-of-Network

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One of the biggest challenges for an urgent care is billing insurance as a non-participating provider.

When opening a new practice or adding a clinic, completed credentialing and contracting is essential and has a direct impact on the overall success for a new business.

Even when your practice is fully credentialed, the challenge continues as you bring on new providers. Contracting and credentialing remains an archaic process with little oversight to complete processes in a timely manner. A new practice can expect the process to take from nine up to 12 months. With new providers, it can take 90 to 120 days to add them to your contract when full credentialing is required. Full credentialing is when all claims must be billed under the rendering (ie, face-to-face) provider. Billing under a provider that is not the rendering provider when full credentialing is required is also the biggest compliance risk in urgent care with multi-million-dollar settlements with the Department of Justice in recent years. With private payers creating similar policies, it is no longer a gray area. Practices risk denial of claims, recoupments, and loss of contracts.

"Fee-for-time compensation arrangements" (formerly called "locum tenens") is not an option for physicians, as once credentialing starts, the physician becomes a member of your group practice. One member of a group practice cannot be a locum to another member of a group practice.

For non-physician practitioners, billing services under the incident-to guidelines is also not an option. "Incident-to" is for practices where the patient's condition requires follow-up. It is not for patients with new problems, which is almost all of what is seen in the urgent care setting. Even in the case of longitudinal care, incident-to billing is not an option as often as the industry would lead practices to believe. Once a treatment plan changes (ie, changing the dosage of a medication), it is no longer an incident-to service.

Generally, claims process in one of three ways:

1. *Claim will pay to the patient:* When this occurs, a payment is made to the patient directly from the payer. This does not guarantee that the practice will eventually get the payment.
2. *Claim will process toward the patient deductible:* This only occurs when the patient has out-of-network coverage.
3. *Claim will fully deny as out-of-network:* Not all patients will have out-of-network coverage, and they may be responsible for the entire bill.

Asking the patient to pay cash at the time of the visit is not an ideal option. Even with excellent care, patient satisfaction can come down to the amount of the bill. The cash-pay option will cause delays in the ability to become profitable due to lower patient volumes.

Start the contracting process at the beginning of your project to avoid delays. Do not wait until you are ready to open the doors. Once your business opens, your expenses will inevitably go up. Heather Real, a senior consultant at Experity, recommends having 75-85% of your credentialing completed prior to opening.

Require new hires to provide all the information required for credentialing during the onboarding process. The new hire should not start until all necessary items are received. The credentialing process cannot start until this information is obtained.

In the case of one non-participating provider when multiple providers are available, train your front office staff to direct patients to the in-network provider. Make sure the patient knows when they are seeing a non-participating provider and that they may be responsible for a large portion of the bill.

Provide your customer service team instructions on what to do if a patient calls to complain. This can be tricky as well. Be sure to check with your legal team to set up a policy that is compliant with all state and federal laws.

Bottom line: The best option for reducing the challenges of out-of-network billing is planning. ■

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