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# Rules of The Game: Contracting, Credentialing, and Negotiating with Managed Care in Audiology

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continued<sup>®</sup>

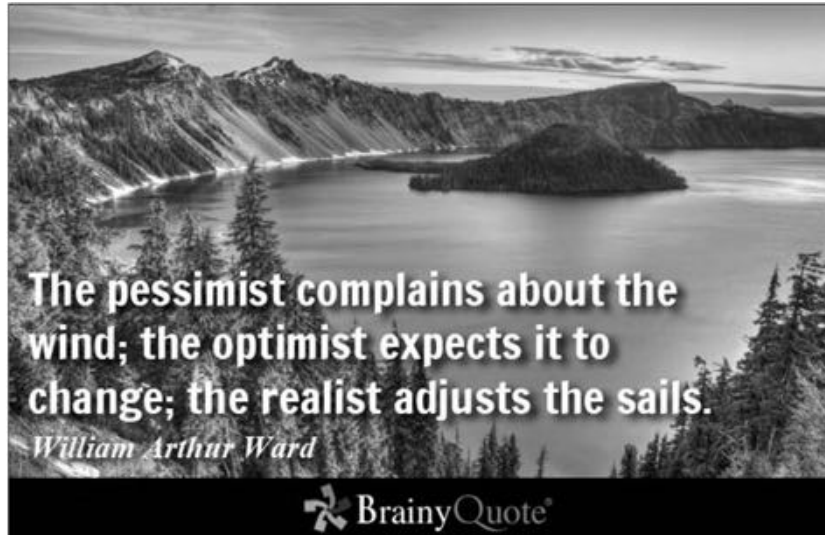
## Learning Objectives

After this course, participants will be able to:

- Describe the steps involved with insurance enrollment.
- Describe the important questions to consider in a managed care agreement.
- Describe the role of CAQH in the credentialing process.

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## Coverage versus Reimbursement

- Coverage is when a third-party is paying all or part of the cost of the item or service.
- Reimbursement is when you, the provider, receive payment for the cost of the item or service.
  - Reimbursement can come from third-party payers or from the patient.
- Lack of coverage does NOT mean a lack of reimbursement.
- WE NEED TO CARE MORE ABOUT REIMBURSEMENT AND LESS ABOUT COVERAGE!

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continued

## Facts

- Other than Medicare, you are a **VOLUNTARY** participant in managed care.
  - Participation in managed care is a business decision.
- Providers must be credentialed with a payer before they can bill a payer as a participating/in-network provider.
  - Otherwise, you are an out-of-network provider and patient should pay in-full for any item or service they receive on the date the item or service is provided.
  - The patient should be informed of your network status (as it pertains to their insurance) prior to making an appointment and be informed of their resulting financial obligations.

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## Medicare Enrollment

- Audiologists CANNOT opt out of Medicare.
  - Medicare beneficiaries have the right to access their benefits for Medicare covered services.
- Need enrollment as an individual (855-I) and practice (855-B) IF you plan to receive reimbursement for diagnostic testing.
- Audiologists must have an NPI, license, and a place of business (address) before proceeding with enrollment.
- Can enroll online through:
  - <https://pecos.cms.hhs.gov/pecos/login.do>
    - Best way to enroll.
      - Do not submit paper applications.
    - Read the tutorials.

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## What Is the Medicare Opt Out?

- Approved providers enter into private contracts with Medicare beneficiaries for Medicare covered services.
  - Services will not be covered by Medicare.
- A private contract is signed between the provider and the patient.
- Providers collect payment from patients.
- Neither the provider or the patient files claims to Medicare.
- The provider is opted out for two years.
  - <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/OptOutAffidavits.html>
- **Audiologists cannot opt out!**

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## Never Enroll in Medicare

- Audiologists cannot NOT enroll IF they want:
  - To be reimbursed for diagnostic testing
  - To be able to submit claims to Medicare for denial
  - To be able to contract with a Medicare Part C plan
- Audiologists also cannot accept orders from physicians or other ordering healthcare providers who are not currently enrolled in Medicare or who have formally opted out of Medicare.



## Medicare Enrollment

- Determined on 855-R.
- Options
  - Participating
  - Non-Participating
  - Not Enrolled

<https://www.cahabagba.com/part-b/enrollment-2/participating-vs-non-participating-part-b/>

[https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Medicare\\_Provider-Supplier\\_Enrollment\\_National\\_Education\\_Products.pdf](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf)

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## Medicare Enrollment

- Participating:
  - Accept Assignment.
  - Listed in provider directory.
  - Rolls-over to secondary.
  - Medicare pays 5% more.

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## Medicare Enrollment

- Non-Participating:
  - Accept assignment on claim by claim basis or charge patient limiting charge (115% of allowed amount).
  - Patient pays provider on date of service.
    - Patient receives 95% of Medicare allowed charge from Medicare/secondary payer.
  - Typically does not roll-over to secondary carrier.

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## Medicare Enrollment

- Not Enrolled
  - In other words, all of your testing all of the time is no charge, regardless of patient or payment source
  - Remember, Audiologists cannot opt out of Medicare.
    - If charge \$X to one person, you must charge \$X to all.

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## Medicare Enrollment Options

	Par	Non-Par who accepts assignment	Non-Par who do not accept assignment (Limiting Charge)
Billed Amount	\$125	\$125	\$115
Medicare Allowed Amount	\$100	\$95	\$95
80% of Medicare Allowed	\$80	\$76	\$76
Beneficiary Co-Insurance	\$20	\$19	\$19
Total Payment to Provider	\$100	\$95	\$115 (95 x 1.15 limiting charge); patient paid \$20 difference

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## Medicare Provider Transaction Access Number (PTAN)

- Upon application to a Medicare Administrative Contractor (MAC), you will also be issued a Provider Transaction Access Number (PTAN).
- While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier's NPI.
- Providers will only ever have one NPI but generally will be assigned a different PTAN for every practice, group, or MAC they are connected with or submitting claims to.
- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1216.pdf>

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## Medicare Revalidation

- This is Medicare's attempt to update your enrollment.
- <https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/revalidations.html>
- <https://data.cms.gov/revalidation>
- This WILL occur every three to five years.
- You have 60 days to re-validate.
- ONLY do it online via PECOS at <https://pecos.cms.hhs.gov/pecos/login.do#headingLv1>

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## Which Third-Party Payers Should My Practice Contract With?

- Providers need to do a market analysis.
  - What are the socioeconomics of your community?
  - What insurers represent the major employers in your area?
  - What insurances do your referral sources and local hospitals accept?
    - Some referral sources cannot, by contract, refer to out of network providers.
  - What insurers offer lucrative hearing aid benefits?

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## Step #1 to Contracting: Request Information from the Payer

- Begin the process with a Google search.
  - Most payers have excellent websites that contain useful information regarding provider enrollment and guidance.
    - Take a look at their medical policies, provider manuals and/or administrative guidance.
  - You can often begin the application request/enrollment process directly from the payer website.
    - Provider/enrollment/healthcare professional section of the website.

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## Step #2: You Will Receive a Reply from the Payer

- Once your application/enrollment request is completed, you will receive a reply from the payer. This can include:
  - Rejection:
    - Closed Network.
      - They can and do say “no.”
  - Provider Agreement and, possibly, Payer Fee Schedule.

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## How to Handle Rejection

- Reach out to the human resources department of the employer providing these benefits to their employees.
  - Have data to illustrate how many of their members are seeking your services, how underserved your community is (if a patient has to drive more than 5 miles to see an in-network provider), or how your practices offers services or products not provided by other in-network providers (such as auditory processing, vestibular or tinnitus evaluation or management, pediatrics or implants).

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## How to Handle Rejection

- Periodically, attempt to re-enroll if participation with this payer is lucrative for your business.
  - Have data to illustrate how many of their members are seeking your services, how underserved your community is (if a patient has to drive more than 5 miles to see an in-network provider), or how your practices offers services or products not provided by other in-network providers (such as auditory processing, vestibular or tinnitus evaluation or management, pediatrics or implants).

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## How to Handle Rejection

- Have your patients advocate for your inclusion in the plan.
  - Encourage them to contact customer service or the human resources department of their employer.

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## How to Handle Rejection

- Purchase a practice that is in-network with the payer in question.
- Again, you will need an attorney and an accountant to assist you in insuring that your type of business purchase enables you to retain their managed care agreements.

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## How to Handle Enrollment: CAQH

- Credentialing clearinghouse.
- Can use this to enroll with multiple payers.
- Free.
- <http://www.caqh.org/>
- To participate:
  - Must be a contracted provider with a least one of the CAQH participating payers.
  - Must be invited by CAQH once registered.

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## Step #3: Understanding the Provider Agreement

- Read the entire agreement and review the fee schedule.
  - Fee schedules TYPICALLY lack all of the codes.
- Things to consider:
  - You want answers to any clarification questions IN WRITING ONLY!
    - What products does this contract obligate the practice to participate with: Medicare Advantage? Medicaid? HMOs?
      - If Medicare Part C, what are the organizational pre-determination requirements?

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## Step #3: Understanding the Provider Agreement

- Does it allow for patient upgrades for hearing aids?
  - Does the practice have to offer a "basic" or "standard" device first?
  - Is there a required waiver process for upgrades?
  - Does it recognize or process S1001 (Deluxe item, patient notified)?
  - How does this "upgrade" reflect on the EOB the patient receives?
- Does the payer allow for hearing aid rentals?
  - If yes, does it require specific modifiers?
- How many line items are allowable on a hearing aid claim?
- Does the agreement require patients complete notices of non-coverage before non-covered services are provided?
- Is the hearing aid benefit inclusive of all of the items and services associated with the dispensing fees, fittings, batteries and repair services?

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## Step #3: Understanding the Provider Agreement

- Can student externs or technicians see members of this plan for covered services?
  - If yes, are there supervision requirements?
- Can hearing aid dispensers see members of this plan for covered services?
- Can audiology assistants see members of this plan?
  - If yes, are there supervision requirements?
- Is hearing aid coverage contingent on receipt of a medical clearance? Does it have to be from an ENT? Does the patient have to be physically seen by the ENT? What evidence needs to be provided of that ENT visit?
- Can certain services be carved-out of the contract?
- What are the termination terms? Renegotiation terms?
- For hearing aids, is the practice required to supply a manufacturer's invoice?
- What are the renewal terms?
  - "Evergreening" of contract.

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## Step #3: Understanding the Provider Agreement

- Does the payer cover telehealth services provided by an audiologist? Are there only specific services the payer covers via telehealth? Does the payer require a modifier? Are there specific requirements?
- How is medical necessity defined?
- What are the requirements for standard processes and procedures for all patients?
- What are the means of provider notification of substantive changes to the agreement?
- What are the requirements for standard fee schedule/charge master?
  - Can the practice bill differently to the payer than they bill their general population?
- What are the timely claims filing requirements?
- Are there any other claims filing requirements.
  - Can the practice file paper claims?

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## Step #3: Understanding the Provider Agreement

- Are there clinic hour requirements?
- What are the medical record retention requirements?
- Does the payer allow for and cover evaluation and management services to be provided by an audiologist?
  - If not, does it allow for the financial responsibility to be assigned to the patient?
- Do they require hearing aid patients be referred to a third-party administrator for dispensing?
- Does the fee schedule address all of the items and services you provide?
  - Every HCPCS and CPT for the items and services you currently provide or might want to provide.
  - How are unlisted codes (92700, L9900, V5298, V5299) processed?

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## Step #4: Understanding the Fee Schedule/Chargemaster

- What the payer allows, per contract, for each specific item and service you provide for each specific product you are contracted to provide.
  - Never accept less than you can afford to receive unless you will have significant volume.
    - Need to know your breakeven plus profit amount per hour to properly analyze this.
    - Do the benefits of participation outweigh the costs?
  - Be careful of:
    - Inclusive hearing aid coverage benefits.
    - Restrictions on number of line items allowed.
    - Large hearing aid discounts (percentages of dollars billed).
    - "Fitting fee only" or Invoice plus arrangements.
      - Requirements to provide the manufacturer invoice.
      - Sometimes you do not buy the aid in this equation.

Sometimes it is a better business decision to be out-of-network providers as patients pay you in full on the date of service and can often, still, access some of their benefits.

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## Third-Party Administrators (TPA)

- TPAs (third-party administrators) are becoming more and more prolific in the audiology space.
- They exist to:
  - Allow payers a single point of contact and payment for hearing aid related items and services.
  - Defined risk for the payer.
  - Cost containment for the member.
  - An established standard of care for the member.

Audiologists helped create the need for these programs and help maintain their existence through their participation.

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## Considering TPA Participation

- Before you agree to participate, please consider the following:
  - Can I afford to provide the level of care, at the agreed upon rates, required by the plan?
  - Is the plan offering a funded or unfunded (discount) benefit?
  - Is your practice bundle or unbundled?
    - Can you create a competitive product offering?
  - What is my responsibility in informing the patient of their benefits, either funded or unfunded?
    - In MOST cases, you have no contractual obligation to notify someone of their TPA benefit unless the plan refers the patient to your office.
    - What are the ethical implications?

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## Considering TPA Participation

- Do any of their policies conflict with my other managed care agreement terms?
  - The “free” hearing test, for example
- What products does the plan offer?
  - What if the member wants a product that is not in the program?
- How many patients do you stand to potentially lose if you do not enroll in the program?

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## Considering TPA participation

- Can I charge the patient or their healthcare insurer for a hearing test?
- What items and services are included in the fitting fee?
  - If it is not included in the fitting fee, are their limits to what I can charge?
  - Do I have to notify patients of these costs, in writing, upfront?
- Do I receive a greater fitting fee if I am a member of a specific buying group or membership organization?

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## Considering TPA participation

- How long is the trial period?
- What do I receive if the patient returns the aids for credit?
- How long do I have to manage the patient for the fitting fee?
- Are their limits as to what I can charge for service outside of the fitting fee window?

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## Before You Initially Sign ANY Agreement...

- Make a copy of the entire contract and fee schedule and SAVE IT.
- Ask questions, in writing, when you lack answers.
  - Don't sign until you get your answers!
- Do not be afraid to negotiate.
  - The worse they can do is say "no."
- What are the pros versus cons of contracting with each payer?
- If unsure of some of the contract terms, hire a consultant and/or attorney to assist you.

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## If You Have Already Signed: Renegotiation

- It is NOT the payers responsibility to have a copy of your contract.
  - If you cannot locate it, request, in writing, a copy of their current agreement and review any bulletins, medical policies, administrative guidance and/or provider manuals on their websites.
  - Request, in writing, a copy of the current fee schedules or access to the current fee schedule.

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## Renegotiation

- You have more leverage the more services you bring to the payer and the more locations you offer.
- Know what you want and defend why you deserve it.
  - Have a knowledge of your current agreement and your Medicare fee schedule for your area.
- Follow the guidance in the contract on termination but, instead of sending a termination letter, send a request for renegotiation.
- You must also be willing to walk away in negotiation or you have no power or leverage.
- Follow the same contract evaluation process you would follow if you were signing up for the first time.

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## Non-Participation as an Option

- Again, other than Medicare, you are a voluntary participant in managed care.
- It is an option to not participate in third-party, managed care plans and be an out of network provider.
  - But, once you terminate, you may not be able to get back into the plan if you change your mind.

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## Non-Participation as an Option

- Analyze your situation before terminating.
  - How many patients are represented by this payer?
  - How many dollars are represented by this payer?
  - How many referral sources are represented by these patients who are represented by this payer?
  - Does this payer contractually allow for hearing aid upgrades?
  - Does the payer offer lucrative, audiology direct, hearing aid coverage and benefits?
  - Does the payer utilize a TPA for their hearing aid coverage and benefits?
  - What are the socioeconomics of the area?

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## Non-Participation as an Option

- When out of network, the patient pays in full on the date of service.
  - One exception is Medicaid QMB/dual eligibility recipients.
    - Many of these situations do not let you collect the Medicare co-insurance or deductible if you are non-participating with the Medicaid plan.
  - Another exception can be when seeing Medicare Part C (Advantage) patients.
    - Many of these plans do not let you collect any more than the Medicare limiting charge.
      - The explanation of benefits will guide you in these situations.

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## Non-Participation as an Option

- Your office can submit claims to the payer as a courtesy to the patient.
  - The patient is reimbursed, from the payer, their out of network benefits.
  - You often see this in mental health, dental and optometry offices.

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## Two Separate, Legal Business Entities

- This option is often selected when a practice has a large physician referral base or a large diagnostic practice.
- An option that many physician practices choose is to spin their hearing aid or auditory rehabilitative practice off into a separate business, with a separate legal structure and separate tax identification and facility NPI number.
- As a result, this second entity would not be encumbered by the managed care obligations of the original business.
- This new, second business could be strategically enrolled in various managed care enterprises, while avoiding those with poor coverage and benefits for treatment, including hearing aids.
  - This is becoming more common in audiology practices as well.
  - In order to do this, you will need to hire an attorney and an accountant to evaluate this option for your situation and effectively and legally create this new business entity.

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