



Payor Contracts and the Connection to Rendering Provider

As organizations work with health insurance funders, one of the most critical items to thoroughly understand is how to use the Rendering Provider appropriately on claims.

If a provider or organization chooses to become in network with insurance, there are various elements to know about the contracting and credentialing process.

Find additional information in the other parts to this series:

- Part 1 = Understanding NPI, Tax ID and Taxonomy Codes
- Part 3 = Types of Providers
- Part 4 = Details of the 1500 Claim Form
- Part 5 = Billing Scenarios and Potential Denials

Payor Contracts

What are Payor Contracts?

Payor contracts are a part of the credentialing process. **Contracting** is the process by which Agency's and/or providers enter into an **agreement** to perform those services at an agreed upon rate using appropriate CPT and HCPCS billing codes. Contracts also include other **binding terms and conditions** between the Agency/Provider and the Insurance Payor.

Payor contracts define and explain a provider's reimbursement arrangement for delivering healthcare services to the patients covered by a specific health plan. The **contracts** cover everything from reimbursement rates and provider networks to medical necessity and provider credentialing.

Understanding the **terms and provisions** in a payor contract is essential to **ensure correct and timely reimbursement, prevent** claim denials, achieve a **healthy** revenue cycle, and keep a practice running. Knowing the ins and outs of each contract is **crucial** to understand billing and credentialing standards.



IDENTIFYING DIFFERENCES

What is the difference?

What is the difference between contracting and credentialing?

Aren't they the same?



Credentialing

Credentialing is a process used to evaluate the qualifications and practice history of a provider. This process includes a review of a provider's completed education, training, residency and licenses. It also includes any certifications issued by a board in the provider's area of specialty.

Once the **credentialing** phase is complete and the payor has approved the provider, the payor will extend a **contract** for participation.



Contracting

Contracting (a.k.a. being 'in network') is the process of becoming contracted with the insurance company. Being a contracted provider means you have a **fully executed contract** between yourself (or group) and the insurance company and are considered to be an in-network provider.

What does this have to do with rendering provider?

Providers need to go through the **credentialing** process to verify to the insurance payors that they are qualified to perform the services being rendered to their members. Not only is this process validating their qualifications, but the result is a **contract** that binds them to render services and get reimbursement.



Within the ABA realm, services are rendered based on a **tiered model**. Which means there are levels of supervision and oversight occurring for services being rendered face-to-face with the patient.

It is important to note that some payors **do not require** the RBT/BT to get credentialed but do require the oversight and supervision in the tiered model be performed according to the BACB standards. An overview of the tiered model will be covered in an upcoming step.

TYPES OF CONTRACTS

There are different types of contracts:



Facility



Group



Individual



Facility contracts: These are very rare, but at times some groups will have this type of contract and be allowed to bill under the Group NPI. They typically must maintain a roster with the funding source. They are accountable to individual providers to meet the criteria of performing services based on the scope of their certification.

Group contracts: They are confused with facility contracts. In most cases this is the indication that there is a Tax ID and a Group NPI in the contract **BUT** the need to credential each individual is still required as well as billing under the supervising/rendering NPI is required.

Individual contracts: Occasionally, a provider may have an individual contract and be a sole provider practice under their social security number and not an Agency Tax ID. Cigna has been known to do individual contracts with BCBA's when the Agency is smaller but will still reference the Tax ID of the Agency in the contract.



IMPORTANT CONTRACT TERMS

There are some important areas to focus and review in Insurance Payor Contracts.



Contracted Rates

Contracted Rates is the amount that an insurance company will pay for a given service code. This applies to providers that are in-network with a specific payor.



Timely Filing Deadline

Some contracts will have standard language with timely filing deadlines as short as 60 days. This is a very difficult deadline to meet, therefore reading what the insurance payors contract require is important.



Appeal Deadlines

Contracts will list the amount of time you have to file an appeal or dispute a claim if it is not paid correctly. State laws are also available that may contribute to appeal deadlines. For example, Arizona and Colorado mandate that all providers have 365 days to dispute incorrectly processed claims.



Electronic Claims and Payments

This ability to bill and receive payment electronically is a critical aspect of efficient billing practices. Verifying that this process is available helps submit claims electronically faster, expedites payments, and gives you the ability to track everything online through the PM Software and the insurance payor portal.



Contract Terms

Although keeping old contracts on file is necessary for the Agency, not having the current contract on file cascades issues throughout Claims Management. There is a brief section that will state how many years the initial term of the contract will last, and how frequent the contract will renew from that point forward. Possible changes that can occur are treatment limitations, authorization requirements, or contracted rate changes.



Length of Authorizations

This portion of contracts outlines how frequent the Agency will need to obtain an authorization. Common authorization lengths are for 6 months, though some funding sources could be more frequent or longer.

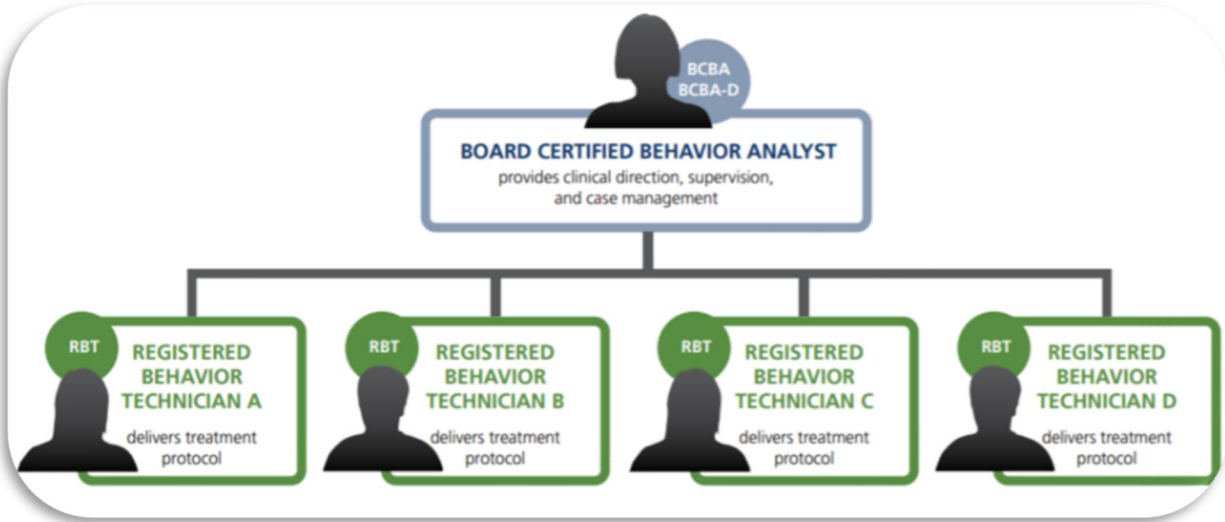


State Addendums

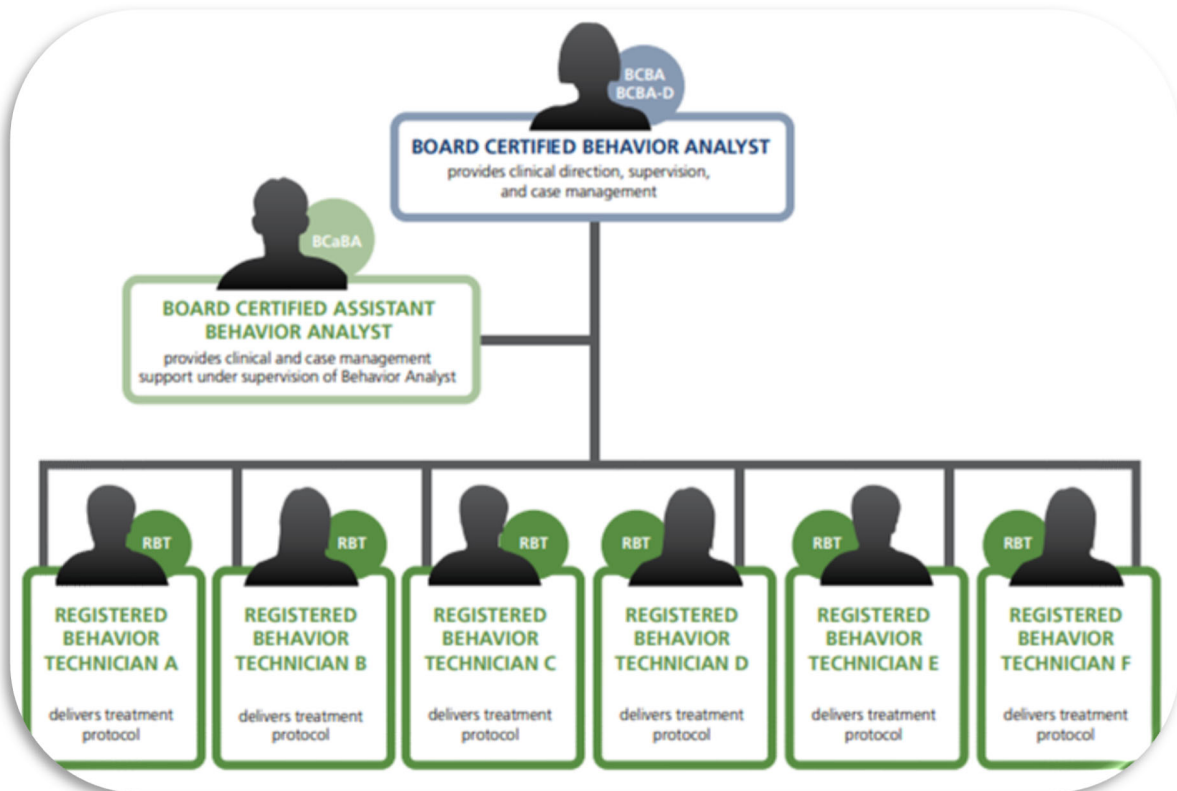
Many contracts have standard language that is sent to every Agency or Provider, and an additional addendum will have terms specific to the state in which they practice. <https://www.autismspeaks.org/state-regulated-health-benefit-plans>



ABA TIERED SERVICE-DELIVERY MODEL



In the above example, the BCBA is overseeing the treatment team of RBT's/Behavior Technicians. In the second example (below), the Behavior Analyst is supported by an Assistant Behavior Analyst; the two of them jointly oversee a treatment team of Behavior Technicians.





Such models assume the following:



The BCBA or BCBA-D is responsible for **all aspects** of clinical direction, supervision, and case management, including activities of the **support staff (for example, a BCaBA) and Behavior Technicians**.



The BCBA or BCBA-D must have **knowledge of each member** of the treatment team's ability to **effectively carry out** clinical activities before assigning them.



The BCBA and BCBA-D must be familiar with the **client's needs and treatment plan** and regularly observe the Behavior Technician **implementing the plan**, regardless of whether or not there is clinical support provided by a BCaBA.

When securing contracts and submitting credentialing applications, refer to payor policies and funder information related to which provider types require credentialing.

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For additional information on working with health insurance funders, check out our book at www.capecodcollab.com – Revenue Cycle Management for ABA Therapy.

If you are in need of Network Participation Management services (Contracting and Credentialing) or Self-Credentialing Consulting, please complete our Perspective Client Form at: <https://www.ababilling.net/new-client/>