MANAGED CARE RESOURCE TOOLKIT

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NATIONAL ASSOCIATION MEDICAL STAFF SERVICES
NAMSS
ADVANCING THE DELIVERY OF QUALITY HEALTHCARE

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SUMMARY

Disclaimer

The resources and templates contained in this resource are not endorsed by any accreditation organization. Users of this toolkit should refer to the appropriate accreditation standards, local and federal regulations, and facility policies for any specific guidance. This toolkit is simply a set of guidelines to assist those using it in creating their own tools.

Introduction

The Managed Care Resource Toolkit was developed and vetted by the National Association Medical Staff Services (NAMSS) Membership Committee's Managed Care Subcommittee. The purpose of the toolkit is to provide individuals new to managed care the resources needed to succeed in the daily operations of their new environment. In this toolkit, individuals will find a roadmap to leadership success, credentialing metrics, resources for credentialing and primary source verification, credentialing job descriptions, and managed care definitions, resources, and acronyms. It is NAMSS' intent that this toolkit will not only be useful for individuals in managed care, but for all individuals in the profession wanting to develop a deeper understanding of the credentialing specificities required within varying healthcare environments.

Acknowledgement

The Managed Care Resource Toolkit exemplifies the hard work and dedication of the NAMSS Managed Care Subcommittee in creating and compiling valuable managed care resources.

NAMSS acknowledges the following individuals for their expertise and guidance:

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NAMSS welcomes any feedback and/or suggestions on the toolkit as we continue to develop this managed care resource.

Please contact NAMSS Executive Office at info@namss.org or 202-367-1196 with any questions, concerns, feedback, or suggestions for the Managed Care Resource Toolkit.

ROAD MAP TO LEADERSHIP SUCCESS IN MANAGED CARE

Taking a leadership role can be a daunting task. Handling new roles and responsibilities coupled with personnel management and team-building can add a significant weight to your day-to-day lives. This resource aims to help you build a strong foundation. The check-list below is meant to provide you with a "road map" to success from Day One of your leadership role. Take into consideration the following:

- √ **Have you located and reviewed your payer contract grid?**
- √ **Have you located and reviewed company policies and procedures?**
- √ **Have you discussed or reviewed your network's system goals or strategic plan?**
- √ **Initial Rounding: Set up personal one-on-one time with your team members. In your discussions, consider asking key questions, such as, "Is there anything else I can do for you?" As a follow-up, provide reports and engage with your team members in a collaborative manner to develop solutions. Identify each team member's strength(s) within the department.**
- √ **What are the existing team goals?**
- √ **Review your direct report's performance review. Identify when your direct report's next review is due.**
- √ **Arrange to meet with key departmental leaders.**
- √ **Identify your department's current tasks, reports, and projects, and the target completion date for each item.**
- √ **Find out when the next survey is due. Find the documents from the last survey conducted.**
- √ **Organize your professional calendar to include standing organizational meetings, ongoing education, and NAMSS educational programs. Determine what additional education you would need.**
- √ **Set up touch-point meetings with your direct supervisor as well as your VPMM, Medical Director, Department Chair, and other key leaders.**
- √ **Identify appropriate resources such as regulatory body standards (i.e. NCQA, URAC, AAAHC).**

The first three to six months is all about understanding the organization's culture and processes. We often want to jump in and provide solutions, but we encourage the art of listening and observation. The

best leaders who see an opportunity for improvement are those who empower their team members to see and create the vision together**.**

MANAGED CARE CREDENTIALING METRICS

*Align your metrics with regulatory body requirements and your organization's policy and procedure.

Establish Department Turn-Around Time	Upon deeming an application to be complete, all required verifications are to be completed within 30 days of receipt.
Completed Application	Application review to be completed within seven (7) days of receipt. The provider will be allowed three (3) days for required elements. If not received, application returned as incomplete.
Scanning	Verifications and required documents are scanned, and the database updated within three (3) business days of receipt.
Expiration Management (Professional License, Malpractice Insurance, DEA, Controlled Substance if required by state, Board Certification, ACLS, BLS, CPR, Flu Shot, etc.)	Faxed notices sent: • 60 days prior to expiration • 30 days prior to expiration • Upon expiration
Outstanding Required Application Verification (Verification Requests to be sent by fax, and, in those rare instances, by USPS)	Letter One: Send Day Seven (7) Letter Two: Send Day Fourteen (14) • Outstanding Items Letter to Provider Letter Three: Send Day Twenty-One (21) • Outstanding Items Letter to Provider

Re-credentialing (Managed Care – i.e. NCQA, URAC, AAAHC) **Reappointment** (Hospital, Ambulatory Surgical Center – i.e. TJC, DNV, HFAP) **Revalidation** (Medicare, Medicaid)	Practitioners due for re-credentialing or reappointment are identified approximately six (6) months prior to expiration. • Application Sent – Due in 14 days (date sent is defined by organization) • Reminder One Email Sent – Day 30 • Reminder Two Email Sent – Day 45 Practitioners due for Medicare revalidation are identified by accessing CMS website as noted below. CMS posts the date the list was last refreshed. https://data.cms.gov/revalidation Practitioners due for Medicaid revalidation – refer to your respective states(s) for dates and process. It is recommended to copy the Medical Director, Department Chair, and/or Leadership as designated by the organization on reminder emails.
Practitioner and/or Demographic Changes	Submitted changes to be updated in the database within three (3) days of receipt. NOTE: Changes requiring verification will need to be completed prior to updating the database and saved as noted by organization policy and procedures.

MANAGED CARE TOOL TO CREDENTIALING & PRIMARY SOURCE VERIFICATION

1.1 Practitioner Credentialing Types

- Practitioner Types
  - Medical Doctors (MD)
  - Doctor of Osteopathic (DO)
  - Oral Surgeon (DMD/DDS)
  - Podiatrist (DPM)
  - Independent Physical Therapist (PT)
  - Chiropractor (DC)
  - Fully Licensed Psychologist (PhD)
  - Licensed Master of Social Work (LMSW)
  - CNP (Certified Nurse Practitioner)
  - CNM (Certified Nurse Midwife)
  - Certified Registered Nurse Anesthetists (CRNA)
  - Occupational Therapist (OT)
  - Optometrist (OD)
  - Audiologist (AUD)
  - Licensed Professional Counselors (LPC)

1.2 Verify License

- **Verify State License** - All practitioners must have an active State license without restriction in [state] and all bordering states [list bordering states]. A state license can be found on the [state medical board] website either by first and last name, or by using the active State license on record with CAQH.
  - Link to State Medical Board: [http://www.fsmb.org/state-medical-boards/contacts]

- **Verify DEA License** – If a practitioner holds a Drug Enforcement Certificate (DEA), it must be active in [state] and all border states where the practitioner sees members. We cannot accept an out-of-state DEA license. If a practitioner does not have a DEA license, you must find out who writes their prescriptions and verify that they are currently participating with the same networks as the practitioner being credentialed.
  - Link to DEA: http://www.deanumber.com/ or https://dea.ntis.gov/

- **Verify CSL/CDL License** – If a practitioner holds a Controlled Substance license (CSL/CDL), it must be active without restrictions in [state] and all bordering states [list bordering states].
  - Link to State Medical Board: [https://www.deadiversion.usdoj.gov/drugreg/statebrd.htm]

1.3 Verify Board Certification

- Practitioners must hold current Board Certification in applicable specialty and be primary source verified within 180 days of Credentialing Committee date. If the practitioner does not have a recognized Board Certification, they will be denied.

- Practitioner types are: MD, DO, DPM, DMD

- Examples of Allied Specialty types are Certified Nurse Practitioner (CNP), Certified Nurse Midwife (CNM), and Certified Registered Nurse Anesthetist (CRNA).

❖ Web sites used to verify Board Certification:

- **Certifacts** (https://www.certifacts.org/DC/Login.aspx)
  - Board Certifications for MDs and DOs
- **AOA** (https://www.doprofiles.org/)
  - Board Certification for DOs Only
- **ABFAS** (https://www.abfas.org/)
  - Board Certification for Podiatrists Only
- **ABPM** (https://www.abpmed.org/)
  - Board Certification for Podiatrists Only
- **AMCB** (https://ams.amcbmidwife.org/amcbssa/f?p=AMCBSSA:17800)
  - Certification for Nurse Midwife
- **AANA** (https://portal.nbcrna.com/credential-verification)
  - Certification for Nurse Anesthetists
- **ANCC** (http://www.nursecredentialing.org/certification/verifycertification)
  - Certification for Nurse Practitioners

1.4 Verify Education and Training

❖ Primary source verification of the highest level of education/training in the applicable specialty must be obtained for practitioners within 180 days of credentialing for all practitioners who are not board certified and board eligible.

❖ MDs and DOs primary source verification may be obtained from the AMA website.
- **AMA** (https://profiles.ama-assn.org/amaprofiles/)

❖ DOs primary source verification may be obtained from the AOA website.
- **AOA** (https://www.doprofiles.org/)
  - Board Certification for DOs Only

❖ If you are unable to obtain primary source verification from AMA or AOA, you must contact the school/hospital where the practitioner completed their training.

1.5 Work History

❖ Five-year work history verification is required for initial practitioners only. Work history can be compared to what is found on CAQH.

❖ Gaps in the work history require an explanation:
- Gaps six (6) months to one (1) year require a verbal explanation.
- Gaps greater than one (1) year require a written explanation.

1.6 Verify Hospital Privileges

❖ **Verify Hospital Privileges** – Hospital privileges on file with CAQH must be primary source-verified. This can be done by checking the current hospital rosters on file, sending a letter to the hospital(s), and/or requesting verbal confirmation from the hospital verifying privileges.

❖ **Verify Admitting Arrangements** – If a practitioner does not have hospital privileges, you must call and ask what the admitting arrangements are.

- i.e., Do you have a practitioner who will admit for you? Emergency Room is acceptable if you know to which hospital they will send their patients.

❖ Certain practitioner types are not required to have hospital privileges: DPM, DMD/DDS-Oral Surgery, or MD/DO-Allergy/Immunology, Anesthesiology, Dermatology, Pathology, Radiology, Psychiatry, Ophthalmology, Emergency Medicine, Independent Physical Therapists.

❖ Allied Practitioners are not required to have admitting privileges, regardless of how they answer the question, "Do you have hospital privileges?"

1.7 Verify Professional Liability Insurance

❖ Verifying Professional Liability Insurance must be done for all practitioner types.
❖ Professional Liability Insurance should be listed on the practitioner's CAQH application. All practitioners must have the specified minimum aggregate amount in keeping with organization's policy and procedures.
❖ Primary source verification of Professional Liability Insurance is completed in keeping with organization's policy and procedures.

1.8 Verify NPDB

❖ The National Provider Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB) are now one system that queries practitioners and organizational providers.

- NPDB must be queried for **all** practitioners.
  - **NPDB** (http://www.npdb.hrsa.gov/)

1.9 Query Sanctions

❖ Sanction Screening single and batch searches of employees, medical staff, physicians, contractors, vendors and businesses against federal and state databases.
- **Sanction Screening Services (S3)**
  - (https://www.complianceresource.com/products/sanction-screening-services/)
- **Medicare Opt-Out (all practitioners and facilities must be queried)**
  - (https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z)

Re-Credentialing

❖ Re-credentialing is a credentialing workflow where an existing credentialing cycle exists as active. Re-credentialing occurs every three (3) years and must be done within the required 36-month timeline.
❖ The re-credentialing workflow is comprised of the same core tasks as the Initial Practitioner Credentialing workflow, the Categorization/Issue sheet, plus an additional Record Practitioner Performance task (performed by Quality Management staff) and Utilization review criteria.
❖ Medicare providers must revalidate their enrollment record information every three (3) or five (5) years. CMS sets every provider's revalidation due date at the end of a month and posts the upcoming six (6) months online. A due date of 'TBD' means that CMS has not set the date yet. It is recommended the verification of the practitioner's Medicare revalidation be completed as part of the onboarding process.
- (https://data.cms.gov/revalidation)

Mid Cycles:

- A mid-cycle workflow is initiated when one of the core tasks from the Initial Credentialing process (e.g., update Education and Training, Specialty, Hospital Affiliations, etc.) needs to be updated within an active credentialing cycle (before re-credentialing is due).
- Users are able to manually initiate system tasks necessary for updating.

NOTE: Credentialing guidelines and verifications will need to be aligned with regulatory body requirements, organization's policy and procedure.

Credentialing Specialist

KEY RELATIONSHIPS:

Reports to:
Supervises:
Other Key Relationships:

POSITION PURPOSE:

Responsible for performing credentialing activities to ensure that [Employer] has a provider network of the highest quality. [Position should reference alignment with mission, values of the organization.]

PRINCIPAL DUTIES:

Essential Functions:

- Responsible for the timely processing and tracking of credentialing files.
- Review credentialing files for accuracy and completeness. Performs primary source verification of practitioner credentials based on the policies and procedures of [Company Name] and the federal and state regulatory agencies and accrediting bodies. [Provide a list of federal and state regulatory agencies and accrediting bodies to abide by for policies and procedures. Include in the list the National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS).]
- Monitor and assist further investigations as deemed necessary during the credentialing process by document evaluation, primary source verifications, or as requested by [Company Name] Credentials Committee and Credentials Committee Chair.
- Prepare initial credentialing and re-credentialing files for the Medical Director and/or the Credentials Committee.
- Works closely with [Department(s) - i.e. Provider Contracting and Provider Data Services] to ensure the credentialing application process is efficient and meets established turnaround times.
- Responsible for expirable tracking to ensure all licensing, professional liability, and verifications are current at the time of Committee decision.
- Attend monthly Credentialing Committee meetings, and act on the decisions of the Committee.
- Attend and participate in departmental team meetings.
- Maintain confidential credentialing files and electronic credentialing database.
- Participate in credentialing team quality audits.
- Participate in the development and implementation of departmental policies, procedures, forms, etc.
- Perform site visits as necessary or requested.
- Ability to report to work on time and work the days scheduled is essential to this position.

OTHER FUNCTIONS:

- Other duties as assigned.

QUALIFICATIONS:

Education:

- High School diploma or equivalent required. Associate's degree preferred.

- Certified Provider Credentialing Specialist (CPCS) or Certified Professional Medical Services Management (CPMSM) preferred. If not certified, must obtain certification within one year of reaching eligibility.

Prior Related Experience:

- Minimum three (3) years' experience in a healthcare delivery environment or one (1) to two (2) years in credentialing activities.

Employment Eligibility:

- The candidate has not been sanctioned or excluded from participation in federal or state healthcare programs by a federal or state law enforcement, regulatory, or licensing agency.

Knowledge, Skills, and Abilities:

- Good oral and written communication skills.
- Ability to meet scheduled deadlines with minimal supervision.
- Strong organizational skills and accurate work results.
- Ability to maintain a professional demeanor and confidentiality.
- Knowledge of CMS, NCQA, State and Federal regulations related to health plan credentialing activities.
- Detail-oriented.
- Accomplish responsibilities accurately and expeditiously.
- Ability to multitask and deal with complexity on a frequent basis.
- Flexible, team player.
- Self-starter and self-motivated, functions independently with minimal direction.
- Proficient in Word, Excel, and web-based credentialing software.
- Must be able to work with a variety of people and under varying circumstances.

Credentialing Coordinator

KEY RELATIONSHIPS:

Reports to:
Supervises:
Other Key Relationships:

POSITION PURPOSE:

Responsible for performing credentialing activities to ensure that [Employer] has a provider network of the highest quality. [Position should reference alignment with mission, values of the organization.]

PRINCIPAL DUTIES:

Essential Functions:

- Responsible for the timely processing and tracking of credentialing files.
- Review credentialing files for accuracy and completeness. Performs primary source verification of practitioner credentials based on the policies and procedures of [Company Name] and the federal and state regulatory agencies and accrediting bodies. [Provide a list of federal and state regulatory agencies and accrediting bodies to abide by for policies and procedures. Include in the list the National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS).]
- Monitor and assist further investigations as deemed necessary during the credentialing process by document evaluation, primary source verifications or as requested by [Company Name] Credentials Committee Chair or Medical Director.
- Prepare initial credentialing and re-credentialing files for the Medical Director and/or the [Company Name] Credentials Committee.
- Ability to complete a minimum of [#] practitioner and/or facility files per month and meet the departmental performance target.
- Works closely with [Department(s) - i.e. Provider Contracting and Provider Data Services] to ensure the credentialing application process is efficient and meets established turnaround times.
- Attend monthly Credentialing Committee meetings and act on the decisions of the committee regarding files processed.
- Participate in preparation of payer delegated credentialing audits as required by NCQA.
- Attend and participate in staff meetings.
- Maintain confidential credentialing files and electronic credentialing database.
- Participate in credentialing team quality audits.
- Participate in the development and implementation of departmental policies, procedures, forms, etc.
- Perform site visits as necessary or requested.
- Ability to report to work on time and work the days scheduled is essential to this position.

OTHER FUNCTIONS:

- Other duties as assigned.

QUALIFICATIONS:

Education:

- High School diploma or equivalent required. Associate's degree preferred.

- Certified Provider Credentialing Specialist (CPCS) or Certified Professional Medical Services Management (CPMSM) preferred. If not certified, must obtain certification within one year of hire date.

Prior Related Experience:

- Minimum four (4) years' experience in a healthcare delivery environment or three (3) years in credentialing activities.

Employment Eligibility:

- The candidate has not been sanctioned or excluded from participation in federal or state healthcare programs by a federal or state law enforcement, regulatory, or licensing agency.

Knowledge, Skills, and Abilities:

- Strong oral and written communication skills.
- Ability to meet scheduled deadlines with minimal supervision.
- Strong organizational skills and accurate work results.
- Ability to maintain a professional demeanor and confidentiality.
- Maintain knowledge of CMS, NCQA, State and Federal regulations related to health plan credentialing activities.
- Participate in preparation of payer delegated credentialing audits as required by NCQA.
- Detail oriented.
- Accomplish responsibilities accurately and expeditiously.
- Ability to multi-task and deal with complexity on a frequent basis.
- Flexible, team player.
- Self-starter and self-motivated, functions independently with minimal direction.
- Word processing and database computer skills, including Word and Visual Cactus, preferred.
- Must be able to work with a variety of people and circumstances.

Lead Credentialing Coordinator

KEY RELATIONSHIPS:

Reports to:
Supervises:
Other Key Relationships:

POSITION PURPOSE:

Responsible for performing credentialing activities to ensure that [Company Name] has a provider network of the highest quality. [Position should reference alignment with mission, values of the organization.]

PRINCIPAL DUTIES:

Essential Functions:

- Responsible for the timely entry, processing, and tracking of credentialing files.
- Maintain confidential credentialing files and electronic credentialing database.
- Review credentialing files for accuracy and completeness. Performs primary source verification of practitioner credentials based on the policies and procedures of [Company Name] and the federal and state regulatory agencies and accrediting bodies. [Provide a list of federal and state regulatory agencies and accrediting bodies to abide by for policies and procedures. Include in the list the National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS).]
- Monitor and assist further investigations as deemed necessary during the credentialing process by document evaluation, primary source verifications or as requested by [Company Name] Credentials Committee and Credentials Committee Chair.
- Prepare initial credentialing and re-credentialing files for the Medical Director and/or the Credentials Committee.
- Ability to complete a minimum of [#] practitioner and/or facility files per month and meet the departmental performance target.
- Monitor and conduct ongoing monitoring reports as required by the accrediting and regulatory bodies.
- Work closely with Provider Contracting and Provider Data Services to ensure the credentialing application process is efficient and meets established turnaround times.
- Attend monthly Credentialing Committee meetings, and act on the decisions of the Committee regarding files processed.
- Responsible for preparing and overseeing the payer delegated credentialing audits as required by NCQA.
- Attend and participate in credentialing staff meetings.
- Serve as point of contact for Center and Plan staff regarding credentialing issues.
- Participate in credentialing team quality audits.
- Participate in the development and implementation of departmental policies, procedures, forms, etc.
- Perform site visits as necessary or requested.
- Ability to take a lead role in assisting with accreditation audits.
- Ability to train/orient new employees of the Credentialing Department on how to process initial, re-credentialing and facility credentialing applications, and enter them into the company databases.
- Monitor and audit completed files in the Credentialing Department as well as audit 100 percent of new team member's files to ensure the employee is consistently applying NCQA/CMS credentialing guidelines while processing applications.

- Ability to report to work on time and work the days scheduled is essential to this position.

OTHER FUNCTIONS:
- Other duties as assigned.

QUALIFICATIONS:

Education:
- Associate's degree required. Bachelor's degree preferred.
- Certified Provider Credentialing Specialist (CPCS) or Certified Professional Medical Services Management (CPMSM) required.

Prior Related Experience:
- Minimum seven (7) years' experience in a healthcare delivery environment, or five (5) years in credentialing activities.

Employment Eligibility:
- The candidate has not been sanctioned or excluded from participation in federal or state healthcare programs by a federal or state law enforcement, regulatory, or licensing agency.

Knowledge, Skills, and Abilities:

- Strong oral and written communication skills.
- Ability to meet scheduled deadlines with minimal supervision.
- Strong organizational skills and accurate work results.
- Ability to maintain a professional demeanor and confidentiality.
- Maintain knowledge of CMS, NCQA, State and Federal regulations related to health plan credentialing activities.
- Experience in creating performance data reports and setting meeting agendas.
- Detail-oriented.
- Accomplish responsibilities accurately and expeditiously.
- Ability to multi-task and deal with complexity on a frequent basis.
- Flexible, team player.
- Self-starter and self-motivated, functions independently with minimal direction.
- Word processing and database computer skills, including Word and Visual Cactus, preferred.
- Must be able to work with a variety of people and circumstances.

MANAGED CARE AND PROVIDER ENROLLMENT TERMS

Managed Care / Provider Enrollment	Definition
Credentialing	The process by which a healthcare organization reviews and evaluates the qualifications and professional background of licensed professionals and provider organizations to ensure the delivery of quality care to its members.
Managed Care	A system of healthcare delivery that uses a planned and coordinated approach to managing costs while ensuring quality services and access. This approach integrates resources with financial incentives to aid healthcare providers in offering services that focus on patient health and safety. Healthcare providers and facilities enter into contracts with managed care organizations in order to provide a range of services to health plan members at reduced costs in exchange for increased patient volume in keeping with state, federal, and regulatory body requirements.
Provider Enrollment	The process of requesting participation in a health insurance network as a participating provider or supplier. Often considered as part of the onboarding process, the provider enrollment process will include the request to enroll and/or contract with a plan or medical group through completion of required documents that may include a credentialing application, enrollment forms, and other payer specific requirements.
Delegation	A formal process by which an organization grants another entity the authority to perform certain functions on its behalf. The agreement will outline the expectations of the delegating organization as well as reference state, federal, and regulatory body requirements. The process will include a pre-delegation evaluation and execution of an agreement, contract, or Memorandum of Understanding that defines the role, responsibility, accountability of delegated tasks/process, and provider data reporting requirements. Regular audit of the delegated tasks is completed at a prescribed time to ensure full compliance. The delegating organization retains the ultimate responsibility for all delegated functions.
Policies & Procedures	Policies are principles, rules, and guidelines formulated and adopted by an organization to reach its long-term goals. Procedures explain how the policies are put into action in day-to-day operations of an organization. Policies and procedures are created to assist organizations in decision making and operations. Policies and procedures are often approved by an oversight/governing body prior to implementation with an annual review to ensure they are aligned with the organization's mission, as well as state, federal, and regulatory body requirements.

Credentialing Verification Organization (CVO)	A credentials verification organization (CVO) is an organization that gathers data and verifies the credentials of doctors and other healthcare practitioners. A CVO typically provides credentialing support to health plans and other entities providing healthcare services to consumers.
URAC Accreditation	URAC Accreditation ensures a meaningful, rigorous, and fair credentialing process that protects both patients and providers from poor credentialing practices. Credentialing is a critical function that allows healthcare organizations to properly identify qualified healthcare practitioners for participation in their networks. The accreditation process is an important way to protect patients and to minimize legal exposure for healthcare organizations due to malpractice claims.
NCQA Certification	The NCQA Certification Survey includes rigorous onsite and offsite evaluations conducted by a survey team that includes at least one credentialing surveyor and one administrative surveyor. A Review Oversight Committee (ROC) of physicians analyzes the team's findings and assigns a certification status based on the CVO's performance against core standards and the requirements within applicable certification options.
AAAHC Accreditation	AAAHC accreditation confirms the organization participates in ongoing self-evaluation, peer review, and education to continuously improve its care and services. The organization also commits to a thorough, on-site survey by AAAHC surveyors, who are themselves healthcare professionals, at least every three (3) years.
Network Management	Network management is typically a department or division of a Managed Care Organization tasked with ensuring appropriate and adequate provider contracting within their organization's service area to meet the needs of their health plan members.
Physician Hospital Organization (PHO)	Physician-Hospital Organizations (PHO) are legal entities formed by physicians and one or more hospitals for the purpose of negotiating contracts with payers/managed care plans. This arrangement allows for the sharing of financial gains while controlling healthcare costs. The PHO will contract directly with the payers, securing one contract that may cover several services; thus eliminating the need for several individual contracts.
Practitioner	A licensed or certified professional who provides medical care or behavioral healthcare services.
Provider	An institution or organization that provides services, such as a hospital, residential treatment center, home healthcare agency, or rehabilitation facility.
Primary Source	The entity that originally conferred or issued a specific credential. This entity may designate a vendor or organization as a secondary source that may be utilized to provide a true and accurate representation of the credential.

Primary Source Verification	Verification of credentialing information directly from the entity (e.g., state licensing board) that conferred or issued the original credential. Primary Source Verification is documented verification by an entity that issued a credential, such as a medical school or residency program, indicating that an individual's statement of possession of a credential is true. Verification can be done by mail, fax, telephone, or electronically, provided the means by which it is obtained are documented and measures are taken to demonstrate there was no interference in the communication by an outside party.
Organizational Provider	An institution or organization that provides medical service. Examples include but are not limited to hospitals, residential treatment centers, home health facilities, ambulatory surgery centers, etc.
Provisional Credentialing	The process by which a practitioner is authorized by an organization to participate in its network based upon minimum requirements being met. This authorization is provisional for a prescribed period of time during which the collection and verification of all credentials required to meet organizational and NCQA standards have been completed and full approval is given by the organization's decision-making body.
Provider NPI	The National Provider Identifier (NPI) is a unique 10-digit numeric identifier issued to health care providers by the Centers for Medicare and Medicaid Services (CMS) for use in billing transactions. This number does not contain any identifying intelligence about the healthcare provider and includes a check digit in the 10th position. The NPI is permanent and remains with the provider regardless of changes in practice locations.
Physician	Professionals who are legally authorized by the respective state licensing board to practice medicine. Examples include, but are not limited to, doctors of medicine or osteopathy (MD, DO), doctors of dental medicine or dental surgery (DMD, DDS), doctors of podiatric medicine (DPM), doctors of optometry (OD), and doctors of chiropractic medicine (DC).
Taxonomy	The Healthcare Provider Taxonomy Code Set established by the Centers for Medicare & Medicaid Services (CMS) is a hierarchical code set that consists of codes, descriptions, and definitions. These codes are designed to categorize the type, classification, and/or specialization of healthcare providers. The Code Set is divided into two sections: Individuals/Groups of Individuals, and Non-Individuals. The Code Set is updated by CMS twice per year, typically effective April 1 and October 1.
Provider Relations	Department or division of a Managed Care Organization tasked with providing effective communication and support to contracted providers.
Preferred Provider Organization (PPO)	Health insurance arrangement that awards participants discounts in cost for obtaining services from providers within the insurance plan's network, while still providing coverage for out-of-network services.

ICD-10	The International Classification of Diseases (ICD) is a billing code system created by the Centers for Medicare & Medicaid Services (CMS) for governmental and health provider claims processing and billing. ICD-10 includes over 75,000 codes.
Incident To	"Incident to" services are non-physician services or supplies that are furnished as an integral but incidental part of a physician's professional services; sometimes known as ancillary services. When billed to Medicare, these services are billed as Part B services as if personally provided by the physician and are paid under the physician fee schedule. Note: “Incident to” services are also relevant to services supervised by certain non-physician practitioners such as physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, or clinical psychologists. These services are subject to the same requirements as physician-supervised services. Remember that “incident services” supervised by non-physician practitioners are reimbursed at 85 percent of the physician fee schedule. (Refer to CMS for current requirements).
Independent Physician Association (IPA)/Physician Organization (PO)	An Independent Practice Association (IPA) or Physician Organization (PO) is a legal entity organized and directed by physicians in private practice to negotiate contracts with insurance companies on their behalf. Contracts can be negotiated per capita rate, flat retainer fee, or negotiated fee-for-service basis. The typical IPA encompasses all specialties, but an IPA can be solely for primary care or single specialty area.
Managed Behavioral Health Care Organization (MBHO)	An organization that combines the functions of health insurance, delivery of care, and administration but specializes in the behavioral health setting. May consist of affiliated and/or owned hospitals, physicians, and others that provide a wide range of coordinated health services.
Managed Care Organization (MCO)	An organization that combines the functions of health insurance, delivery of care, and administration in the acute care setting. May consist of affiliated and/or owned hospitals, physicians, and others that provide a wide range of coordinated health services.
Health Maintenance Organization (HMO)	An organization that awards participants discounts in cost for obtaining services from providers within the insurance plan's network. There is no coverage for services from of out-of-network providers.
Point of Service (POS)	Managed care plan that combines HMO and PPO plans wherein it awards participants discounts in the cost of obtaining services from providers within the insurance plan's network and provides partial coverage for services from out-of-network providers.

MANAGED CARE RESOURCES

Organization	Website	Description
Center for Medicare and Medicaid Services (CMS) **CMS – Medical Learning Network**	www.cms.gov www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/index.html	
National Committee for Quality Assurance (NCQA)	www.ncqa.org	
URAC	www.urac.org	
Accreditation Association for Ambulatory Health Care (AAAHC)	www.aaahc.org	
CAQH	www.caqh.org	

MEDICARE ACRONYMS

Term	Acronym
Centers for Medicare & Medicaid Services	CMS
Children's Health Insurance Program	CHIP
Civil Monetary Penalty	CMP
Continuing Medical Education	CME
Corporate Integrity Agreements	CIA
Data Users	DU
Data Users Agreement	DUA
Food and Drug Administration	FDA
Graduate Medical Education	GME
Group Purchasing Organization	GPO
Indirect Medical Education	IME
Inpatient Prospective Payment System	IPPS
National Drug Code	NDC
National Plan and Provider Enumeration System	NPPES
National Provider Identifier	NPI
Outpatient Prospective Payment System	OPPS
Over the Counter	OTC
Medicare Provider Enrollment, Chain and Ownership System	PECOS
Taxpayer Identification Number	TIN