Credentialing

National Family Planning and Reproductive Association

September 30, 2013

St. Louis, MO

Session Content

- Overview of payer credentialing
- Types of Providers that payers will credential and contract
- Getting started
- Best practices for timely and efficient completion of the credentialing process
- Credentialing complexities – RED FLAGS!
- Case Studies
- Ongoing maintenance – CAQH, Revalidations, etc.

Overview

- What is Credentialing?

Credentialing Overview

- Credentialing is NOT contracting
- Credentialing is the process of verifying and validating background and qualifications for providers
- Allow at least 3-6 months to complete the process (can be longer)
- Individual enrollment required for Medicare and Medicaid

Health Plan Credentialing *In*consistencies

- Types of providers
- Credentialing/provider enrollment/contracting process
- Timeframe
- Applications
- Requirements

Get to Know the Health Plans

- Visit insurance company web sites
  - See handout
- Meet with the provider relations reps to learn about:
  - Mission, vision, and values
  - Existing provider network (clinicians, facilities, ancillaries)
  - Number of covered lives in your community
  - Local employers that are covered
- Gather input from other local providers
- Find out about the health plan's performance: http://www.ncqa.org/HEDISQualityMeasurement.aspx
- ASK!!!!!

Types of Products

- Indemnity
- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Point of Service (POS)
- Private Fee for Services (PPFS)

Types of Providers

- Group or facility
- Individual Provider

Health Plan Obligations

- Provide member ID cards
- Provide fee schedules
- Do not include “Most Favored Nation” clause
- Prompt payment provision
- Written consent for additional benefit plans
- Electronic capabilities
- Credentialing
- Privacy Protection

Provider Obligations

- Office hours/after hours care
- Timely filing
- Claim submission
- Non-discrimination
- Medical records
- Policy manual
- Provider directory
- Collect Co Pay

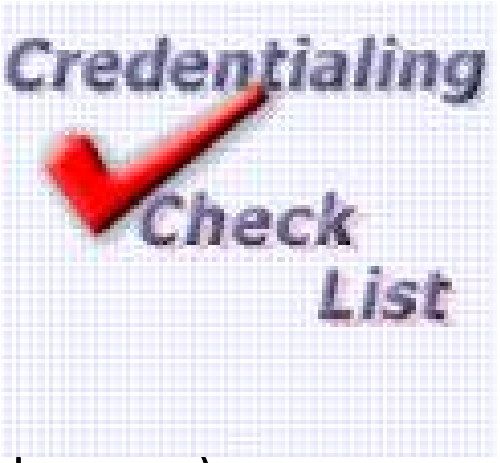
Types of Providers the Payers will Credential

- **Medicare** – physicians, audiologists, nurse practitioners, physician assistants, certified nurse midwives, clinical social workers, mass immunization roster billers, registered dieticians
- **Medicaid** - check with your state
- **Aetna** – credentials physicians, rosters mid-levels
- **Anthem**- credentials physicians, rosters mid-levels
- **Cigna** – credentials physicians, mid-levels on request, pay at 85%
- **Humana** – credentials physicians, mid-levels who want to be listed in directory
- **UHC** – credentials mid-levels

Can vary state to state!!

Getting Started

Gather PROVIDER INFORMATION:



- Full LEGAL Name
- Other Used Names and Dates Used
- Date of Birth
- Place of Birth (including state/province/country)
- Social Security Number
- Individual Medicare PTAN (if provider already has one)
- Individual Medicaid Number (if provider already has one)
- Individual NPI Number, Username *and* Password (if provider already has one – if not, will need to apply for one, information to follow)
- CAQH Number, Username *and* Password (if provider already has one – if not will need to obtain one, information to follow)

Getting Started (cont.)

Gather PROVIDER DOCUMENTS

- State Credentialing Application
- Medical License(s) – Wallet size and signed
- DEA Certificate (if applicable)
- Board Certificates (i.e. American Nurses Credentialing Center for NP)
- Internship Certificate of Completion (if applicable)
- Residency Certificate of Completion (if applicable)
- Fellowship Certificate of Completion (if applicable)
- Medical School Diploma or Equivalent for NP/PA/RN
- All Training Certificates
- Malpractice Issues/Cases
- Peer References
- BLS, ACLS, ATLS
- Current CME Credits (within last 36 months)
- Current CV
- Professional Liability (Malpractice) Insurance Facesheet
- Copy of Picture ID (valid driver's license or passport are acceptable)

Getting Started (cont.)

Public Health
Prevent. Promote. Protect.

Gather AGENCY INFORMATION:

- Legal Business Name and any DBA's
- Type of clinic/practice
- Authorized/Delegated Official – person registered with Medicare to sign official documents, usually an owner, senior partner or administrator
- Name(s) of Owner(s) and % of Ownership
- Clinic Manager Contact Information (name, phone, fax, email)
- Clinic Address(es)
- Pay to Information (name and address)

Getting Started (cont.)

Gather AGENCY INFORMATION (cont.):

- Tax ID
- NPI Number
- Medicare PTAN
- Medicaid Number

Gather AGENCY DOCUMENTS:

- IRS 575 or 147c
- Bank Information (contact name and phone number) and Voided Check (EFT)
- W-9
- CLIA Certificate
- FDA/Radiology Certification
- Current Provider Roster

Ingredients!

PECOS

NPI

CAQH

Time

PECOS: *Provider Enrollment, Chain, and Ownership System*

- **Online** access to your information *as* Medicare has it in their system

- Complete applications/make changes to your information through PECOS
  - Online applications processing times are shorter than for paper applications
  - Allows for electronic signatures by the provider and the authorized/delegated official

- Required for Meaningful Use

NPI *National Provider Identifier*

NPI
National Provider Identifier

- Standard, unique identifier for health care providers
- Mandated by HIPAA
- Assigned by the National Plan and Provider Enumeration System (NPPES)
  https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart
- Required by most major payers for pre-authorizations, referrals, care notifications, etc.
- Replacing use of the Tax ID #

NPI *National Provider Identifier*

- Information needed to submit online application for NPI
  - Individuals
    - Provider Name
    - Social Security Number
    - Date of Birth
    - Place of Birth – State/Province and Country
    - Gender
    - Mailing address
    - Practice location – address and phone number
    - Taxonomy (pick list – and a number appears)
    - State License information
    - Contact person name, phone number and email

NPI *National Provider Identifier*

– Groups

- Organization name – legal and d/b/a (doing business as)
- Employer Identification Number/Tax Identification Number
- Name and phone number of Authorized Official for the Organization
- Organization mailing address
- Practice location – address and phone number
- Taxonomy
- Contact person name, phone number and email

CAQH: *Council for Affordable Quality Healthcare*

simplifying healthcare administration

CAQH

- Universal Provider Datasource
  - Individuals only
- Used by most major health plans for centralized credentialing
- Participation is voluntary
- No cost to providers
- Register through health plan to obtain login info
- Providers must attest data regularly (every 120 days)

CAQH: *Council for Affordable Quality Healthcare*

How do I apply?

1. Contact payer credentialing department
   - United Healthcare is a great one to get this started!
2. After receiving your CAQH Provider ID, go to www.upd.caqh.org/oas
3. Authenticate your Provider ID and personal information
4. Select a Username and Password
5. Enter your data into the CAQH system
   - Be prepared - average completion time for initial entry of data is 2-4 hours
   - Its worth it!

CAQH

What information do I need to have available to complete CAQH online?

- **Basic Personal Information**
- **Education and Training**
  - Name, address, phone and fax numbers of schools/facilities
  - *Current* contact information to include full name, phone, fax and email of person/office who can verify your affiliation – ***primary source verification***
    - Medical/Professional school, Graduate school, Internship and Residencies
    - Fellowships and preceptorships
    - Teaching appointments
- **Specialties and Board Certification**
  - Name of issuing board
  - Certification and expiration dates
  - Admissibility/eligibility information if not currently board certified
- **Practice Location Information**
  - Practice name, type, address and contact information
  - Billing, office manager and credentialing contact
    - Name, phone, fax and email for all of these contacts
  - Services, certifications, limitations and hours of operation
  - Partners and covering colleagues

CAQH

What information do I need to have available to complete CAQH online? (cont)

- **Hospital Affiliation Information – including current, past and pending affiliations**
  - Date of application submission/approval
  - Staff status
  - Name, address, phone, fax and email of contact (usually Medical Staff Office personnel)
- **Malpractice Insurance Information – including current and all past carriers**
  - Carrier name, address and phone number
  - Policy information
    - Policy number, Type of coverage – claims made vs occurrence
    - Per claim and aggregate limits; Tail/nose coverage information
- **Work History - include all professional work history from end of formal training**
  - Employer name, Positions held, Dates employed
  - Address, phone, fax, email and contact name
- **Professional Peer References – from your same professional discipline**
  - Name, address, phone, fax and email
  - Provider specialty
  - Dates of association
  - Primary Source Verification

CAQH

What Information Do You Need to Complete CAQH Online?

Disclosure and Malpractice History

- Disclosures-Questions commonly covered
  - Relinquishment/resignation of hospital privileges
  - Voluntary or involuntary
  - Relinquishment/revocation of board certification
    - Voluntary or involuntary
  - Adverse actions or investigations
  - Felony or misdemeanor charges
  - Medical conditions affecting your ability to practice

Malpractice claims (past or pending)

- Date of occurrence, Date claim filed
- Description of allegations
- Method of resolution
- Amount of award or settlement
- Is the case included in the National Practitioner Data Bank (NPDB)?
- Primary or Co-defendant
- Number of other co-defendants
- Description of:
  - Your involvement in the case
  - Alleged injury
  - Malpractice carrier involved
  - Include address, phone and fax numbers
  - Policy number

The Credentialing Players

The Credentialing Process

Mixing!

Completing Initial Applications - Medicaid

- **Requirements and applications vary from state to state**
- Generally group application required, group identifier assigned on completion of credentialing process
- Individual application is made and individual identifier is assigned. The individual enrollment record is tied to the group record for payment purposes
- Payments are generally made to groups and not to individuals.

Completing Medicare Applications

Helpful Hints for Efficient and Timely Processing:

- Complete the *correct* application(s) – Applications based on entity type, provider specialty, etc.
- Complete *all* required sections!
- Ensure that your legal business name matches the name on your tax documents **E X A C T L Y!**

  E X A C T L Y!
- Ensure that the correct person (authorized or delegated official) signs the application
- Enter all applicable dates correctly!
- Return the completed application, with original signatures, and supporting documentation to the designated MAC
- Keep a copy of the completed enrollment package for your records!

Completing Initial Applications – Medicare

855A - Application for enrollment of INSTITUTIONAL Providers – including but not limited to Community Mental Health Center, Critical Access Hospital, Home Health Agency, Hospice, Hospital, Rural Health Clinic

- **Billing for Medicare Part A medical services**
- In addition, use this application for these same groups when:
  - submitting **changes** to your current Medicare Part A enrollment information
  - **reactivating** your Medicare billing privileges
  - **voluntarily terminating** your Medicare enrollment
  - have a **change in ownership**
  - **Revalidating** your enrollment information per request of the MAC

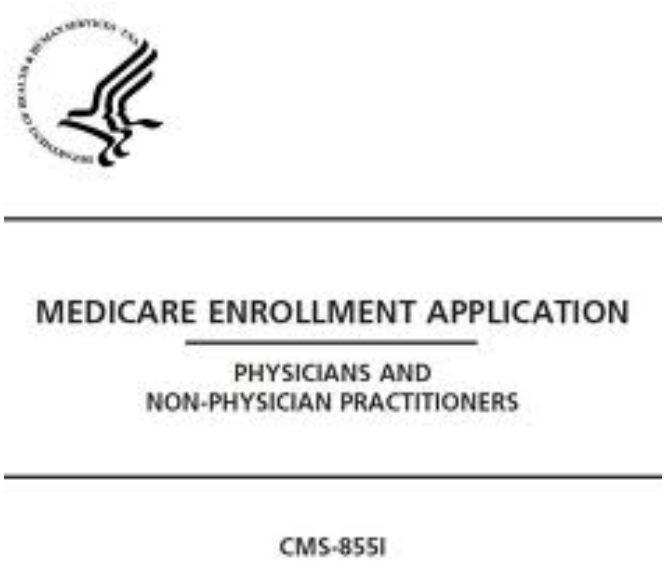
Completing Initial Applications – Medicare

855B

Application for enrollment of Clinics, Group Practices, Mammography Centers, Mass Immunization (Roster Biller only)

- **Billing for Medicare Part B services**
- Use this application for these same groups when:
  - submitting **changes, reactivating , voluntarily terminating, revalidating**

Completing Initial Applications – Medicare


MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND
NON-PHYSICIAN PRACTITIONERS

CMS-855I

855I

Application for enrollment of Physician and Non-Physician Practitioners - individual practitioner who provides services in a private or group setting

Including but not limited to Physician, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Mass Immunization Roster Biller, Nurse Practitioner, Physician Assistant, Sole Owner/Sole Proprietor

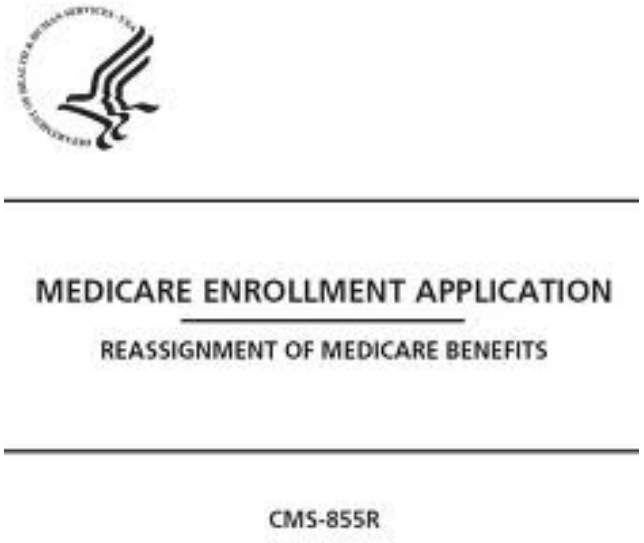
In addition, use this application for these same providers when:

- submitting **changes, reactivating , voluntarily terminating, revalidating**

Completing Initial Applications – Medicare

855R

Application for the Reassignment of Medicare Benefits - used by Physician and Non-Physician practitioners to reassign their benefits (right to bill)


MEDICARE ENROLLMENT APPLICATION

REASSIGNMENT OF MEDICARE BENEFITS

CMS-855R

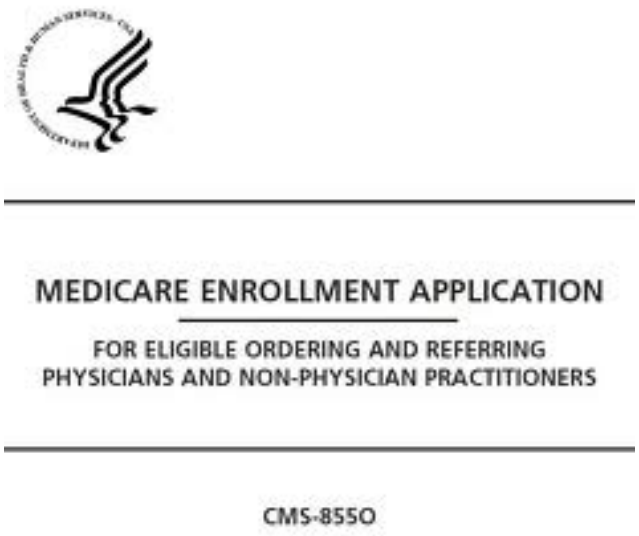
This application does **NOT** apply to:

- Individual providers who are sole owner of their corporation, LLC, etc.
- Physician Assistants (report employment arrangements using the 855I)

Use this application for these same providers when:

- **Terminating** a reassignment
- Submitting a **change reassignment** information

Completing Initial Applications – Medicare


MEDICARE ENROLLMENT APPLICATION

FOR ELIGIBLE ORDERING AND REFERRING PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

CMS-855O

855O

Registration for eligible Ordering and Referring Physicians and Non-Physician Practitioners - used by Physician and Non-Physician practitioners to register for the sole purpose of ordering and referring items or services for Medicare beneficiaries

These providers do NOT and will NOT send claims to the MAC for services they furnish – include but not limited to – dentists, residents, interns and fellows in an approved medical residency program and providers employed by Dept of Veterans Affairs, Public Health Services, Dept of Defense/Tricare & Indian Health Services

Use this application for these same providers when:

- **Voluntarily withdrawing registration** to solely order and refer
- Submitting a **change of information** as an ordering and referring provider

Completing Initial Applications – Medicare

588 - Authorization Agreement for Electronic Funds Transfer E.F.T.

REQUIRED for all new providers/groups receiving payment (non-reassigned providers)

Supporting documentation to submit with 588:

- a voided check, or
- confirmation of account information on bank letterhead
  - needs to include the name on the account
  - routing number
  - account number and type
  - bank officer's name and signature

- Use this agreement for these same providers when Revising current authorization information
- **Ensure that the legal business name for the group is shown in Part II and that it matches the name on the check or bank letter**
- Ensure that the correct person (authorized or delegated official) signs the application
- Return the completed application, with original signatures, and supporting documentation to the designated MAC

Keep a copy of the completed agreement for your records


ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I - REASON FOR SUBMISSION

PART II - PROVIDER OR SUPPLIER INFORMATION

PART III - DEPOSITORY INFORMATION (Financial Institution)

PART IV - CONTACT PERSON

Completing Initial Applications – Medicare

460 - Medicare Participating Physician or Supplier Agreement

Used by providers/groups to enter into agreement with the Medicare program to accept assignment of Medicare Part B payment.

Accepting assignment (in this agreement) **means requesting direct Part B payment from Medicare.** The approved charge, as determined by the MAC shall be the full charge for the service covered under Part B. **Provider/Participant shall not collect from the beneficiary or other person for covered services more than the applicable deductible and coinsurance.**

This agreement should be filed with the initial application. Individual providers follow the participation status of the group they are reassigned under

- Participation status can be changed during "open enrollment" generally mid-November through December 31
- Contact the MAC to learn where to send the agreement and exact dates for the open enrollment period

A provider is considered non-participating unless they submit this agreement form

Return the completed application, with original signatures to the designated MAC

Keep a copy of the completed agreement for your records

Medicare – Online Application Process

Many enrollment applications and functions can be accomplished online via the PECOS website

The information required to complete the online application is the same as for a paper application with the addition of the email address for the authorized/delegated official if the electronic signature route is chosen

Individual providers can utilize their NPI User ID and Password to login to PECOS. Groups/Practices need to set up an account for access to the business information by an authorized official.

Once logged in, **Established Providers** are able to:

- View and print current Medicare information
- Initiate changes to existing Medicare information

New Providers can:

- Enroll in Medicare for the first time
- Save and continue an incomplete Medicare application

PECOS Application **Advantages**:

- The opportunity to upload supporting documents
- Options for electronic or paper signatures, including for authorized/delegated officials performing reassignment duties
- MACs processing times for online applications are shorter than for paper applications.
- The electronic signature method offers more flexibility, especially for providers and authorized/delegated officials in different locations.

Completing Initial Applications – Commercial Payers

Aetna

Credentialing required for Physicians and Health Care Professionals (i.e. Nurse Practitioners, Physician Assistants) not employed by a participating Physician, Physician group or facility

Health Care Professionals employed by a participating physician, physician group or facility will be rostered only.

Adding the provider to the roster provides demographic information for the Aetna database and allows the provider to be listed in Aetna directories

Process:

Fill out the online form: http://www.aetna.com/healthcare-professionals/join-aetna-network/join-provider-network.html

Be prepared with:

- personal information
- professional licensing information
- group information, including TIN, practice location and billing address

Follow up to ensure that Aetna has received your information and has begun the appropriate processes!

Behavioral Health Providers

https://www.aetna.com/about-aetna-insurance/contact-us/forms/doctors_hospitals/bh_form.html

Completing Initial Applications – Commercial Payers

Blue Cross and Blue Shield

Access Anthem's New Provider Application and information at: (check your local BCBS Carrier)
http://www.anthem.com/forms/co/NewProviderApplication.html

Credentialing required for Physicians, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists and Licensed Professional Counselors

Ancillary Providers include Acupuncture, Audiology, Durable Medical Equipment, Home IV Therapy, Occupational Therapy, Physical Therapy & Registered Dietician (not an inclusive list)

- check If your ancillary specialty network is open or closed
- obtain application instructions, guidelines and expectations pertinent to your specialty

Nurse Practitioners and Physician Assistants should complete the Non-Credentialed Provider form

Be prepared with: personal information, professional licensing information, group information, including TIN, practice location and billing address. Submit supporting documentation as requested, i.e. W9

Behavioral Health Providers: http://www.anthem.com/home-providers.html

Follow up to ensure that Anthem has received your information and has begun the appropriate processes!

Completing Initial Applications – Commercial Payers

Cigna

To join the Cigna medical network, call 1.800.882.4462 and speak with a representative. The representative will assist you and send the necessary information to initiate the credentialing and application process.

http://www.cigna.com/healthcare-professionals/join-our-network

Be prepared with:

- Personal information
- Professional licensing information
- Group information, including TIN, practice location and billing address

Submit supporting documentation as requested, i.e. current medical license, DEA, malpractice insurance and claims history

Behavioral Health Providers

http://apps.cignabehavioral.com/web/basicsite/provider/customerService/individualPractitioners.jsp

Follow up to ensure that Cigna has received your information and has begun the appropriate processes!

Completing Initial Applications – Commercial Payers

Humana

To begin the contracting/credentialing process, go to:
https://www.humana.com/provider/medical-providers/network/learn-more/

Complete the online form

Be prepared with:

- personal information
- professional licensing information
- group information, including TIN, practice location and billing address

Behavioral Health Providers

http://www.lifesynch.com/providers/join_our_network/

Follow up to ensure that Humana has received your information and has begun the appropriate processes!

Completing Initial Applications – Commercial Payers

United Healthcare - Tricare

Providers can initiate credentialing for both United Healthcare by contacting their National Credentialing Center at 877.842.3210 or visiting the website at https://www.unitedhealthcareonline.com/b2c/CmaAction.do?txnType=SignUpNow&forwardToken=SignUpNow

When speaking with the credentialing representative, be sure to ask about Tricare credentialing if interested in joining the Tricare network.

Be prepared with:

- personal information
- professional licensing information
- group information, including TIN, practice location and billing address

Behavioral Health Providers

https://www.ubhonline.com/cred/credIndex.html

Follow up to ensure that United Healthcare has received your information (if submitted online) and has begun the appropriate processes whether you apply online or via phone!

Best Practices

Best Practices for Credentialing Completion

Review EVERY application before it goes "out the door". Double check all the names and numbers are correct and that all information is filled in. Are all the required supporting documents attached?

- "Clean"(complete) applications get processed faster and enable your provider to see patients sooner, resulting in increased revenue and cash flow quicker!

After submission of any credentialing application/data sheet:

- follow up with payer to confirm receipt of application in 7 – 10 business days
- obtain tracking IDs for Medicare applications
- once receipt is verified – continue to **check status of your application approximately every 3 weeks through to completion** of credentialing

This helps address any processing delays due to:

- need for additional documentation, clarifications on information
- inability to contact any peer references or verification sources

Best Practices for Credentialing Completion

How to follow up

Interactive Voice Response System (IVR) vs Call Centers

- Some follow up can be done through an IVR - careful here – it's a machine and only as good as the information put into it.
- Use it to verify credentialing has started… but from there, speak to a "real" person so you can ask questions. You are more likely to pick up on something that isn't "right" that way.

Out of state Providers:

- When a provider joins your group from out of state, send up the CAUTION flags! **These providers require extra follow up!**
- Payers may look at this file and say "Wow, he/she is already credentialed with us." Then they stop the credentialing process, without seeing that the new request is for a different practice state
- Problem is, they are credentialed in the state they are leaving and you need them credentialed in the state where you are. You need to know this and have them reinstate the process ASAP!
- Regular, diligent follow up will help prevent long delays and lost time

Best Practices for Credentialing Completion

- Review all approval letters received from payers and verify that the information in the letter is correct. **Mistakes made in the data entry or credentialing process can be costly**
- If your DO is entered into a payer system as an OD, claims are going to be denied as the provider isn't "qualified" to provide the billed service.
- While not deadly, you now need to contact the payer, have the mistake corrected and then claims need to be resubmitted. This is time consuming.
- Catch these mistakes before claims are submitted and denied!

"Closed Panels" – another hurdle to providers!

- The payers say they have enough of your provider type in your geographic location
- Submit your application along with supporting documents, letter of interest stating why YOU are needed (what service/s do you provide that are unique and needed by that payer's members?)
- Plead your case with the payer, you might be surprised at the outcome! Payers can't know what is special about you vs the other 15 providers already in network with your specialty, in your area, unless you tell them. Don't be afraid to brag a bit!

"Not Qualified, don't meet the requirements for credentialing" – says who? "NO is a request for information"

- This is one more place where you may need to advocate for yourself. If your credentialing is denied for lack of board certification or other "required" certification, ask if there is something else that could substitute (additional training, on the job experience, etc)
- Contact the medical director via phone, letter, fax or email. Let him/her know what you have done that covers the requirement. Explain any extenuating circumstances that prevented you from finishing that certification residency, etc.
- With the right additional information, a personal interview or endorsement from an impartial entity, payers have been known to approve providers on a case by case basis

The #1 BEST PRACTICE…….

FOLLOW UP, FOLLOW UP, FOLLOW UP!!!!!

And

MORE FOLLOW UP!!

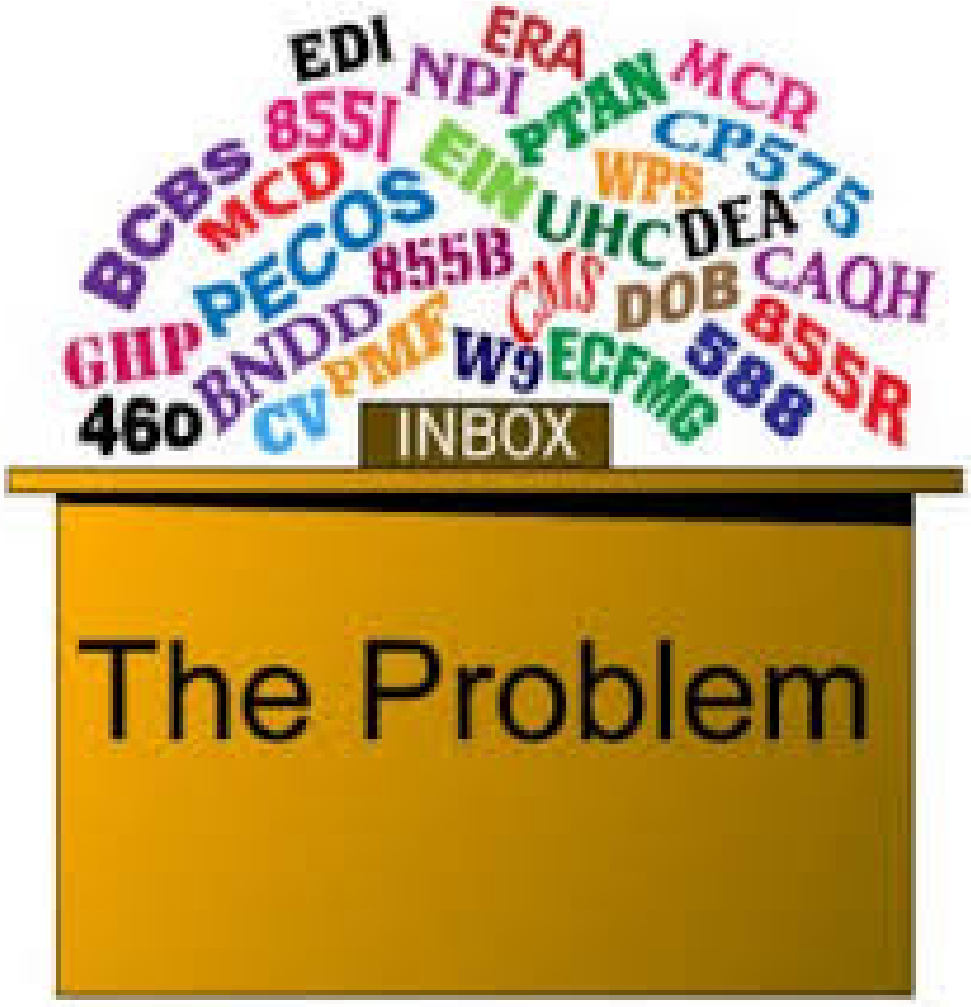
Red Flags: Credentialing Complexities

- Slow payments from some payer sources
- Incorrect payments based on contracts
- Trouble with referrals and precertification
- Incorrect co-pay amounts applied
- Sporadic claim denials on standard CPT codes
- Out of state issues

Be aware: Medicare Provider Revalidation

- **5-year** effort to re-validate (re-credential) ALL Medicare Providers
  - Ensure all provider/group information is correct and current
  - projected end in 2015
  - Providers/groups submitting initial applications will not need to revalidate this time around
- Notification letters are sent to providers
- 60 days from postmark to complete and return necessary application
- PTAN's (Provider Transaction Access Number) will be deactivated if applications are not **received** within 60 days
  - Not processed but received by MAC
  - **If your PTAN is deactivated, this can be fixed…contact your MAC!**

Case Studies



Case Study #1

Scenario:

- The provider failed to read correspondence sent to them by Medicare while in the process of updating information for the practice. This practice manager was dealing with a family emergency and no one in the practice followed up with the corrected forms within the required time frame.
- Medicare revoked the practice's billing privileges per CMS regulations. Again no one saw or read the revocation notice.
- The provider continued seeing Medicare patients and was unable to collect any funds from Medicare or the patients. (What a nightmare for everyone involved!)

Solution:

- This practice needed to complete all new enrollment forms and send in a corrective action plan in order to have Medicare review and reconsider the practice's billing status.
- With consistent and timely follow up, billing privileges were reinstated and Medicare accepted newly submitted claims for payment consideration.

Moral of the Story:

All of this could have been avoided by reading incoming correspondence and submission of the additional documentation as requested. Continued follow up on the change application and the subsequently requested information would have brought the simple updates that were needed to a successful conclusion.

Case Study #2

Scenario:

- A provider was moving from Ohio to Colorado
- Credentialing was initiated via phone with United Healthcare approximately 2 months prior to the anticipated start date for the provider
- 6 weeks later, office personnel called United to check the credentialing status and were told that there was no credentialing in process (it was dropped internally) as the provider was already credentialed
- Yes, this provider is credentialed, but in Ohio not in Colorado
- The provider is now scheduled to begin work in 2 weeks and credentialing will NOT be completed in time for the provider to see United Healthcare patients in network

Solution:

- You have to follow up every 2 weeks at a minimum to ensure that credentialing is not dropped!
- United will now have to restart the credentialing process and your provider will be out of network until the credentialing and contracting have been completed – at least 60 days!

Moral of the Story:

- Patients will not want to schedule with this provider, having to utilize out of network benefits resulting in higher out of pocket costs.
- This costs $$$$ for everyone from the patient to the provider and group!!

Credentialing is an ONGOING Processes

Stay Active, Stay Engaged in this process!

- CAQH requires attestation every 120 days for credentialing
- Make sure new providers are credentialed and affiliated with health plans
- Make sure re-credentialing requirements are met

Physician Designation Programs

- Evaluate provider data based on specialty, quality, cost and efficiency
  - United: Premium Physician Designation Program
  - Cigna: Care Designation "tree of life"
  - Aetna: Aexcel Program

- Providers incorrectly loaded, could receive a "negative" designation!
  - Request your data, review it and fight it!
  - Patients that see physicians who are not considered "preferred" may incur higher out of pocket costs

Questions & Discussion

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