



# **Provider Reference Manual**

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*Proud members of the (OMA) Office Managers Association*

## Introduction

### Who is 4-Most?

- A regional network of physicians, dentists, ancillary providers and hospitals that provide claims payors with contracted discounts fees through PPO agreements and in turn generate additional patient volume for providers.
- Contracted network with over 16,000 group health provider locations and over 450 dental locations within West Virginia and bordering states.
- Contracted network to Third Party Administrators (TPA's), Insurance Companies and self funded employer groups
- The network consists of providers who participate in one or more of the following programs; group health, workers compensation, discount choice medical plans and dental plans.

## Operational Guidelines

### Billing Procedures:

Claim forms must be completed in their entirety. The accuracy in which the claim form is completed directly affects the efficiency in which the claim is processed for payment. Line items left blank can result in the claim being returned to the provider, therefore, delaying payment.

- All claims should be submitted to the address listed on the individual member's identification card.
- Claims submitted without the following specific items will greatly delay payment as the claim may be returned to the provider:
  - Payor or Third Party Administrator Name
  - Employer Name
  - Group Name
  - Group Number (if present on ID Card)
- At the time of service, PLEASE DO NOT COLLECT, any amounts other than the patients co-payments or co-insurance.
- It is required that all claims be submitted with accurate and current billing codes. Group Health/Work Comp - CPT 4, HCPCs as well as ICD coding. Dental – CDT codes. For each procedure listed on the claim, a diagnosis code must support the services to ensure expeditious and accurate processing of the claim.
- Providers should bill their normal BILLED CHARGES. The PPO contracted fee schedule will be applied at the point of claim adjudication and will be reflected on the final EOB or EOP document the provider receives from the plan/payor.
- Members may not be billed for any amounts other than co-payments, co-insurance and deductibles, until after the provider receives an explanation of benefits (EOB) or explanation of payment (EOP) from the payor.

### Referrals:

- A written referral or authorization is generally not necessary when referring to another provider in the 4 MOST Network(s). The benefits, however, may differ if not referred to an in network provider. Please refer to our Provider directory or our website; [www.4MOST.com](http://www.4MOST.com), for a complete listing of the participating providers in the network.
- Please remember for emergency coverage to supply patients with a provider who is in the 4MOST network.

## **Pre-Admission Certification and Utilization Review:**

- 4 MOST does not perform Utilization Review Services. If pre-admission or pre-certification is required by the patient's benefit plan, a telephone number will be denoted on the ID Card as to where to call to obtain this authorization. It is recommended that the office refer to the individual member identification card for the appropriate telephone number to contact for pre-admission certification and utilization review services.
- Always contact the telephone number listed on the member identification card to obtain specific plan requirements and benefit information.

## **Definitions**

### **Co-Insurance:**

Co-Insurance is the provision of each Benefit Plan by which the participant shares in the cost of the various covered services on a percentage or flat rate basis. These amounts vary by benefit plan. The benefit plan will pay their percentage of the maximum allowable or flat rate amount set forth in the compensation fee schedule, the participant will be responsible for the remaining amount up to the stated maximum allowable, (i.e. benefit plan pays 80% of the fee schedule amount, the participant pays 20%). Because appropriate discounts are not applied until the claim is adjudicated, do not collect the co-insurance amount until the final explanation of benefit (EOB) has been received and reviewed for the correct remittance amount. No amounts, other than co-payments and/or deductibles should be collected at the point of service.

### **Co-Payments:**

Co-payments are generally fixed amounts rather than a percentage and are due at the time the services are rendered. Co-payment amounts are most often found on the participants ID Card. These amounts will vary by benefit plan. It is recommended that a copy of each member's card be made at the time of each visit.

### **Deductibles:**

This is the amount of covered charges that the insured person must pay each calendar year before the policy pays the benefits payable.

### **Allowed Amount:**

The allowed amount is the contracted amount allowed after the PPO discount is subtracted from the total billed amount. The difference between the billed amount and the allowed amount must be adjusted and not billed to the patient or the plan.

**Third Party Administrator (TPA):**

An organization hired by certain employers to facilitate benefit plan determinations and processing of benefit plan claims. TPA's do not assume the financial risk or liability of making such benefit plan payments, only their remittance of benefits upon final approval of the employer. TPA's & employers partner with managed care organizations, like PPO's, to obtain provider discounts and to assist in controlling healthcare quality and total plan cost.

**Insurance Carrier:**

An organization that sells insurance contracts to certain employers and individual plan holders, whereby the insurance carrier assumes financial risk and liability of making benefit plan determinations, processing of such benefit plan claims and the remittance of benefit plan payments. The individual and employer purchasing such contracts have no approval or denial abilities of actual benefit payments or the decision affecting such payments. These are governed based on the plan policy document that was purchased by the individual or employer group. Insurance carriers partner with managed care organizations, like PPO's to obtain provider discounts and to assist in controlling healthcare quality and total plan cost. Insurance carriers can also act as claims administrators only, when they act in this fashion they are referred to as an ASO account or Administrative Services Only.

**Explanation of Benefits (EOB)/ Explanation of Payment (EOP):**

This is the document that is produced each time services are submitted to a claims administrator. The statement will identify the participant, date of services, procedure (s) performed, amount charged, allowable amount per the PPO contract, percentage of coverage, applicable co-payments / co-insurance and the deductibles applied and patient financial responsibility. Please note you may not collect the difference between your charged amount and the maximum allowable from the participant. This is the contracted discount based on the PPO fee schedule applied to the services provided.

**Coordination of Benefits:**

When a participant has two benefit plans covering services provided, benefits are coordinated to potentially pay 100% of covered charges. You or your staff should contact the claims administrator directly in order to verify the rules used to determine the order of benefit payment. Please note – if the 4 MOST contracted payor is not the primary payor, then reimbursement to the participating providers from 4 MOST contracted payors shall not exceed the amount allowed by the 4 MOST network fee schedule.

## **Credentialing**

The credentialing process will verify the professional qualifications of all participating providers that provide services to our members. The initial credentialing process includes:

- Provider application to be completed in its entirety
- Copies of (and verification of)
  - Licensure
  - DEA registration
  - Current, adequate professional liability insurance policy (face sheet from liability policy showing expiration dates and limits)
  - Copy of Board certification certificate or specialty certificate for dentists (if not board certified, copies of residency certificates and medical school diploma)
  - Hospital privileges (as applicable by Degree)
- Copy of W-9 for verification of each tax identification number used
- Work History
- National Practitioner Data Bank Report

As documents from any of these areas expire, it is imperative that we receive updated information as quickly as possible.

## **Recredentialing**

4MOST recredentials all practitioners in the network every three years. The recredentialing process includes verification of:

- Updated provider application
- Licensure
- Valid DEA certification
- Board certification status
- Current, adequate professional liability insurance policy (face sheet from liability policy showing expiration dates and limits)
- Professional liability claims history
- Current hospital privileges
- National Practitioner Data Bank Report

## Standards for Participation

To become a 4MOST provider, 4 MOST must first assess the need in the requested geographic location, if the assessment shows a need, the provider will be sent a credentialing application and participation agreement. The provider must be credentialed and meet the standards of participation as developed by 4 MOST. A provider must maintain the following credentials, standards or processes:

- Drug Enforcement Administration (DEA) registration number (if the scope of practice warrants)
- Professional Liability Coverage – minimum amount of \$1 million per occurrence, \$3 million aggregate or an amount mutually agreed by 4MOST.
- Admitting privileges at a participating 4MOST hospital (as applicable to specialty)
- Board Certified or Board Eligible, if not Board certified or Board eligible, the physician must demonstrate appropriate training for specialty listed
- Proof of state license
- Sufficient information concerning any malpractice actions pending or resolved
- Completed confidential questionnaire
- Signed attestation document
- Signed and dated provider agreement
- Continued compliance with OSHA and CDC requirements
- Adhere to standard industry practice after hours coverage for patients, mechanism for handling emergency and urgent care treatment
- Agreement to accept reimbursement based on 4MOST fee schedule.

## Important Numbers and Contact Information

### 4 MOST

- Toll Free Number: 888-258-6477
- Local: 304-720-6801
- Fax: 304-720-6805
- Website: [www.4most.com](http://www.4most.com)

To locate information on providers in the 4 MOST network: [www.4most.com](http://www.4most.com) or call 888-258-6477.

To locate information on clients using the 4 MOST programs (s): 888-258-6477.

To inquire about a status of a submitted claim: Please refer to telephone number on member identification card.

Benefits and eligibility: Please refer to telephone number on member identification card.

Pre-authorization: Please refer to telephone number on member identification card.