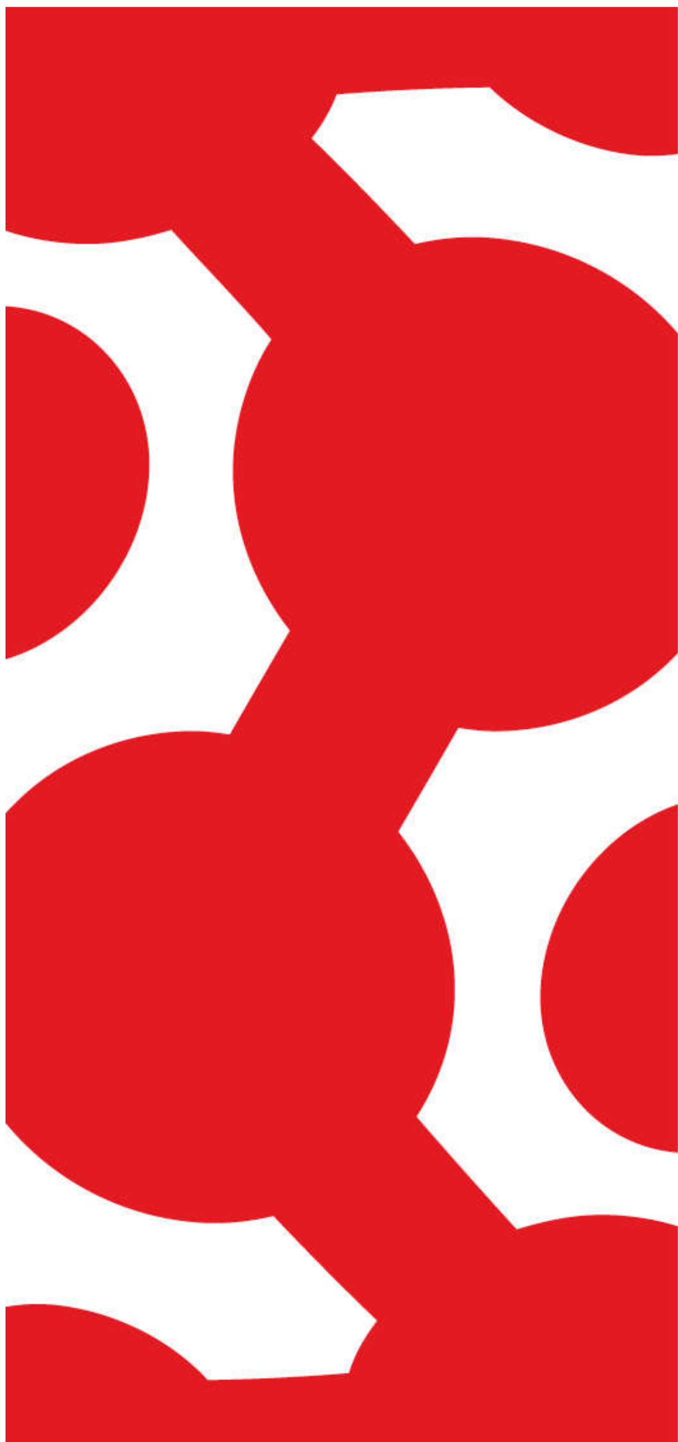


REBUILDING HEALTH CARE: ONE BRICK AT A TIME

IHCC 2021

CONTRACTING & OPERATIONS TEAM

← Barb Morris
Operations Manager

← Codi Tomisser
Operations Team Lead

Megan Smith →
Payor Relations

Gina Stewart →
Auditing & Quality

←Michelle Ridlon
Provider Relations

← Leona Campbell
Data Support

Amy Campbell →
Contracting Specialist

Allyssa Wood →
Data Support

NEW & NOTEWORTHY

- Cigna Update
- HR 133 – No Surprises Act
- Fee Schedule Updates
- Senate Bill #1093 regarding Physician Assistants
- Electronic Recredentialing Applications

My Contract Says What?

Patient Billing

- Providers can bill the member for Coinsurance, Copayments & Deductible only

- Providers are obligated to bill insurance

Charge Master

Facilities are required to submit their Charge Masters to IPN annually and/or upon an increase.

Notice of Changes

Physicians and Facilities are required to notify IPN within thirty (30) days of any changes being made, including name, phone number, address, TIN and personnel changes.

Provider Information form (PIF)

When to Use:

- New Applications
- Additional Locations
- Change Information
- Hospital Based Providers
- Terminations

Remember:

- Effective Date
- SSN & Military Status
- Directory (Y or N)
- Summary of Changes/Notes

NOTE: Please ensure data on the PIF matches the data provided on the Initial Credentialing Application. This will help eliminate additional outreach and further delay in the credentialing process.

Provider Information

Return to: PO Box 5406, Boise ID 83705
Fax to: 208-433-4605
Email to: ipn@ipnmd.com
Website: www.ipnmd.com

The information provided on this form is required for claims processing and directory information.
Please use additional forms for additional practice locations or practitioners/organizations.

EFFECTIVE DATE OF CHANGE: PLEASE NOTE: IPN IS UNABLE TO GUARANTEE A RETROACTIVE PAYOR IMPLEMENTATION DATE

☐ Add Provider to Group ☐ Change Information ☐ Add a New Location ☐ Add Provider to Hospital Based Location[1]

☐ Termination **Reason:**

Provider Information (name as shown on CMS 1500 Field 31 OR UB box 1)

☐ Individual Practitioner ☐ Organizational Provider | Name:

NPI: | SSN (TRICARE required): | Degree: | DOB: | ☐ Male ☐ Female

License No.: | DEA No.: | Is Practitioner Currently Active Military or Reserve? ☐ Yes ☐ No

Practice Location Information (for patient visits and directory listing)

Practice Name (as it should appear in directories):

Physical Address (Address, City, State, Zip): | County:

Practitioner Specialty (as practicing at this location):

Location to appear in a directory for this practitioner? ☐ Yes ☐ No

Location NPI: | Tax ID No. (Attach IRS W9):

Practice Phone (where patients call to make an appointment): | Practice Fax:

☐ Clinic Hours of Operation (complete specific hours below) (*ex. 8-5 – do not include midday closures*) ☐ Hospital Based Location[1] (hours are 24/7)

Mon | Tues | Wed | Thurs | Fri | Sat | Sun

Practice Contact Name: | Practice Contact Email:

Billing Information (as billed on CMS 1500 Field 33 OR UB box 2)

Billing Name (as it should appear on claims):

Billing Address (Address, City, State, Zip): | County:

Billing Contact Name: | Billing Contact Email:

Billing Contact Phone: | Billing Contact Fax:

Summary of Changes/Notes

Form completed by (Name): | Email: | Phone:

[1]**Hospital-Based Provider:** An individual participating practitioner who provides health care services exclusively at an IPN-participating hospital. A *credentialing application is not required.*

IPN Payor List

Benefits
Join IPN
Education
Provider Resources
Newsletters
Payor List
Provider Tools
Forms
Credentialing

Payor List

About the IPN Payor List

This list provides details about each payor and TPA that have groups accessing the IPN network. This information is useful in helping providers identify their patient's insurance company, where claims should be submitted, what product type(s) utilize the IPN network, if the insurance company has reciprocity and if there are any exclusions for provider type(s) and/or service area(s).

IPN Payor List (July)

Important to Know

Patient ID Cards

The provider should always obtain a copy of the patient's ID card and contact the patient's insurance company for precertification, benefits, eligibility and claim information. The ID card and insurance company have the most accurate and complete information and should always be the first point of reference.

Reciprocity

Some payors and TPAs have members based in other states; therefore, the IPN logo may not appear on their ID card. If the payor or TPA is identified as Reciprocity 'Yes' and the ID card identifies one of the products listed on the payor list then the IPN network discounts would apply. If the payor or TPA shows Reciprocity 'No' and/or the ID card does not identify one of the products listed on the payor list then the IPN Network discounts would not apply.

Will IPN be used?

For Cigna and Moda:

Verify product type is listed & Geographic Exclusion Area

Cigna HealthCare

Claims Mailing Address: Varies-See Member ID Card
Send to: Payor

Customer Service: (800) 244-6224
Website Address: www.cigna.com

EDI Payor ID: 62308

Fee Schedule: B
Reciprocity: Yes

Geographic Exclusion: Asotin & Baker County
Provider Exclusions: None

Affiliated with:
Products: PPO & EPO & POS   Open Access   Open Access Plus   Starbridge

For All Other Payors:

Verify group name or number & Geographic Exclusion Area

Coastal Administrative Services (CAS)

Claims Mailing Address: PMB 404, 15560 N Frank Lloyd Wright
Scottsdale AZ 85255
Send to: Payor

Customer Service: (800) 870-1831
Website Address: www.casbenefits.com

EDI Payor ID: 88057

Fee Schedule: C
Reciprocity: No

Geographic Exclusion: Asotin & Baker County
Provider Exclusions: None

Affiliated with: Zelis Network Solutions
Products: PPO

Group/Employer	Effective Date	Group Number
MOUNTAIN LAND REHABILITATION	1 /1 /2017	21512232
THERAPEUTIC ASSOCIATES	1 /1 /2018	21544527

CIGNA UPDATE:

Cigna to end contract with IPN, effective June 30, 2022

What's happening?

- Effective June 30, 2022, Cigna will end its relationship with IPN.
- Letters were mailed on June 1, 2021 to notify providers of this change.
- In order to remain participating, providers must directly **contract & credential** with:
  - Cigna – Core Medical and Behavioral Health Care
  - American Specialty Health (ASH) – Acupuncture, Chiropractic, Massage Therapy
  - eviCore – Durable Medical Equipment (DME), Home Health, Home Infusion, High Tech Radiology

Consolidated Appropriations Act (CAA), 2021 (HR 133): Deadlines

The Consolidated Appropriations Act COVID-19 relief bill signed into law on December 27, 2020 is a legislative package that includes COVID-19 related relief for physicians as well as several other provisions through the end of 2021.

- Included are the following which are effective January 1, 2022:
  - "No Surprises Act" (the Act)
  - Provider Directories
  - Patient Financial Protections

By January 1, 2022, providers and facilities must:

- Have a practice in place to ensure timely provision of directory information to a plan.
- At minimum, the provider must submit to the plan:
  - When the provider begins a network agreement with a plan with respect to certain coverage.
  - When the provider terminates an agreement.
  - Any material changes to the content of provider directory information.
  - When office email address and/or website URL change or are created.
- If a patient relies on erroneous directory information, health plans will process the claim using in-network benefits for the patient, counting toward the patient's deductible and out-of-pocket-maximums.
  - Providers are expected to treat the reimbursement as in-network and may not balance-bill the patient.
  - If a balance-bill is sent and paid by the patient, providers must refund the overpayment with interest.

https://www.ama-assn.org/system/files/2021-01/ama-summary-of-select-provisions-of-the-consolidated-appropriations-act.pdf

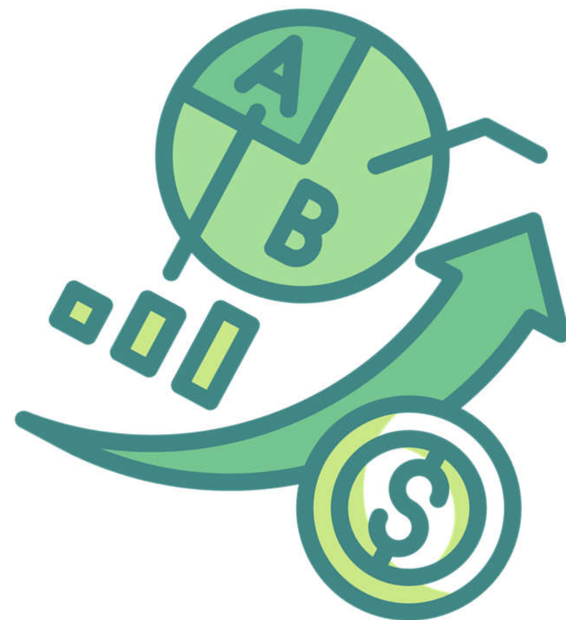
HR 133 – IPN's Compliance Plan:

To comply with HR 133 on behalf of its network Payors, IPN will:

- Increase Provider Data Verification from semi-annually to quarterly
- Remove providers from directories if no response to verifications is received
- Collect and include "digital contact information" (email address and website URLs) in the IPN Directory and on Payor reports for their directories.
    - Some payors have already requested email addresses by 1/1/2022 for their own compliance with HR133.

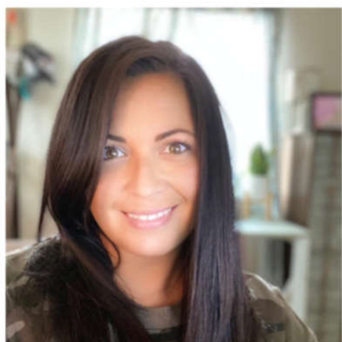
Fee Schedule Update:

- New fee schedules for providers were effective 05/01/2021
- Provider offices were sent conversion factors that can be entered onto the table on our website to populate allowables.
- Please contact your Provider Relations Representative if you need assistance using the table



CREDENTIALING

Credentialing Team

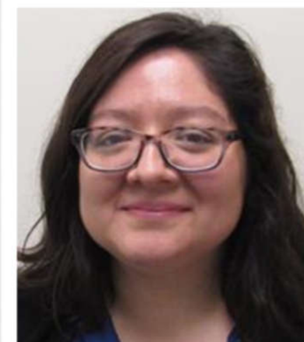


Meagan Meter
Credentialing Team Lead

Jennifer Ford
Credentialing Coordinator

Samantha Adams
Credentialing Coordinator

Frankie Campbell
Credentialing Specialist



Stefani Borja
Credentialing Specialist

CREDENTIALING ELIGIBILITY CRITERIA

- Current, unrestricted **license** to practice for each state, as applicable
  - **NEW - Senate Bill #1093:** Effective 7/1/21, PA's must have a Collaborative Practice Agreement (CPA) in Idaho at initial & recredentialing.

  https://elitepublic.bom.idaho.gov/IBOMPortal/BOM/Newsletters/2021-03%20Summer%20Newsletter.pdf

- Current **DEA** and State Board of Pharmacy certificates for each state, as applicable OR written Prescription Plan

- Proof of **professional liability** insurance for minimum of $1,000,000 per occurrence and $3,000,000 aggregate

- Current **Hospital Admitting Privileges** or **Admit Plan** for all providers eligible to be a PCP

- Completion of the Universal Provider **Credentialing Application**

IPN Credentialing Application Checklist

Idaho Practitioner Credentials
Verification Checklist

The following documentation is required when submitting a practitioner credentialing application. Please complete the information below and return this page with the application.

*Documentation
☐ Complete Provider Information form
☐ Current medical malpractice insurance face sheet
☐ Provider Authorization and Release of Information page; signed and dated
☐ Complete Attestation (action history)
☐ DEA or prescription plan (MD, DO, DPM, PA, NP, CRNA)
☐ Completed hospital admitting privileges or admit plan (MD, DO, PA, NP)
☐ Current and active license in the state of practice
☐ Attestation of Collaborative Practice Agreement for Physician Assistants (PA only)

**Please be advised that IPN will hold an application for 10 days from the date received and will resume processing if required documentation is received during this time. After 10 days, IPN will return the incomplete application and discontinue the credentialing process.*

Completed By (print name):			
Email:		Phone:	

IPN Credentialing Matrix

Credentialing Items Required Upon Initial Application Submission: **Not supplying may lead to processing delays*	Attach Copy	Documented in Application	MD/DO/DPM	APRN	PA	All other provider types
State License for each state provider is contracting to practice in.	X	X	X	X	X Note: (ID) Must have a Collaborative Practice Agreement (CPA) or be employed by a facility w/ a credentialing & priviliging program. (MT, WY, WA, OR) Must have participating supervising physician.	X
Current Malpractice Coverage **Note:** Minimum limits of liability are $1 million per occurance, $3 million aggregate. **Note:** If malpractice coverage is for a future start date which aligns with practice start date, practitioner must attest to having zero coverage.	X Note: If facesheet attached, it must be current at time of credentialing review.	X Note: If documented in application, it must be current at time of practitioner attestation.	X	X	X	X
DEA/CS or Prescribing Plan (Rx Plan) **Note:** DEA or Rx Plan is needed for each state provider is contracting to practice in. (MD, DO, DPM, APRN)	X	X	X	X	X	NA Note: PHD's are now able to prescribe in Idaho. They should provide their DEA if they hold one, however an Rx Plan is not required if they do not hold a DEA.
Areas of Application to pay special attention to: **Left incomplete may lead to processing delays*	**Attach Copy**	**Documented in Application**	**MD/DO/DPM**	**APRN**	**PA**	**All other provider types**
Graduate Education Information: - Attendance dates - University - Degree achieved	Not required to attach	X	X	X	X	X
Training: -Completion of Residency Program -Any additional training such as internships & fellowships if they apply -Attendance dates in month/year format	Not required to attach	X	X	NA	NA	NA
Board Certification if attesting to being Board Certified on application.	Not required to attach	X	X	NA	NA	NA
Specialty: Providers can only be listed in the directory with a Specialty for which education and training can be verified.	Not required to attach	X	X	NA	X	NA
Active Hospital Admitting Privileges or admit plan (MD, DO, DPM, APRN) **Note:** Please provide the following for active admit privileges; - Can they admit (yes/no) - Facility Name - Status - Appointment Dates	X If no admit privileges, please supply admit plan	X	X	X	X	NA
Work History: Must provide the most recent five years of work history in month/year format. If licensed for less than five years, provide work history from date of initial licensure to current.	X Only required to attach if additional space is needed from what the application provides.	X	X	X	X	X
Provider Attestation Questions: Provider must answer all yes/no questions. Theproviders explanation must be supplied for any "yes" answers.	X Explanation for any "yes" answers must be supplied.	X	X	X	X	X

Matrix can be found on IPNMD.com under **Provider Tools.**

RECREDENTIALING – WHAT TO EXPECT:

Time frame:

- IPN requires all practitioners to recredential at least every 36 months.

NOTE: *Recredentialing may be required sooner if requested by IPN's Credentialing Committee.*

NEW - Send Out Process:

- IPN *emails* applications four months in advance and follows up with a reminder letter every month thereafter until expiration.
- Emailed applications will be sent to the credentialing contact email on file for each provider individually with an attached PDF application.

Termination resulting from failure to recredential timely:

- IPN will term any provider who has not returned their application and required documentation prior to their expiration date.

RECREDENTIALING PROFILE HIGHLIGHTS:

Recredentialing Application

Joe Schmoe MD

Current Appointment: 10/22/2018 - 10/21/2021

Please review the information below and make a dated note for any changes.

NPI #: 1234567890 Primary Tax ID: 450000001
Other Name(s):

Specialty | Board Certification

Board Certified?	Specialty	Board
Yes	Pulmonary Disease	American Board of Internal Medicine
	Critical Care Medicine	American Board of Internal Medicine
	Internal Medicine	American Board of Internal Medicine
	Pediatrics	American Board of Pediatrics

License(s)	State	Certifications	State
M-0000	ID	DEA #:JS0000001	ID
		CS #: CS00001	ID

Hospital Affiliations	Admit Privileges	Staff Category	Start Date	End Date
St, Joe's Hospital	Yes	Active	10/11/2005	
	Yes	Active		

Malpractice Insurance Coverage Limits	Policy Dates
$1,000,000 - $3,000,000	6/1/2021 - 6/1/2022

Credentialing Contact Name:	Credentialing Contact Email:

Please provide any additional updates here:

Click here to report demographic changes for locations.

If **Joe Schmoe, MD** is no longer affiliated with this group, please provide the effective date of termination:

____

Completed by (please print): ____________________ Email address: ____________________

Return required documents and this application before the first day of *October, 2021*.

Fax to 208-433-4604 or Email to Credentialing@ipnmd.com

Questions? Call 208-333-1513 or 866-476-1076

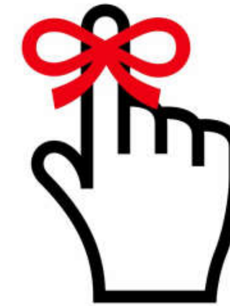
To confirm Recredentialing approval, please visit https://www.ipnmd.com/Providers/Credentialing/ after October, 2021.

Review, Update and/or Complete:

- Hospital Affiliations/Admit Plan
- Insurance
- Board Certification
- Licensure
- DEA and Controlled Substance
- Credentialing Contact Info
- **NEW:**
  - Click the circled link on the left to access a provider information form (PIF) if you have location adds/changes to report to IPN.

Recredentialing Profile Highlights

- Provider needs to answer **ALL** attestation questions; if there is a “YES” answer, an explanation from the provider must be submitted.
- Sign & date attestation and authorization for release of information



Recredentialing Application
Joe Schmoe MD

	ATTESTATION QUESTIONS – This section to be completed and signed by the Practitioner **Modification to the wording or format of these Attestation Questions will invalidate the application.**		
	Please answer **all** of the following questions “yes” or “no.” If your answer to any of the following questions is “yes,” please provide details and reasons, as specified in each question, on a separate sheet.		
1	**Since your last recredentialing cycle,** has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction been denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you been fined or received a letter of reprimand or is any such action pending or under review?	YES ☐	NO ☐
2	**Since your last recredentialing cycle,** have you been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES ☐	NO ☐
3	**Since your last recredentialing cycle,** have you been denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization been placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES ☐	NO ☐
4	**Since your last recredentialing cycle,** have you surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	YES ☐	NO ☐
5	**Since your last recredentialing cycle,** has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* been withdrawn on your request prior to the organization's final action?	YES ☐	NO ☐
6	**Since your last recredentialing cycle,** has your membership or fellowship in any local, county, state, regional, national, or international professional organization been revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES ☐	NO ☐
7	**Since your last recredentialing cycle**, have you voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?	YES ☐	NO ☐
8	**Since your last recredentialing cycle**, have you had board certification revoked?	YES ☐	NO ☐
9	**Since your last recredentialing cycle**, have you been the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES ☐	NO ☐
10	**Since your last recredentialing cycle,** have you been charged with a criminal violation (felony or misdemeanor)?	YES ☐	NO ☐
11	**Do you presently** use any illegal drugs?	YES ☐	NO ☐
12	**Do you now have, or have you had**, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation*, the privileges requested? **If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.*	YES ☐	NO ☐
13	**Are you unable to perform** any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES ☐	NO ☐
14	**Since your last recredentialing cycle**, have any professional liability claims or lawsuits been closed and/or filed against you? *If yes, please complete the attached **EXPLANATION FROM ACTION HISTORY** for each past or current claim and/or lawsuit.*	YES ☐	NO ☐
15	**Since your last recredentialing cycle**, has your professional liability insurance been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you been denied professional liability insurance?	YES ☐	NO ☐

**e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system.*

Recredentialing Application

ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize IPN and its representatives to consult with others who have information bearing on our professional competence, character, professional practice or ethical qualifications. I authorize all malpractice carriers to release coverage and/or claims history information which may exclude direct patient identification including name, address or telephone numbers to IPN and its representatives. I hereby further consent to the inspection by IPN and/or its representatives of all documents, including medical records, which may be relevant to evaluation of our professional practice, competence or moral and ethical qualifications. *IPN complies with the Health Insurance Portability and Accountability Act of 1996 “HIPAA” (as defined in 45 CFR § 160 et seq.) as well as other state and federal statutes, rules and regulations relating to confidentiality and privacy.* We understand that we have the right to review any information submitted in support of this credentialing application.

I hereby release from liability any and all individuals and organizations that provide information to IPN concerning my professional competence, practices, ethics, character or other qualifications for participating Practitioner's status and hereby consent to the release of such information. I further agree to release and hold harmless, from any liability, IPN, Inc. and any and all persons who participate within the scope of their duties at IPN in review of or any action or recommendations relating to my professional competence, practice, ethics, character or other qualifications. I understand and agree that I, as an applicant to IPN, Inc., have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I also understand that to participate as an IPN practitioner, this application must be verified and approved. I hereby certify that the information contained herein, including but not limited to any and all information added to, changed or provided in this application, is true, accurate and is completed in good faith. Any information found herein which subsequently is found to be false could result in my immediate termination from participation or employment with IPN. In the event that any information contained herein ceases to be accurate at any future time, I agree to immediately notify IPN, Inc. in accordance with executed Participating Physician Agreement, of such change.

Failure to notify IPN of changes in the information contained in this application may result in immediate termination from participation with IPN. A copy of this release is to be treated as an original and remains in effect from the date of this document until revoked.

Joe Schmoe MD Date

QUESTIONS

CONTACT US:

Customer Service/Contracting: ipn@ipnmd.com

Credentialing: credentialing@ipnmd.com

THANK YOU!