2018 MMGMA Day with the Payers Questions & Answers: PreferredOne

- Credentialing
  - Overall process, timelines – PreferredOne maintains a relationship with a third party credentialing vendor, Aperture, for specific provider specialty credentialing. Aperture's timeline is 60 days from clean application receipt for processing. If the provider specialty is one that PreferredOne credentials internally that process is about 2-3 weeks.
  - Is there a direct contact providers can work with on status of Credentialing. Our provider website is a great resource to view what practitioners are actively linked to your clinics/facilities. We also have a credentialing email address that questions can be sent to, Credentialing@PreferredOne.com.
  - When a provider is Credentialed, are they automatically enrolled in all plans that the Clinic/Group is participating in or do you have to specifically request to have the provider added to each plan? The majority of our networks are determined at the tax ID level so a practitioner add should net an add to all networks that the tax ID is enrolled in.
  - Will you adhere to a requested start date in the future if the application is received and all required material and documentation is correct? (example: application sent in on 3/1/18 with a requested start date of 4/1/18) Yes, PreferredOne is able to use the start date listed on the application as long as the application is submitted within 30 days of the effective date. This includes retroactive effective dates.
  - How do you decide on an effective date for providers after Credentialing process is completed? PreferredOne uses the effective date listed on the application or 30 days prior to receipt of the application if that effective date is greater than 30 days from application receipt.
  - Can you address the process of Credentialing and your companies view/thoughts and understanding of the stressors that clinics/groups face during the credentialing period? We believe that credentialing is an integral part of ensuring that your patients/our members are being seen by the most appropriate & qualified practitioners in the market. We also understand that the credentialing process can be cumbersome for providers to keep track of what providers are up for recredentialing, what specialties require credentialing, along with a host of other issues that arise from the day-to-day operations of a clinic. With that in mind PreferredOne tries to be as flexible as possible with regards to provider effective dates and our policy to attempt to retro effective date a practitioner within 30 days of receipt of a credentialing application when applicable.
- Claims Issues
  - Primary Care specific; Billing an office visit in addition to a Preventative visit with a modifier 25 – what is your policy on this? (example: 99213-25 with a 99392 both have separate diagnosis codes). Please see our payment policy located on our secure provider website. The policy is **P-32 Reimbursement for Evaluation and Management Office Calls when billed with a Preventative Medicine Service**.
  - Do you require a modifier when billing vaccines with a preventative visit? If so, does this reduce reimbursement on the preventative visit? (What is your policy?)AMA has

developed modifier 33 that may be used by providers to indicate a preventive service was performed. PreferredOne does not require this modifier. Our system is set up by the CPT/HCPCS code and submitted diagnosis code to adjudicate claims based on the member's benefit. Claims will be accepted with this modifier but will not be used in the adjudication process. February 2011 Newsletter.

- How far back are you in processing claims? There are reports/feedback from membership that there are payers that are still not processing January and February dates of service (in April). If you are behind, what is the reason and when do you expect to be caught up in claims processing? PreferredOne is not aware of any systematic issues delaying the payment of clean claim submissions.
- What is your standard turnaround time on appeals processing? Where are you currently in processing appeals? What is causing backups and what can providers do to help this process? Our timely filing appeal timeline has historically & is currently at a 60 day turnaround timeframe from submission of the appeal to a new remittance generating whether that be for an approval or a denial. We recommend providers use our Claims Adjustment Request Form located on our website at https://www.preferredone.com/providers/provider-forms.aspx & fill out the form completely. Please also include clear supporting documentation. Screenshots from internal provider software are not typically something that assists in the review of an appeal for timely filing so we recommend using this form along with any other supporting documents (auto denial, work comp denial, other insurance recoupment EOB, etc) to have an appeal considered for reprocessing.
- Wait times to speak with customer service representatives continue to increase. What is your current data on how long it takes a service representative to connect with a caller? Are you doing anything currently or in the future to bring wait times down? (Feedback from MMGMA membership is that online tools are not adequate and do not offer proper channels for clinics to address issues, tracking of appeals)
  We continuously look for ways to improve our self service capabilities through Preferredone.com. At this time we average 30 seconds or less to reach a Customer Service Representative.

- Products
  - Please provide a brief overview of your products
  - Do you have a Medicare product? If so, please explain No
  - Do you have Cost Sharing products? If so, please explain. We do offer a wide variety of plans including deductibles, coinsurance and copayments.
- Referrals, Prior Authorizations
  - What is your Prior Authorization process? Is there a way to do this online? PreferredOne recommends prior authorizations, both medical & pharmacy. Inpatient admission notification & medication authorizations forms can be completed online via our secured provider website.
  - What is your Referral process? Is there a way to do this online? PreferredOne highly recommends referral submissions, both medical & pharmacy, be completed online via our secure provider website as this cuts down significantly on processing times. For

example, paper form submitted pharmacy referrals can take roughly 3 days for processing while online pharmacy referrals take about 1-3 hours for processing.

- User Tools/Website
    - Do you currently have a claims estimator on your website for providers? If not, is this something that can be added in the future? We do not on the provider website but are always open to new ideas. We will take this back internally for consideration.
    - Do you currently have an online tool to track appeal status? If not, is this something that can be added in the future? We do not but are currently reviewing system setup & options in order to attempt to add this feature in the future. We do not have a set timeframe on this as it is a large systematic change. If we are able to accomplish this in we will notify providers via our quarterly provider newsletter.
    - Provider updates – how are they delivered to membership? Do you have an email list that people can sign up for? If not, how should clinics find provider updates? What is the plan for this in the future? PreferredOne notifies members of forthcoming clinic terminations to their network via our online provider directory. We also notify members who have a primary care clinic (PCC) enrollment when there is a change to their PCC, whether that change be a clinic name or address change or a caresystem affiliation change. Contracted providers are also able to update their practitioner listings for specific clinic sites via our secure provider website by clicking on the Your Clinic Provider Maintenance link in the Administration section of the site.