# Definitions

**Credentialing**- is the process of obtaining, verifying, and assessing the qualifications of practitioner to provide care or services in or for a health care organization. Credentials are documented evidence of licensure, education, training, experience, or other qualifications. This is the application process, the first step in getting into the carrier's participating system.

**Contracting**- is the process of establishing a mutual agreement between the provider and payer for reimbursement of service. Negotiation of contract language along with rates are addressed during this phase. Negotiation of rates and the contract completion will need to be performed for each payor individually.

**Privileges**- are the rights granted to a doctor by a hospital to admit patients to that particular hospital. The basic premise is that, if you need to go the hospital, your primary care physician can admit you at any hospital that has granted them privileges. Some carriers require that a provider have admitting privileges to become a participating provider.

**Hospitalist**- a dedicated in-patient physician who works exclusively in a hospital. They provider general medical care to the hospitalized patients and admits patients to the hospital on behalf of the primary care provider or other provider type.

**DEA**- Drug Enforcement Administration- is to enforce the controlled substances laws and regulations of the United States and bring to the criminal and civil justice system of the US, or any other competent jurisdiction, those organizations and principal members or organizations, involved in growing, manufacture, or distribution of controlled substances appearing in or destined for illicit traffic in the US; and to recommend and support non-enforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets.

**CAQH**- Council for Affordable Quality Healthcare- It is essentially an online database that stores provider information. Providers grant access to their information to the insurance companies. A CAQH number is required for each individual provider. A CAQH number is given to each individual provider to identify the provider within the system. The CAQH number is required by most carriers.

**PECOS**- Provider, Enrollment, Chain and Ownership System- It is a database where physicians register with the Centers for Medicare and Medicare Services (CMS). PECOS enrollment process by allowing registered users to securely and electronically submit and manager Medicare enrollment information.

**DOPL**- Department of Professional Licensing- Provider must enroll with their state prior to performing medical services. Some states are not named DOPL, but just professional licensing.

**Malpractice Insurance**- is the professional liability insurance that protests healthcare professionals against patient or client lawsuits. Typically, all provider types (MD/NP/PA/LCSW, etc.) must have $1 mil in occurrence and $ 3mil in aggregate per year.

**Board Certification**- is an extra step that many doctors choose to take to demonstrate that they know the latest advancements in their specialty. Board Certified doctors demonstrate their desire to practice

at the top of their profession and deliver high-quality care to their patients. Some carriers require a provider to be board certified to be participating within their plans.

**Certification(s)**- Required for Certified Nurse Practitioners are Advanced Practice Registered Nurses who have advanced training to diagnose illnesses and prescribe medication in areas such as primary care, acute care, geriatrics, psychology, and women's health.

**Employment Gap**- an explanation, usually found on the CV/Resume, for a gap in employment. Typically, the gap is when a time has been at least three to six months or more. Carriers require this explanation to complete the credentialing process. This must be added under employment in CAQH.

**Supervising MD**- is the individual who provided oversight of the Rendering provider and the care being reported. Some carriers require a midlevel provider have a supervising MD. The supervising MD must be of the same specialty as the rendering provider. The supervising MD must be enrolled and participating with the carrier for the rendering provider to become participating with that same carrier.

**Mid-level**- an advanced practice provider and non-physician practitioner, are health care providers who have a defined scope of practice. They are typically NP, PA, nurse anesthetists, clinical nurse specialists, Chiropractors, Optometrists, Social workers, Psychologists, LCSW, CSW/ MSW, and Certified Nurse-Midwives.

**MD/DO**- Medical Doctor; Doctor of Osteopathic

**Fee Schedule**- is a complete listing of fees used by Medicare, Medicaid, or other carriers to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. Fee schedules are negotiated between the payor and the provider. Since the provider can bill any amount, this allows insurance companies to pay less than billed charges while still allowing the providers to be reimbursed an amount they deem reasonable.

**PPO**- Preferred Provider Organization- No requirement for referral to specialist. Has out of network and in network services and deductible.

**POS**- Point of Service (type of HMO)- a type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans require referral/prior authorization from the PCP in order to see a specialist.

**HMO**- Health Maintenance Organization- requires referral to see specialist. Has no out of network benefits.

**EPO**- Exclusive Provider Organization (type of HMO)- is a type of health plan that offers a local network of doctors and hospitals for you to choose from. A Primary care provider is not necessary but must be seen within the predetermined network. Out of Network (OON) is not provider and visits require referral/pre-authorization.

**PFFS**- Private Fee for Service- is a Medicare Advantage health plan, offered by a state licensed risk bearing entity, which has a yearly contract with CMS to provide beneficiaries with all their Medicare benefits, plus any additional benefits the company decides to provide.