Deep dive: What lies beneath the surface?

Reassessing your credentialing process could mean more money in your practice

By Scott T. Friesen

Effective credentialing processes represent more than gaining approval from payers; they have a direct impact on your revenue cycle and physician alignment success. Yet many industry professionals lack the tools to create effective credentialing processes and might not have the necessary support from industry executives to implement them. A deeper assessment of what the credentialing process represents — and how it can affect your bottom line — can provide the right incentives for change.

"The problem is that many professionals are in a reactive mode when it comes to credentialing," says Donna Knapp, MA, FACMPE, independent consultant, MGMA Health Care Consulting Group. "It should be a continuous process with dedicated resources."

Industry shifts have prompted more practice managers to recognize the importance of timely credentialing processes. A growing number of people acknowledge that by reducing the credentialing timeframe and obtaining Provider Identification Numbers (PINs) faster, you are able to bill for claims that would otherwise be written off with a slower credentialing process. For example, Medicare does not allow you to retroactively bill for claims unless you have a PIN.

Decreasing reimbursement, rapidly increasing costs, health information technology and the popularity of accountable care organizations (ACOs) have facilitated clinical, operational and financial integration in recent years. Prior to passage of the Patient Protection and Affordable Care Act, healthcare organizations (both hospital- and physician-owned) operated almost exclusively on a fee-for-service model, which can be likened to an all-you-can-eat buffet that rewarded providers for the number of services provided, not the clinical outcome of those services. The rise of ACOs prompted a gradual change in clinical, operational and reimbursement delivery in which some providers are reimbursed for the

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» quality and successful clinical outcomes of their efforts.

As a result, hospitals and physician groups have begun to align in various forms of ACOs or integrated delivery networks to facilitate the shift to a fee-for-quality model that includes quality and clinical outcomes. For example, Kaiser Permanente, Mayo Clinic and Geisenger have had success with their fee-for-quality reimbursement models, which many large health systems are trying to emulate, according to industry experts.

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The ability to optimize the credentialing process with operational and financial metrics is an essential component to this success. For example, data can be used to assess the days in enrollment (DIE) calculation for delegated and non-delegated payers. The ability to link gross charges to in-process credentialing applications, workflow tools, robust reporting, and analytics will facilitate physician alignment strategies, improve productivity, reduce credentialing timeframes and generate incremental revenue for healthcare organizations.

"Physician and allied health provider credentialing requirements have been overlooked by most hospitals and physician organizations," says Pam D'Apuzzo, president, RR Health Strategies, a consulting group that specializes in physician practice management, coding and compliance. "This has led the OIG [Office of Inspector General] to scrutinize incident-to services. Organizations can mitigate their risk by using robust software to credential and bill for their services in a compliant manner."

The number of hospital professionals who have initiated efforts to acquire and/or merge with other hospitals and physician organizations to reduce costs and improve clinical outcomes is on the rise, according to published reports. Hospital mergers and acquisitions activity increased 33 percent in 2010 from 2009, according to *Healthcare Finance News*.[1] Drilling down, 980 healthcare merger and acquisition deals valued at $227.4 billion took place in 2011, according to *Modern Healthcare*.[2] And many of those deals included physician medical groups.

Although we are seeing an increased interest in physician practice and hospital integration, history shows that some executives might not understand the operational and financial implications of setting up the robust billing, credentialing systems and operations required to successfully execute a physician-alignment strategy. As a result, many hospital professionals are seeing an increase in physician-related denials, frustrated doctors and lost revenue. For example, many see that credentialing denials are not easily reversed by payers and represent a loss of valuable revenue.

Credentialing

Credentialing requirements and challenges have been part of healthcare operations for decades, but market pressures have emphasized the need for efficient programs to capture available revenue and ensure workforce efficiencies. A dramatic increase in physician onboarding efforts and regulatory complexities from health plans and credentialing locations (for example, cross-credentialing providers at multiple or all locations) have forced professionals to seek workforce efficiencies, such as reducing administrative denials to collect all revenue.

"Having a robust workflow and analytics software solution that is tied to key performance metrics ensures that we are proactively managing our credentialing process," says Motti Edelstein, director of managed care at North Shore – LIJ Health System, N.Y. Those metrics include provider-related denials, "collecting every dollar owed to our organization and ensuring that we are adequately staffed to handle provider growth," he adds.

The state of credentialing software is a prime example of an industry failure to connect the credentialing and revenue cycles. In the late 1990s, software companies developed products that reduced the data-entry time needed to credential a physician by allowing doctors to create a database of physician demographic data and

auto-populate applications from the same data-base. This reduced the processing time to submit all applications from approximately 40 hours to four hours. However, these products do not show how credentialing affects the revenue cycle.

More than paperwork

Healthcare professionals need to understand the different segments of the credentialing life cycle to gain perspective on the larger opera-tional and financial processes. They include:
- Human resources (HR)
- Hospital credentialing/privileging
- Physician credentialing
- Revenue cycle

If healthcare professionals fail to view the credentialing life cycle as an integral com-ponent of the revenue cycle, they will see increased denials, frustrated physicians, frag-mented operations and lost revenue. Ideally, physician credentialing will be considered in the following light:
- It is an integral component of the revenue cycle, not a separate and siloed department.
- It is one of the first steps in the revenue cycle and considered a continuous process.

Physician credentialing should be aligned with the HR and hospital credentialing pro-cess in these ways:

HR works closely with the hospital and physician credentialing departments to set a start date, integrate the hiring, privileging and physician credentialing process into one seamless process.

After a physician is hired, HR shares the news with the hospital credentialing depart-ment to initiate primary-source verification services.

Working concurrently, HR and credential-ing department personnel tell the medical privileging committees/boards how many physicians will be up for review and privileg-ing approval. If there are multiple medical privileging committees/boards in your orga-nization, inform them in advance. Consider increasing the frequency of committees/board meetings. Every day that passes without privileges means that physicians cannot see patients to generate revenue.

After a physician is hired and the medi-cal privileging committee/board review is underway, HR and hospital credentialing department personnel ask the physician credentialing department to begin the data collection process. Collect as much demo-graphic information and primary-source documentation as early as possible because there is significant overlap with the data these groups need to conduct their respec-tive jobs. By leveraging HR and credentialing department data collection efforts, physi-cian credentialing department personnel can prepare all credentialing documentation in advance and have enrollment applications ready for submission to payers once a physician is granted privileges.

Incorporate revenue-cycle concepts into physician credentialing to identify revenue loss and incremental revenue opportunities. Physicians are often granted privileges to prac-tice at hospitals before they are enrolled with

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an organization's insurance payer. Although this might fill the need for a specialist's services, there is a negative revenue impact for the organization. For example, a physician starts seeing patients June 1 but has not been enrolled with the 20 insurance payers by the physician credentialing department. This phy-sician generates gross charges of $5,000 in one day and $400,000 in gross charges over the course of 120 days. Now apply that scenario to 10 physicians and the total gross charges dur-ing that 120-day period is $4 million. Keep in mind that the physician credentialing depart-ment takes at least 120 days (four months) to obtain a PIN for all 20 insurance payers.

If the organization's gross collection rate is 30 percent, the expected net cash translates into $1.2 million. However, many insur-ance payers do not retroactively reimburse for services conducted without a PIN, so the

organization is faced with a $1.2 million write-off. If 50 percent of insurance payers retroactively reimburse, this still translates to a $600,000 write-off.

Create robust metrics to identify, track, trend and manage the physician credentialing life cycle. The following metrics should be considered standard practice in any physician credentialing department:

- Total physician credentialing opportunity: Total physicians x total payers x total locations* = Total opportunity
- Total participating status: Total PINs / total opportunity
- Total non-participating status: Total nonparticipating statuses / total opportunity
- Total in-process status: Applications in the process of being granted PINs / total opportunity
- Total financial impact of in-process applications: What is my gross charge impact, what is my net cash impact, how do my in-process applications affect my cash on hand, accounts receivable (A/R), etc.?
- DIE — non-delegated payers: Total number of elapsed days from the time an application was submitted to an insurance payer compared with a standardized non-delegated metric (90 to 120 days).
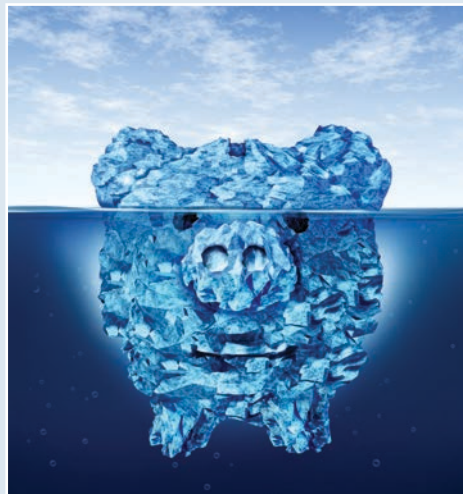- DIE - Delegated payers: Total number of elapsed days from the time an application was submitted to an insurance payer compared with a standardized delegated metric (30 to 45 days).

Use physician credentialing workflow tools similar to those used in A/R and revenue cycle management to reduce credentialing timeframes, increase productivity and generate more cash. Recommendations for this department:

- Create dynamic work lists that focus on the physicians and payers who generate the most revenue. This approach might be controversial for multispecialty groups but can help maximize the 80/20 rule and ensure that the majority of top-performers are fully enrolled.
- Establish productivity tools to gauge credentialing specialist activities and ensure these activities are geared toward PIN completion. Develop productivity benchmarks and baselines to improve overall productivity. Industrywide productivity metrics do not exist for physician credentialing.

Physician credentialing needs robust reporting and analytics to better understand how departments are performing, identify process breakdowns and implement corrective actions.

Robust and easy-to-use reporting and analytic tools allow healthcare professionals to understand how their credentialing departments are performing. Most credentialing software companies provide limited reporting

Some payers require location PINs, others require one PIN for multiple locations. It depends on your payer and the state in which you practice.

Hospital credentialing:

The process for hospital professionals to review a physician's education, licensure, training, certifications, work and malpractice history to ensure that the physician to whom they are granting privileges will safely and securely provide patient services. The industry has developed strict hospital credentialing standards to ensure uniformity across all hospitals.

but do not link charges to in-process applications or DIE calculations that highlight payer performance.

Robust data analysis tools must be used during the physician credentialing life cycle so that professionals can see how their credentialing departments are performing.

When an operational process breakdown is identified, immediate corrective action should occur. For example, a credentialing department will compile a credentialing application and give it to a physician for signature in a short period of time. However, occasionally a physician is late returning the signed application. This delay, while inconsequential to the physician, has a real and direct revenue impact for the organization. By tracking and trending this process in the credentialing life cycle, the department can tell the physician how the delay affects the overall bottom line. When you identify a financial process breakdown, implement immediate corrective action. If a physician is delinquent in providing a signed signature page to the credentialing department but generates $5,000 of gross charges on a daily basis, analytics can identify the financial impact of that delinquency, which could prompt the physician to return the page sooner.

Analytics allow administrators to take the anecdote out of physician credentialing and compile statistical and financial data that can be used to provide incentives for physician adherence. Robust analytics can also be used with payers. Healthcare professionals can show specific examples of when payers have been delinquent in processing their physician credentialing applications. For example, healthcare professionals can identify how long it takes each payer to credential their physicians. If payers are taking longer than contractually obligated, show how the behavior affects your bottom line and use the data to negotiate better credentialing guarantees and/or contracted rates.

"Credentialing software can also help you identify breach of contract," Knapp adds. "I don't think people use this enough to keep payers honest with what they've told us they will do."

As the healthcare environment shifts and changes, professionals must understand that if their physicians are not credentialed correctly, groups will not be paid correctly, and physicians will not be fully integrated with their healthcare organizations. The implementation of a clearly defined physician credentialing life cycle that encompasses physician credentialing metrics, workflow tools and robust reporting will result in a seamless hospital/physician alignment strategy and increased net revenue. ✎

Notes:

1   *Healthcare Finance News* – Hospital M&A Activity Jumped 33 Percent is 2010 - healthcarefinancenews.com/news/hospital-ma-activity-jumped-33-percent-2010

2   *Modern Healthcare* – M&A Activity Stayed Strong in 2011, Levin Says - modernhealthcare.com/article/20120120/NEWS/301209964/m-a-activity-stayed-strong-in-2011-levin-says

Physician credentialing (also known as provider enrollment):

The process to credential a physician and/or allied health provider with a particular insurance payer to receive reimbursement for services rendered. Physicians and allied health providers are required to fill out credentialing applications that can be 30 to 50 pages long to obtain a Physician Identification Number (PIN) and receive payment from Medicare, Medicaid, commercial or managed care insurance payers. Some statistics show that a single physician submits 20 to 25 individual enrollment applications annually and spends up to 40 hours annually to manage these credentialing requirements. To provide perspective: There are more than 1.4 million physicians and nonphysician providers who need enrollment and reenrollment management, and the national average enrollment per physician or allied health provider is 20 to 25 insurance payers.