FOUR TIPS: THE INVISIBLE IMPACT OF CREDENTIALING

TIP 1 OF 4

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Credentialing Can Disrupt Your Patient Satisfaction Outcomes.

With the advent of Accountable Care Organizations (ACOs) and population health management initiatives, healthcare organizations are increasingly implementing technology and processes to encourage patient engagement. Incumbent in these efforts is the collection of more patient satisfaction data to help yield better decision making to promote lower cost delivery models and better clinical outcomes throughout the communities they serve.

As providers in all healthcare delivery networks strive to enhance patient satisfaction scores, they are all too often burdened by events that occur outside the scope of treatment. Parking convenience, patient wait times, and the perception of a courteous medical staff all impact the patient's experience and overall satisfaction. One often overlooked scenario impacting patient satisfaction is the credentialing and enrollment status of a provider that is assumed – both by provider and patient – to be in a payer's network.

Failure to adequately monitor expiring documents, errors in the initial/re-enrollment process, or failing to identify all locations where that provider will see patients can have very damaging effects on patient satisfaction. When a provider's participation status with a health plan is disrupted, patients are at risk for a denied claim when utilizing an "out-of-network" service or higher co-insurance levels than previously disclosed. In these scenarios a patient is generally held harmless as most providers will quickly work with the patient and write-off these charges. However, an unfavorable patient experience is something that is hard to change, regardless of the financial outcome or impact ultimately realized.

Compounding the problem, is the failure to record the root cause of a patient's dissatisfaction. Unless a patient takes time to write a narrative describing their experience, most survey forms do not specifically address credentialing-related issues. Therefore, the patient's dissatisfaction can manifest in other reporting areas that are monitored. This leaves an organization with a skewed data set of unfavorable survey outcomes and an inability to take appropriate corrective actions.

Tip 1

TAKE PRO-ACTIVE MEASURES

POINT OF SERVICE VERIFICATION

Validate enrollment status at the point of scheduling. Create and update daily active provider-rosters for each of your payers. When scheduling or registering a patient, cross check the patient's insurance carrier against your rosters to insure the provider is currently active.

CUSTOMIZE YOUR SURVEYS

Create survey questions around the patient's billing experience and ask if provider eligibility was an issue. Without this response type a patient may manifest their dissatisfaction in other parts of the survey which could impact your scoring without giving you data to address the root problem.

RAPID RESPONSE

Act quickly. When a patient identifies billing errors caused by problems related to credentialing it is imperative that your staff understands what your protocol is. The longer a patient believes they're going to be responsible for charges above those stipulated by their plans, the more likely they are to escalate their concerns.

REPORTING

Measure the problem. Understanding which providers and which payers contribute most frequently to your credentialing related denials will help you enact proactive guidelines to prevent them from happening. It will also help you measure the revenue impact these errors have on your revenue cycle.

LET'S GET STARTED

With these best practices in place, change your provider enrollment department from a cost center to a revenue generator.

To learn more, contact Newport Credentialing Solutions at info@newportcredentialing.com or 516.593.1380.

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