FOUR TIPS: THE INVISIBLE IMPACT OF CREDENTIALING

TIP 3 OF 4

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TIP: 3

PREVENT SURPRISE MEDICAL BILLING

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Prevent Surprise Medical Billing.

In 2016 a number of states across the US enacted laws aimed at shielding patients from surprise medical bills. These laws have been enacted to protect insured patients from surprise medical bills when services are performed by an out-of-network provider at an in-network hospital or outpatient services location covered in their health insurance plan or when a participating provider refers an insured patient to a non-participating provider. Surprise medical bills are most often associated with emergency care, when a patient has little to no say in their care-plan. Items may include ambulances, anesthesiologists, radiology, etc. Surprise medical billing can also occur when a patient receives scheduled care from an in-network provider.

When healthcare providers are not enrolled properly with one or more health plans in which they participate, or if they have inadvertently allowed their enrollment status to lapse, billing disruption is inevitable. An otherwise clean claim submitted for services will either be denied by the health plan or covered at out-of-network rates. Either scenario could result in a surprise medical bill as the patient will likely be billed something different than their standard in-network fees.

While most healthcare providers will hold the patient harmless for these denials, it creates unwanted stress on both the patient and the provider's staff. Furthermore, having to write off an encounter because a provider is not enrolled properly can significantly impact a healthcare organization's bottom line.

Insurance verification and provider enrollment are the start of the revenue cycle. If they aren't viewed as such, they should be. When patients are scheduled, provider enrollment verification must become a standard part of the scheduling process alongside patient insurance verification. When a patient's coverage cannot be verified, most providers will suspend the scheduling and registration process until the patient's ability to pay is confirmed. These proactive steps should likewise be taken when a provider's enrollment cannot be confirmed.

Tip 3

THOROUGH MANAGEMENT OF CREDENTIALING EVENTS

CREATE A CREDENTIALING CALENDAR

To avoid payer credentialing issues, implement a credentialing best practices and reporting strategy which includes a credentialing calendar that incorporates key credentialing events and assigns them to appropriate resources. Reporting on the process should be robust and include risks to A/R, staff productivity, and payer enrollment status.

REGULAR PAYER AUDITS

Conduct regular audits for each provider and payer to ensure active participation status. Audits should verify all provider Identification numbers (PINs) and Effective Dates are complete and accurate. Understand which payers use CAQH and incorporate reattestation cycles into credentialing calendars, every 120 days.

THOROUGH PAYER FOLLOW UP

Once a payer application is submitted, conduct application follow up similar to how A/R follow-up is conducted. Follow-up should be systematic, pro-active, frequent and documented. Document all follow-up activities in a credentialing calendar.

UNDERSTAND HOW STATES ADDRESS SURPRISE MEDICAL BILLING

While the term "surprise medical billing" plainly addresses unexpected fees incurred through in-network coverage, the approach to remedy this issue varies from state to state. Therefore, it is important to understand what legal and financial obligations providers have in the state(s) for which services are billed.

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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