FOUR TIPS: THE INVISIBLE IMPACT OF CREDENTIALING

TIP 4 OF 4

NewportCredentialing SOLUTIONS™

TIP: 4

CONSIDER OVERLOOKED COSTS

NewportCredentialing SOLUTIONS™

Consider Overlooked Costs.

Denied claims caused by credentialing-related issues have an obvious impact on a provider's reimbursements. With limited exception, the inability to collect on these denied claims often leads a provider's practice to write off the claim and stop the pursuit of reimbursement. Given just how many patient encounters a provider has in a given day, week or month, the financial impact of having to write off an encounter can be significant.

Practices go to great lengths to ensure a patient's insurance is verified well in advance of an encounter. If he or she isn't covered, the procedure isn't done. While the financial implications of having to write off an encounter are well known, it is surprising that many practices are overlooking another process equally as important as insurance verification – credentialing and provider enrollment verification. To change the way credentialing and provider enrollment are viewed, quantifying lost dollars is essential.

Fortunately, most clinical information systems offer the ability to track denial codes. In doing so providers can easily quantify how much revenue (reimbursement) is lost when encounters are written off. For a true big picture view, information should be tracked over a period of time (quarterly, bi-annually and yearly).

With the reimbursement impact fully measured, a cost/ benefit analysis can be conducted to determine return on investment needed to correct these denials. While this all seems straightforward, there are often other factors associated with unreimbursed encounters which are not fully measured. These factors can further extend the impact lost encounters can have on the bottom line. Having a sense of what these factors are can help providers understand the true business implications of having to write off an encounter and, ultimately, elevate the importance of credentialing and provider enrollment within an organization.

POTENTIAL COST PITFALLS

IT AND TRANSACTIONAL FEES

EHR systems and clearinghouse integration tools frequently charge a transactional fee for each encounter processed. While these fees in isolation may seem nominal, if compiled and bundled collectively over a period of one year, they certainly add up. Additionally, patient records need to be stored and accessible for (typically) seven years. Costs for storage and handling should also be considered.

PERSONNEL COSTS

Front-desk scheduling and registration, patient intake, exam room turnover, and physician scribes all contribute to the "per encounter" expense line. Staffing models typically consider collective personnel costs weighted against average reimbursement per encounter. It is wise to consider how denied claims impact staffing model assumptions, and consider the impact on the overall operating budget.

MEANINGFUL USE

For most providers the window to collect on meaningful use incentives has closed, however providers participating in meaningful use still need to attest to avoid Medicare payment penalties. The first step to attestation is to verify a provider's enrollment record in PECOS (Provider Enrollment, Chain, and Ownership System) has an APPROVED status. Failure to validate an approved PECOS status for new providers not only impacts reimbursements but can also negatively impact attestation of several meaningful use reporting measures resulting in unwarranted penalties (i.e. additional fees).

Tip 4

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.

Phone: 516.593.1380
Email: info@newportcredentialing.com

NewportCredentialing SOLUTIONS™