

FOUR TIPS: THE INVISIBLE IMPACT OF CREDENTIALING



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The Invisible Impact of Credentialing

The past 8 to 10 years have been transformative in the “business” of providing healthcare. The 2009 American Recovery and Reinvestment Act (aka ARRA, aka Stimulus Program) brought with it unprecedented incentives for healthcare providers to widely adopt electronic health records, and they did. The 2010 passage of the Affordable Care Act resulted in more than 20 million more Americans being covered by a health insurance plan or through Medicaid expansion. These transformative events brought new considerations for maximizing operational excellence in the business of healthcare. One often overlooked consideration is the impact credentialing can have on the many aspects of healthcare operations. A well-managed credentialing program will have an impact on information technology, patient satisfaction, and revenue enhancement goals. This e-book is designed to bring awareness to the many invisible “touches” credentialing has in the healthcare setting. It also offers tips to consider when confronting the not so apparent implications of a credentialing program.

Four Tips:

- 1 Credentialing can disrupt your patient satisfaction outcomes.
- 2 Make sure all data is protected – not just PHI.
- 3 Prevent surprise medical billing.
- 4 Consider overlooked costs.



TIP: I

CREDENTIALING CAN
DISRUPT YOUR PATIENT
SATISFACTION OUTCOMES



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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.

TIP: 2

MAKE SURE ALL DATA IS
PROTECTED – NOT JUST PHI



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Make Sure All Data is Protected – Not Just PHI.

More than two decades ago, the Health Insurance Portability and Accountability Act (HIPAA) was signed into law. One of its most significant provisions was to create a standard method of protecting patient data, regardless of where it resides. In 2000 additional safeguards were put in place and Protected Health Information (PHI) became the responsibility of everyone in the healthcare sector. As a result, compliance programs and business associate agreements were created and rolled out to ensure anyone who could be exposed to PHI respected its discreet characteristics and would take necessary steps to protect patient privacy.

While a tremendous amount of work has been done to ensure data security in the healthcare industry, there is still much more to be done. As news of data breaches top headlines, hospitals and other healthcare organizations are stepping up their data security efforts. IT staff are working diligently to ensure EHR systems, accounting systems, and other patient-related software systems are secure. Meanwhile, with the focus primarily on patient information, one-off areas like credentialing and enrollment are being overlooked which is putting many providers sensitive information at risk.

Because provider data is not PHI, it is not subjected to the rigorous protection standards demanded by HIPAA. While many organizations have internal compliance programs designed to shield employees, vendors, and providers from unexpected data breaches, provider data is all too commonly found on loosely protected Excel spreadsheets, Word documents, and in unsecured email transmissions. When this information sits unprotected on an individual desktop, thumb drive, or network server, it becomes vulnerable to hackers and unauthorized individuals (some of whose intentions may be less than honorable).



Tip 2

SECURE CREDENTIALING & PROVIDER DATA

CENTRALIZE ALL CREDENTIALING DATA

Eliminate paper documentation and one-off locations for storing provider data. Provider credentialing and enrollment data should be stored in a protected central repository and made available only to individuals with a need to access it.

CONTROL DATA ACCESS

Ensure policies and procedures are put in place for storing, accessing and sharing provider data. Policies should be detailed and require hard passwords to access any provider data and prohibit users from sharing log in ID's or passwords.

BACK UP YOUR DATA

Take steps to ensure that provider credentialing data is included as part of your organization's data compliance and disaster recovery programs. Co-location backups and off-site storage are sound processes to protect against data loss.

MONITOR DATA ACCESS AND USAGE

Make sure all transmission of provider data is secure. This may mean using a secure portal instead of email to transmit information to plans. IT audit trails should be implemented to track the "who, what, when, and where" each time data is accessed.

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.

TIP: 4

CONSIDER
OVERLOOKED COSTS



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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.



Tip 4

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).

Avoid the risks of doing it alone – partner with the nation's premiere credentialing team that focuses on improving client revenue.

Managing credentialing and provider enrollment can be a time-consuming and costly endeavor, especially when relying on antiquated methods such as paper or Excel spreadsheets for tracking. When managing the process in-house, inadequate staffing levels are often an obstacle to success. However, with the right processes and cloud-based tools in place, lost revenue due to provider enrollment eligibility issues can be significantly reduced, if not eliminated.

For mid and larger size healthcare organizations who are considering outsourcing their provider enrollment processes, Newport Credentialing Solutions offers the necessary resources and cloud-based technology to manage the entire credentialing life cycle. Newport's staff are highly trained and understand what is required to manage the entire credentialing life cycle successfully through the use of cloud-based workflow software, advanced cloud-based reporting and analytics coupled with industry defining domain expertise. Newport provides the tools and services to ensure our client's credentialing and enrollment is on track and meets the demands of a quality driven reimbursement model.

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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