CHC CREDENTIALING

Great Opportunities & Frightening Liabilities

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Many might consider credentialing and enrollment to be a lesser part of the CHC revenue cycle, easily getting lost in the mix when a more pressing issue springs up. We all know that credentialing and enrollment issues can hold up claims and effect revenue but what about the liability side of things? There are many possible hazards that CHC leadership should be mindful of.

In the following article, our team of experts shares some common credentialing and enrollment pitfalls as well as our tips to help you to avoid them at your CHC.

Credentialing and Enrollment are fraught with potential liabilities.

Payer Credentialing vs. Enrollment

Let's begin with some basic but often misunderstood terms. Enrollment and credentialing are not one in the same but two distinct processes that go hand in hand. Enrollment is the process of getting providers or facilities (e.g., CHC clinics) into participation status with payers. Being a participating provider/clinic is essential to see a payer's or plan's members and be paid an optimal fee schedule. During the enrollment process, an application along with supporting documentation is submitted to an insurance plan for their review and approval. Credentialing refers to the process a provider is subject to when seeking participation status within a network. During this process, provider's credentials are verified and presented to a Credentialing Committee who can grant ultimate approval. Once the credentialing process is complete and the provider is considered enrolled or 'participating.'

Individual vs. Facility (Clinic) NPIs

Nearly all payers (including Medicare) require a unique NPI for all CHC core providers. Remember this means not just Physicians but most Advanced Practice Professionals or non-physicians (e.g., Physician Assistant, Nurse Practitioner, Psychologists). An individual provider is only eligible for one unique 10- digit number, a Type 1 NPI. Type 2 NPIs are issued to organizations such as physician groups, hospitals, or incorporated individuals. In order to obtain an NPI, you must complete an online application via the NPPES site, or download a paper application from CMS. At CHCs, Medicare Part A (think PPS and G codes) are billed via the ANSI 837-I (institutional) vs. Part B (think fee-for-service for diagnostics and nonclinic encounter work) via the 837-P (professional). The 837-I is a group number and as such ANY employed providers (even those starting today) may have PPS visits billed under the group NPI. However, Part B–and nearly all other payers–require the 837-P necessitating the individual provider to be credentialed with each payer. This means until the provider is fully credentialed, your CHC is unable to even submit claims to those payers requiring 837-P claim format.

Billing New Providers Under Other Staff NPIs

Hiring new core providers can be expensive and time-consuming. Provider enrollment should be initiated prior to a new hire's start date. Getting paid as quickly as possible for the services they provide to patients is obviously quite desirable. PMG finds too many CHCs billing work rendered by the new core provider under the medical director or other already credentialed staff. Unless your CHC has a statement in writing from a respective payer which allows billing under another provider's NPI, this is patently illegal. It is FRAUD with a capital "F." Beware of anyone with the mindset that "everyone does this so its ok."

If necessary have new providers see self-pay, grant funded or Medicare Part A patients, no individual credentialing necessary for these payers. Non-credentialed staff can also work in an administrative role with no patient care involved. Of course, these options aren't ideal however; they will mitigate loss and risk.

Nearly all payers require a unique NPI for all CHC core providers.

Not just for Physicians!

Advanced Practice Professionals, and many non-physician staff

Medicare Exclusion List

We understand how easy it is to get caught up in proverbial 'crises of the day'. CHC leadership are often just too busy to consider the pitfalls resulting from not regularly reviewing the Medicare Exclusion List. We suggest CHC leaders check the list quarterly or at least monthly for ALL staff but especially for providers.

Our Credentialing team uses automated systems to check individuals against the exclusion list on a recurring basis but a quick check of the Office of Inspector General (OIG) site can work when handling in-house.

A person could be on the exclusion list because they worked at a facility that had been penalized or a provider for something as seemingly innocuous as not repaying a federal student loan. Once an individual has been deemed excluded, they must apply for reinstatement before they are able to participate again in all Federal health care programs. Adding this task to your calendar or delegating it to someone on your team can help avoid unpleasant surprises in the future.

It is against the law to bill a government payer while employing or contracting an excluded person.

Non Physician Practitioners (NPPs)

NPPs is the term CMS uses to define Nurse Practitioners, Midwives, Physician Assistants, Clinical Social Workers, and the host of other clinical staff who are able to be assigned NPIs AND be credentialed by CMS for individual payment.

Utilizing NPPs can help improve patient access by taking some of the workload off physicians and providing them with more flexibility. Most third-party payers (but not all) mirror CMS policy around credentialing NPPs. Often times, if you wish to establish an eligible individual as a Primary Care Provider (PCP), they must be enrolled and designated as such. If a payer credentials an NPP, staff should get them credentialed and use their NPI for submission to all possible payers.

Not credentialing NPPs when a payer requires it creates liability for your CHC. Some CHCs have told PMG they don't credential NPPs because they get paid more money for submitting their work under a doctor. That frightening "F" word was mentioned earlier, we're sure you agree that seeking more money than warranted is at worst an abusive billing practice and a fraudulent act.

It is important that your credentialing staff fully understand each payer's billing policies surrounding NPPs in addition to their requirements for enrolling. As a CHC leader, be sure to keep staff educated and to continually stress the need for compliance in everything they do.

Synopsis

The payer enrollment process can certainly be vexing, even more so when CHCs do not have all the resources you need to manage it effectively. Be sure to find a qualified staff person to manage your credentialing and enrollment. Ensure that they can balance the need to get paid with the need to remain compliant. Always stress the importance of doing things the right way.

For those who cannot find the right internal staff, hiring an outside firm to complete and maintain enrollment/payer credentialing may seem like a luxury. However that is not always the case, consider the fact that he ROI for the price of enrollment/payer credentialing service is usually equal to 10-12 paid visits for the newly enrolled provider. In other words, national UDS data shows CHCs make about $150 per visit. Only 10-12 visits paid equals $1,500- $1,800. Therefore a service costing around this much money pays for itself within 10-12 visits. In truth, the peace of mind for getting it done right and in a timely manner is priceless.

Continue to be vigilant, avoid penalties, maximize income, and feel good knowing your CHC does it right by vetting the processes internally or hiring an outside firm to assure optimal performance and compliance.

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About PMG Credentialing, Inc.

Our team of experts understands the complexities of the credentialing process. Our services help eliminate claim denials caused by inaccurate or incomplete provider enrollment. We are constantly increasing our knowledge base in order to stay up to date on changing regulations and protocol so you don't have to.

We get results for our clients, including enhanced revenue, quickened cash flow, and the alleviation of the headaches associated with the revenue cycle. In fact, PMG has produced increased revenue for every one of our clients.

This is how we are able to make this often daunting process worry-free, to allow you more time to focus on your mission: the care of your patient population.

Contact the CHC/FQHC experts!

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