The River of Revenue Integrity Runs Through It: Paddling through Credentialing and Enrollment Process Risks

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Learning objectives

- Enhance attendee knowledge of key aspects of credentialing and enrollment processes, including regulatory and payer requirements
- Understand commonly overlooked compliance risks associated with provider credentialing and enrollment processes
- Identify revenue integrity opportunities and mitigate financial impact of credentialing-related claim denials and barriers to care created by inefficient or siloed credentialing and enrollment processes
- Apply knowledge acquired from the presentation to ask the “right” questions about the credentialing and enrollment processes within attendee’s own organization

Polling question

Please select the option that best describes your knowledge of the credentialing and payer enrollment function within your current (or most recent) organization:

a. The function reports to me or is in my department's reporting structure, but I am not involved in the day-to-day.

b. I'm involved with the function day-to-day and have a good understanding of the processes.

c. Neither (a) nor (b), I am not familiar with how my organization manages credentialing and enrollment processes.

The Riverbed of Credentialing & Enrollment

- Credentialing requirements are variable by state, payer, accrediting bodies, and organizational standards.
- Credentialing and payer enrollment impacts many areas within organizations including compliance, revenue integrity, and patient care delivery.

Enrollment & Contracting Revenue Cycle Adjacent Functions

The average medical practice may participate with 15–20 different payers, including Medicaid and Medicare.

Hospitals and health systems participate with many more and may have multiple contracts if multiple TINs are in play.

Payer enrollment process/ turnaround time differs, ranging from 30 to 90 days (happy path!).

Recredentialing, Enrollment, and Privileging

- Credentialing, enrollment, and privileging paddle the river of revenue integrity together
- Organization policy, medical staff by-laws dictate frequency of recredentialing and renewal of privileges
- All payers require some flavor of revalidation/ recredentialing

Polling question

Please select the rank that best describes your awareness level of the revenue integrity and compliance risks associated with credentialing and payer enrollment processes:

a. Captain (Full awareness, I could probably take this presentation from here)

b. Lieutenant (Moderate awareness)

c. Seaman (Little to no awareness)

Credentialing & Enrollment Related Revenue Integrity Risks

1. Exposure to malpractice claims
2. Loss of accreditation
3. False Claims Act (FCA) liability
4. Violation of third-party payor contracts
5. Medicare conditions of participation
6. State licensure requirements
7. OIG exclusion

Moonlighting

- Organizations are often unaware of the full employment picture for both their moonlighters and their full-time staff.
- Multi-state, multi-TIN organizations may not understand dynamics of intra-system moonlighting.
- Myriad risks – accreditation, malpractice claims, claim denials, ineligible clinicians providing care.

“Urgent Care Provider and its Management Company to Pay $22.5 Million to Settle False Claims Act Allegations”

DOJ Announcement – April 8, 2021

- Qui tam complaint alleging the organization falsely and knowingly certified services (i.e., submitted claims).
- Evidence of the ‘knowingly’ included internal emails and staff ‘cheat sheets’ used to help billers keep track of credentialed providers that could be used to temporarily bill services of non-credentialed providers.
- **No** allegations that the services were not performed, or that the providers were unqualified or unlicensed.

“Long Island Pediatrics Practice Agrees to Pay $750,000 to Settle False Claims Act Suit Alleging Improper Billing Practices”

DOJ Announcement April 25, 2018

- State and Federal FCA in play.
- Practice did not enroll all employed physicians in the NY Medicaid program.
- Services rendered to Medicaid beneficiaries billed under partner who was enrolled.
- No allegations of substandard care.
- Whistleblower’s allegations corroborated by simple examination of claims data against the posted hours of business of the practice. The math didn’t work.

“Tenet Pays $371,000 CMP for Employing Excluded Individual”

HHS OIG Provider Self-Disclosure Announcement, May 5, 2021

- John F. Kennedy Memorial Hospital (JFK Memorial) and Emanuel Medical Center (EMC), California, agreed to pay $371,001.45 for allegedly violating the Civil Monetary Penalties Law.
- The hospitals, both part of the Tenet Healthcare System, employed the same excluded individual at different times.
- Checking for exclusions is not a one-and-done.
- LEIE [List of Excluded Individuals & Entities] & SAM [System for Award Management]

Place More Paddles in the Water to Manage the Risk

- Apply the concept of ‘Knowing’ and ‘Knowingly’ to how your organization manages credentialing and privileging processes.
- Invite representatives from legal, compliance, and risk to the table.
- Consider a periodic outside review of billing associated with newly onboarded clinicians.

Reeling in Your Organization's Catch

- Ensure billing/revenue cycle staff recognize credentialing related denials (i.e., provider not eligible doesn't always mean not enrolled!).
- Maintain a current list of timely filing/appeal time frames for all payers – including those your organization is out of network but commonly billed for.
- Payment variance audits to help ensure reimbursement matches contract.

Balancing the Cairn

- Policies and Procedures
- Defined Workflows
- Dedicated Staff
- Identified Stakeholders
- Communication

References & Additional Resources

- National Committee for Quality Assurance (NCQA) Credential Verification Organization: https://www.ncqa.org/programs/health-plans/credentials-verification-organization-cvo/
- National Association for Medical Staff Services (NAMSS): https://www.namss.org/
- OIG Exclusion Program: https://oig.hhs.gov/exclusions/
- Long Island Pediatrics Practice Agrees to Pay $750,000 to Settle False Claims Act Suit Alleging Improper Billing Practices: https://www.justice.gov/usao-edny/pr/long-island-pediatrics-practice-agrees-pay-750000-settle-false-claims-act-suit-alleging
- South Carolina's Largest Urgent Care Provider and its Management Company to Pay $22.5 Million to Settle False Claims Act Allegations: https://www.justice.gov/usao-sc/pr/south-carolina-s-largest-urgent-care-provider-and-its-management-company-pay-225-million
- John F. Kennedy Memorial Hospital and Emanuel Medical Center Agreed to Pay $371,000 for Allegedly Violating the Civil Monetary Penalties Law by Employing an Excluded Individual: https://oig.hhs.gov/fraud/enforcement/john-f-kennedy-memorial-hospital-and-emanuel-medical-center-agreed-to-pay-371000-for-allegedly-violating-the-civil-monetary-penalties-law-by-employing-an-excluded-individual/

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