Provider Credentialing, Privileging and Enrollment

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Agenda

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| Understanding Provider Credentialing, Privileging and      | • Overview                                                              |
| Enrollment overview                                        | • Primary source verification process                                   |
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|                                                            | • Sample workflow                                                       |
| The Effects of Provider Credentialing and Privileging on    | • Quality of care                                                       |
| Quality of Care and Compliance                             | • Legal implications                                                    |
|                                                            | • Case studies                                                          |
| Improving the Credentialing, Privileging and Enrollment    | • Suggested strategies                                                  |
| process                                                    |                                                                         |
| Question and answer                                        |                                                                         |
Objectives

At the end of this session, you will be able to:

- Understand the process for credentialing, privileging, and enrolling of providers
- Understand the primary source verification (PSV) process and its importance
- Identify various quality of care issues and compliance risks
- Understand strategies to help improve the credentialing process, transparency, and important controls for organizations and their compliance programs
Provider Privileging, Credentialing & Enrollment Defined

Credentialing and privileging must be completed before a provider can render clinical services. In addition, privileges must be granted before a provider can be enrolled with a third party payer for the purpose of submitting claims and receiving reimbursement for clinical services.

Provider credentialing is the process of gathering and performing Primary Source Verification (PSV) of information regarding provider’s qualifications for appointment to the medical staff. PSV is the act of obtaining the applicant’s credentials (the document itself or verification of the document) directly from the original or primary source.

Delegated credentialing is a formal process by which an organization (e.g. Managed Care payer) gives another entity the authority to perform credentialing, PSV and enrollment functions on its behalf.

Medical staff privileging denotes those specific services and procedures that a provider is deemed, by the medical staff leadership, qualified to provide or perform.

Payer enrollment is the process in which providers are enrolled with third party payers for the purpose of submitting claims and receiving reimbursement for services.

Primary source verification

The act of obtaining the applicant’s credentials directly from the original or primary source

- **Board certification**
  - Demonstrates proficiency in a particular specialty/subspecialty

- **State licensure**
  - Mandatory credentialing process at state level

- **Peer recommendations**
  - As obtained from the medical staff recommendations

- **Prior practice history**
  - Obtained from national databases
Documentation overview

A glimpse into terminology

- **Board certifications**: Demonstrates a physician’s exceptional expertise in a particular specialty and/or subspecialty of medical practice.
- **State licensure**: Mandatory credentialing process established by a government entity, usually at the state level.
- **Prior practice history**: Obtained through National Practitioner Data Bank and the List of Excluded Individuals and Entities database are geared to identify malpractice and exclusions.

Sample workflow

**The process begins with the physician’s request for privilege**

1. **Physician requests privileges at a hospital**
2. Hospital gathers all relevant documentation from the provider
3. Hospital conducts primary source verification
4. Hospital’s credentialing committee and board reviews the documents and approves
5. Hospital grants physician privileges

All documents of training (internship, residency, fellowship), state licenses, previous work history, malpractice insurance coverage claim history, peer recommendations
Below is a high level process flow of the typical privileging, credentialing and enrollment process:

**Initial Data Collection**
- Provider
  - Completes application and provides data
  - Sends facility app and requests provider data

**Credentiaing**
- Central Verification Office
  - Performs PSV
  - Completes application and provides data

**Medical Staff Office**
- Delegated Credentialing
  - Performs PSV
  - Sends applications (Non-delegated)

**Payer Enrollment**
- Third Party Payer
  - Sends applications (Non-delegated)
  - Performs PSV
  - Sends data and performs PSV (Non-delegated)

**Payer**
- Enrolls Provider

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* In addition, both the Risk Management (malpractice) and Physician Recruitment teams traditionally collect much of the same, and often duplicate, information regarding provider’s qualifications.

**PSV** – Primary Source Verification

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Organizations are finding, especially after expansion or consolidation efforts, that they have no “one source of truth” in their provider credentialing and enrollment data. With multiple points of contact, delayed cycle times, and manual processes, they are experiencing multiple issues throughout the process.

- **Credentialing & Privileging:** Complex and inefficient credentialing and privileging processes contribute to duplication of work, delays in the processing of applications, and the reliance on temporary privileges as an overarching solution.
- **Managed Care & Enrollment:** The lack of alignment between payer enrollment and managed care functions has created additional and unnecessary work for the medical staff services, delegated credentialing, and managed care enrollment departments.
- **Quality & Risk Management:** The lack of standard core process across all of the entities related to credentialing and privileging has exposed organizations to unnecessary regulatory risk.
- **Provider Engagement:** Complex and inefficient processes, non-standard forms, and department customer service has created significant provider dissatisfaction with the credentialing and privileging process. Providers are routinely asked multiple times for the same information, required to spend significant amounts of time filling out forms, and are generally uninformed about the process and the progress of their credentialing and privileging applications.
- **Technology:** Deficient implementation of the information technology systems (and/or manual processes) used by the medical staff services department has led to duplication of effort, excess costs, and significant staff dissatisfaction.
- **Staff Engagement:** The duplicative process, lack of clarity of roles, and deficient information technology training resources has created a defeated departmental culture where individuals do not feel they can positively change the status quo. This has resulted in significant staff turnover and decreased staff productivity further contributing to departmental delays.

A strategic role for the compliance officer

Why important to a compliance officer?

- Officer of the Inspector General (OIG) Compliance Program Guidance lists quality of care as area of interest!
- “Government’s heightened focus on quality of care”\(^2\)
- Quality of care corporate integrity agreements are different
- Quality of care is a compliance concern with many risks
- Credentialing and quality departments may be separate

- Compliance tracking investigations, repayments, and regulations and can add value to processes

Sources:
Quality of care

Credentialing and privileging can impact quality of care when inadequate controls enable patient care to be provided by individuals not qualified.

**Quality of Care Risks**
- Careless collection of initial data
- "Grandfathering" individuals into services
- Lack of policies and procedures by privileging

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**Provider credentialing and privileging**

A strategic role for the compliance officer

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Sources:
Duty to assess qualifications

It is the organization’s legal duty to determine the competency of a provider, both qualifications and proficiency.

Not following a rigorous process around credentialing and privileging can leave the organization vulnerable to action from various parties and government enforcement agencies for not meeting the established criteria set forth by governing bodies.

Sources:

Basis for some enforcement action(s)

**False Claims Act**
A request for payment for a service or item that is not reasonable or necessary for the diagnosis or treatment of the patient.

**Reverse False Claim**
Liability where one acts improperly, not to get money from the government, but to avoid having to pay money to the government.

**HIPAA**
Prohibits false statements related to health care matters. Knowingly and willingly make or cause to be made any false statement of material fact.

Sources:
5. FCA Section 3739(a)(1)(G)
Requirements for providing patient care

Medicare has put forth the following conditions of participation for hospitals:

- **Hospital bylaws**
  - Must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.

- **Hospital medical staff**
  - Must operate according to the bylaws and is responsible for the quality of medical care.

- **Credentials**
  - Medical staff must review credentials and make recommendations to the governing body on the appointment of these candidates in accordance to state law, including scope of practice laws and the medical staff bylaws.

Example case #1

- **Inadequate peer review and credentialing procedures for specialist(s)**

  **Background**
  - Hospital performing high number of a certain type of procedure. Truly an outlier, but went unnoticed.

  **Findings**
  - No peer review of such services, and patient safety not assured. As a result, hundreds of patients underwent unnecessary procedures. An FBI raid confirmed suspicions.

  **Outcome**
  - $54 million dollar settlement and divestiture of the hospital from parent company. Restraining orders enforced against providers.
Example case #2

Patients receiving unnecessary care

Background
Provider-owned cancer clinic. Provider administered unnecessary chemotherapy treatments to patients

Findings
OIG, Federal Bureau of Investigation, Department of Justice investigated the provider and determined that provider fraudulently billed government programs and harmed many patients. Prosecuted and sentenced

Outcome
Forfeited $17.6 million received in Medicare payments. Provider sentenced to 45 years behind bars

Important questions

Be skeptical – ask important questions and verify adequacy of controls

Who?
Who is checking the credentials of our providers?

What?
What is being checked through this process?

How?
How are these credentials being verified?
## Suggested strategies

With the help of compliance professionals, organizations must employ strategies to help reduce the risk of credentialing failures

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<th>Credentialing department</th>
<th>Compliance officer’s role</th>
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<tr>
<td>Set of policies and procedures consistent with system bylaws</td>
<td>Help scrutinize the policies and support prevention of “grandfathering” of services and procedures</td>
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<tr>
<td>Obtain and review documentation with a well-structured approach</td>
<td>Assist in confirming the data necessary to meet local and national regulatory requirements</td>
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<td>Document and store primary and subsequent findings</td>
<td>Provide education to providers on quality expectation and give regular feedback with respect to their individual contributions to quality of care</td>
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<td>Perform ongoing monitoring and reviews of providers’ credentials</td>
<td>Review and monitor databases routinely to screen for issues with staff members</td>
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<td>Perform periodic audits of credentialing files</td>
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Additional tips

• Evaluate use of checklists
• Review and approval of credentialing files
• Document appropriate approvals
• Compare services provided to privileges
• Compare providers providing services to credentialing files
• Confirm there are processes in place to grant access to information systems only to credentialed independent practitioners and advanced practice professionals
• Ensure processes to remove system access timely for unlicensed or ineligible providers
• Include advance practice providers, residents and fellows in credentialing process
• Verify timing of credentialing and process to ensure providers don’t treat patients until credentialing is complete

Additional tips (continued)

• Understand relationship between credentialing office and medical staff office roles and responsibilities
• Evaluate, in multi-hospital system, consistency in bylaws and options to standardize
• Support process for reporting of quality of care concerns
Question and answer