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Provider Credentialing, Privileging and Enrollment

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Agenda

Topic	Content
Introduction	• Facilitator introductions • Content overview
Understanding Provider Credentialing, Privileging and Enrollment overview	• Overview • Primary source verification process • Documentation overview • Sample workflow
The Effects of Provider Credentialing and Privileging on Quality of Care and Compliance	• Quality of care • Legal implications • Case studies
Improving the Credentialing, Privileging and Enrollment process	• Suggested strategies
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

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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.

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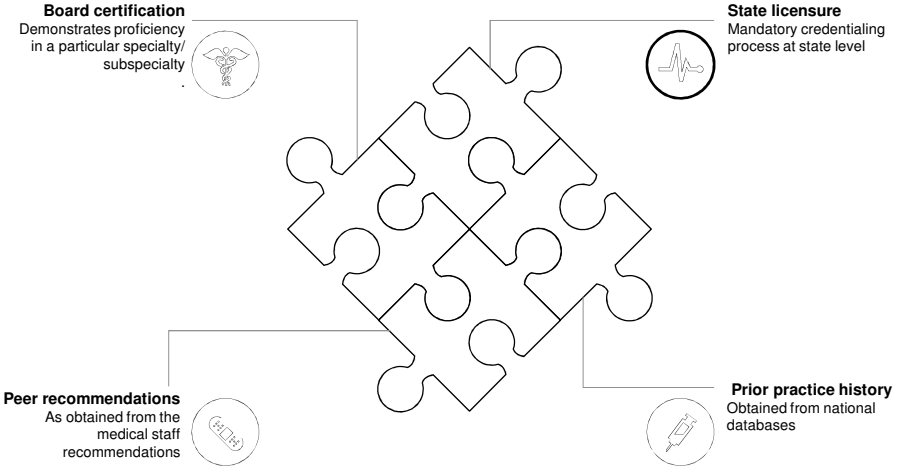
Primary source verification

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



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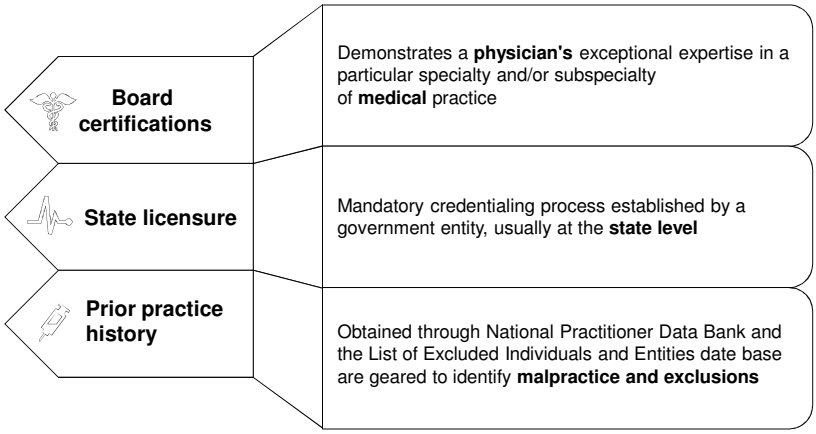
Documentation overview

A glimpse into terminology



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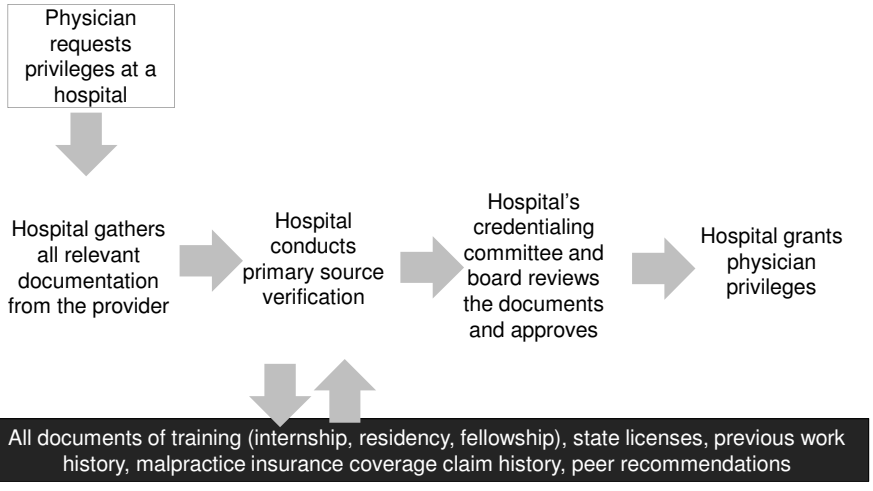
Sample workflow

The process begins with the physician's request for privilege



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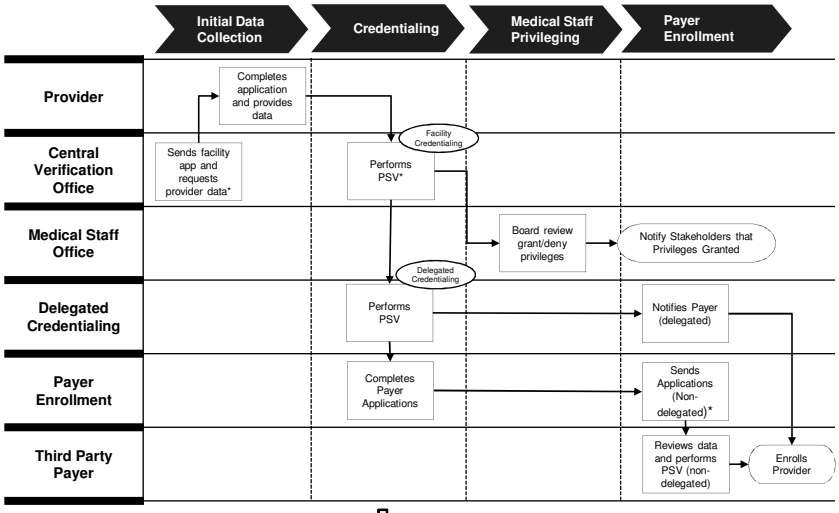
Provider Privileging, Credentialing & Enrollment Process Example

Below is a high level process flow of the typical privileging, credentialing and enrollment process



* 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

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PSV – Primary Source Verification

Provider Privileging, Credentialing & Enrollment: Issues throughout the process

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 filing 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

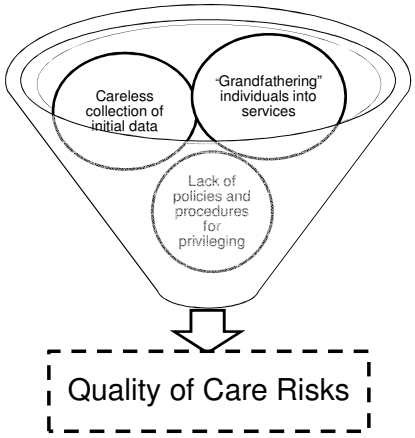
Why important to a compliance officer?

- Officer of the Inspector General (OIG) Compliance Program Guidance lists quality of care as area of interest[1]
- "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:
1. DHHS, OIG CPG (1998-2005). *Compliance Program Guidance (1997-2005).* http://oig.hhs.gov/compliance/compliance-guidance/index.asp.
2. 2008 CPG for Nursing Homes. http://www.oig.hhs.gov/compliance/compliance-guidance/docs/complianceguidance/nhg_fr.pdf.

Quality of care

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



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Provider credentialing and privileging

A strategic role for the compliance officer

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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:
3. OIG Annual Report of the Department of Health and Human Services and Justice; Health Care Fraud and Abuse Control Program FY 2014: http://www.justice.gov/civil/pages/attachments/2014/11/21/fcastats.pdf.

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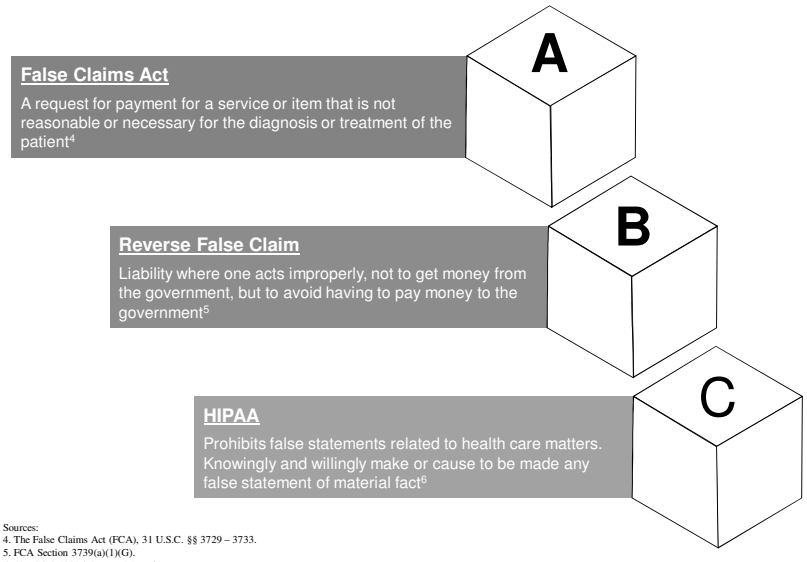
Basis for some enforcement action(s)



Sources:
4. The False Claims Act (FCA), 31 U.S.C. §§ 3729 – 3733.
5. FCA Section 3739(a)(1)(G).
6. 42 USC § 1320d-5 – HIPAA Enforcement.

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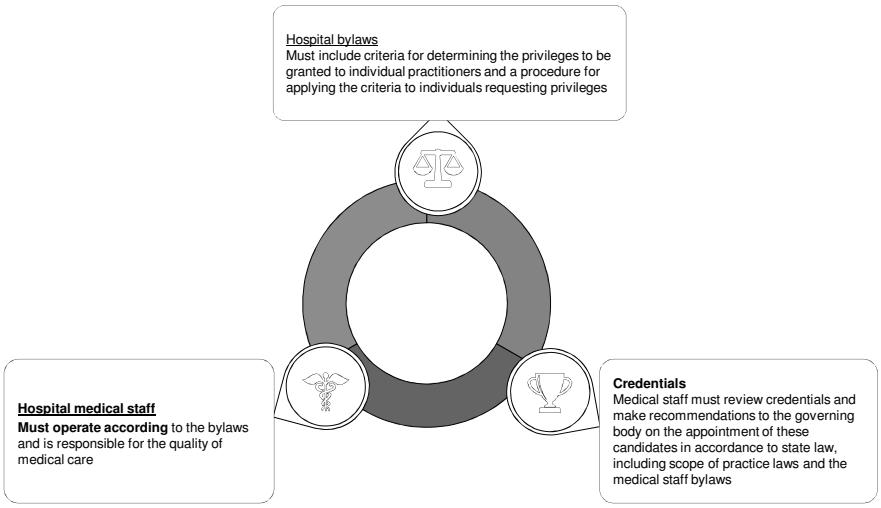
Requirements for providing patient care

Medicare has put forth the following conditions of participation for hospitals



Source:
7. 42 CFR 482.22 – Condition of participation: Medical staff. Available at http://1.usa.gov/1NamzKo.

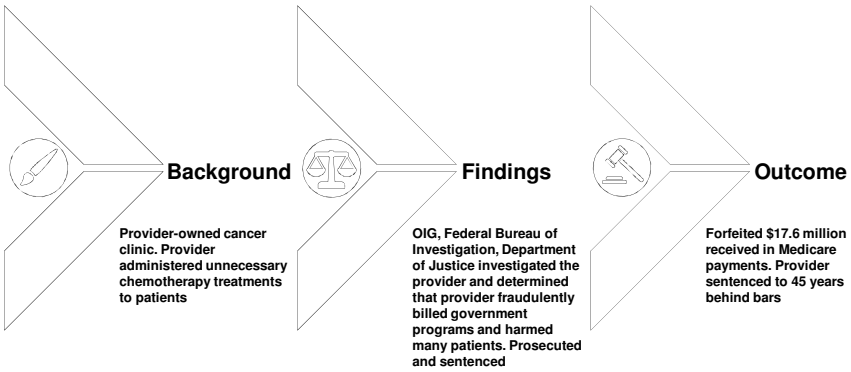
Example case #1

Inadequate peer review and credentialing procedures for specialist(s)

Source:
8. http://www.allianceforpatientsafety.org/redding-failure.pdf..

Example case #2

Patients receiving unnecessary care



Sources:
9. https://www.fbi.gov/news/stories/2014/november/egregious-case-of-health-care-fraud/egregious-case-of-health-care-fraud.
10. https://www.fbi.gov/detroit/press-releases/2013/oakland-county-doctor-and-owner-of-michigan-hematology-and-oncology-centers-charged-in-35-million-medicare-fraud-scheme.

Important questions

Be skeptical – ask important questions and verify adequacy of controls

Who?	What?	How?
Who is checking the credentials of our providers?	What is being checked through this process?	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

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

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

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