A Not So New Frontier: System-Wide Credentialing and Privileging

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A Not So New Frontier: System-wide Credentialing & Privileging

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Objectives

1. Description of a centralized environment
2. Adding value and collaboration
3. Developing processes and standardization
4. Similarities and differences between accrediting bodies related to a centralized environment

Credentialing

Credentialing: Primary source verification of a health care practitioner’s education, training, work experience, license, etc. A variety of resources are used to verify the information involving direct communication from the educational and training institutions, past and current hospital affiliations and employers, peer reference letters, certification boards, licensing agencies and other sources.
Privileging

*Privileging:* Granting approval for an individual to perform a specific procedure or specific set of privileges based on documented competence in the specialty in which privileges are requested.

Enrollment

This involves registering your providers' information with the payers so that their systems know to expect to receive electronic claim and eligibility requests from your providers.

Delegated Credentialing

Delegated credentialing is a formal process by which an organization gives another entity the authority to perform credentialing functions on its behalf.

Practitioners covered under delegated credentialing contracts with health plans do not have to submit credentialing paperwork to health plans. Practitioners get credentialed and appropriate credentialing paperwork is submitted to the health plans. Practitioners are accepted into health plan provider panels the date of credentialing approval.
Growing Pressure

As consolidation drives the formation of larger medical groups and physician employment, administrative staffers are struggling to keep up with the demands of physician onboarding.

If an organization fails to properly credential a physician with Medicare and other payers, the doctor cannot bill for services, which means lost revenue for the group (in the context of employment) and/or the provider.

Benefits

Eliminates duplication and reduces costs because practitioners and their clinics do not have to complete a credentialing application for each health plan.

Enhances third party payer reimbursement for contracted entities because health plans accept XYZ System’s date(s) and primary source verification (versus waiting to go through an approval process by each health plan).

Benefits

- **Cost reduction.** By consolidation of staff, subscriptions (AMA, ABMS, ECFMG, etc) and soft costs (paper, postage, etc).
- **Service improvement.** Centralizing staff and processes leads to better service to physicians. Consolidation avoids duplicate requests to physicians for information, and working proactively helps eliminate deadline crises.
- **Quality and Turn Around Time Improvement.** Centralizing processes requires standardization and consistency. Leads to better auditing and tracking.
- **Revenue cycle optimization.** In my experience, a well-designed credentialing unit can reduce credentialing-related billing problems to essentially zero.
Complexity Of The Problem

Privileging varies from campus to campus mostly differing on whether they require recertification of specialty board certification.

Privilege criteria may also vary from campus to campus for specific procedures.

Five Factors to Success

1. Create a Specialized Team
2. Use Dedicated Credentialing Software
3. Manage Each Physician as a Single Account
4. Emphasize Relationships
5. Take a Flexible Approach to Outside Resources

Bonus: Positive Relationships with Physicians
Create a Specialized Team

The foundation of an effective credentialing unit is specialization.

Members of the credentialing team should focus entirely on physician credentialing, privileging, and related functions.

Team members should not have side responsibilities in other areas such as billing, administration, or recruiting.

Focus on hiring skilled, knowledgeable and passionate MSP’s.

Create a Specialized Team

A strong credentialing team can usually be recruited from within the organization.

As you review internal candidates, focus on identifying the right skill set. A good credentialing professional is detail-oriented and can multitask, but must also possess excellent client service skills.

Choose candidates who can interact positively with physicians, hospital administrators, and payer representatives.

Create a Specialized Team

A major goal of a specialized team is standardization of processes.

The credentialing supervisor should work with other team members to create credentialing policies and procedures that drive the bulk of the unit’s activity.
Use Dedicated Credentialing Software

Many credentialing efforts employ a collection of internally developed tools—spreadsheets, calendars, checklists, reminder systems, etc.

One problem with these systems is their heavy dependence upon the knowledge, memory, and diligence of the individual user.

Effective credentialing teams use specialized software to coordinate credentialing information, automate functional expertise, manage workflows, and ensure continuity.

Use Dedicated Credentialing Software

Vendor systems allow credentialing staff to take a much more proactive approach to their work.

Triggers can be used to efficiently manage deadlines and automation can facilitate repetitive processes.

Dashboards and custom reports allow the team to monitor and steer the entire process more effectively.

Manage Each Physician as a Single Account

When credentialing staff are dispersed throughout an organization, physicians receive poor service.

In a typical scenario, a physician might be contacted by an employee responsible for government credentialing, another person responsible for PHO credentialing, plus privileging staffers from five separate hospitals.
Manage Each Physician as a Single Account

In contrast, centralized credentialing enables staff to treat each physician as a single, coordinated account.

Team members identify all the information and documentation needed for an entire credentialing/privileging panel and contact each physician at designated times.

* TJC = 2 years
* NCQA = 3 years
* CAQH = 120 days (attestation)
* Demographic updates

Three Basic Approaches

Divide the work by function.

For example, one team member will handle hospital privileging, another will manage credentialing with government payers, a third will be responsible for commercial HMOs, etc.

Three Basic Approaches

Divide the work by alpha.

For example, one team member will handle ALL the PSV credentialing, hospital privileging, managed enrollment with government payers and commercial HMOs, etc.
Three Basic Approaches

Assign accounts by specialty. Under this system, individual team members handle all the credentialing for physicians in designated specialties. One staffer might be responsible for cardiologists, urologists, and family practitioners; another would take care of physicians in neurology, nephrology, and gastroenterology; and so on.

Unique Relationships

Emphasize Relationships

Credentialing is not just paperwork. It is a “high touch” discipline that relies on cooperation and input from multiple stakeholders.

Effective credentialing teams focus on building strong individual relationships with payer representatives, government contacts, medical staff liaisons, and many others.
Emphasize Relationships

Personal relationships are often the key to resolving credentialing problems quickly.

The ability to call a known contact (as opposed to the unknown person answering an 800 number) can mean the difference between overcoming a process snag in minutes rather than in days.

Flexible Approach to Outside Resources

Many external credentialing resources are available, and they can often be integrated with in-house efforts to create greater efficiency and cost-effectiveness.

For example, the credentialing process requires provider organizations to authenticate basic information such as the physician’s education, training, licensure, and malpractice history.

Flexible Approach to Outside Resources

Outsourcing certain portions of credentialing can also make sense. For instance, some organizations are comfortable handling hospital privileging and government credentialing, but would rather outsource commercial payer credentialing.

Outsourcing the entire credentialing/privilleging function is also a possibility. This option can provide the benefits of centralization while leveraging existing expertise and relationships.
BONUS! Positive Relationships with Physicians

Medical group leaders seeking new administrative efficiencies should not overlook the opportunity to streamline credentialing staff and processes.

Centralized credentialing, privileging and enrollment can also be an important element of physician relations.

BONUS! Positive Relationships with Physicians

As the provider consolidation trend continues, leaders can expect more points of friction to develop between physicians and administration.

A professional credentialing unit can help minimize avoidable problems and support positive working relations among all parties.

Scope of Responsibility
Scope of Services

- Application Management
- Credentialing – Hospitals, clinics, IPA, Health Plan
- Privileging
- Enrollment - Government and Commercial
- Report creation and maintenance
- Health Status Verification/Tracking
- Management of Expirables
- Management of ongoing monitoring (OIG, Sanctions, etc)

Scope of Services

- CQ (NPBD) enrollment/dis-enrollment and disclosure management
- Downstream data to various systems
- Mergers/Acquisition Due Diligence review for medical staff/credentialing items
- Physician communications and web portal
- Training resource for Credentialing software
Things to think about

Strong Work Flow processes

Use of fields/tables/data – avoid “Work-arounds” – optimize your software

One application: all organizations, regardless if physicians or allied health.

One privilege form by specialty for all organizations

What is verified, how, when – Joint Commission, NCQA, AAAHC, CMS (client matrix)

Expirables and ongoing monitoring

Client Matrix - Initial

Client Matrix-Recredentialing
Promote Consistency from the Beginning... Application Entry

- **Application request**
  - Application Request form: Internal Requests
  - Health Plan
  - Medical Groups
  - Practitioner name entered from verification
  - License status, OIG and board certification (as applicable) verified prior to application release

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**Work Flow Process**

- **Data Collection Tool**
- **Database**
  - Hospital Application
  - Government Payers
  - Commercial Payers
  - Rosters, Portals, Dashboards
  - CV Service
  - Renewals
  - Application Services
  - Other Services

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**General Standardization of reappointment**

Standardization for bringing reappointment data in line (this would include standardizing next reappointment dates across facilities)

- **Hospital** – all facilities have the same reappointment date and it’s a constant dance of synching
- The CVO always has a 23 month reapp cycle regardless of what a facility might have
- To bring in “outliers” if they are 6-9 months difference we synch
IMPORTANT POINTS:
– It will be necessary to decrease the variation.
  • Will allow sharing of documents to decrease requirements for onsite proctoring
– No one is excused from the process of initial evaluation (applies to residents and fellows)
Credentialing Basics

- Process
  1. Collect
  2. Verify
  3. Evaluate
  4. Recommend
  5. Authorize/Approve

Primary Source Verification (PSV)

The original source that can verify the accuracy of a credential, qualification, or other information reported by the practitioner

REQUIRED BY ALL ACCREDITING ENTITIES

Medical Education & Training

TJC, HFAP, DNV Requirement

(I) PSV from medical school
Accepted DES (AMA, AOA, ECFMG)

NCQA Requirement

- (I) PSV from Medical School
- NOT required if Board certified or residency has been verified (aka Highest Level)
- Fellowships do not apply
- DES: AMA, AOA, ECFMG, state licensing agency
- If state licensing agency is utilized documentation that they PSV education must be updated annually
Board Certification

**TJC, HFAP, DNV, CMS Requirement**
- Not required unless bylaws/privileges require it
- (I & R) verify through specialty board, AMBS, AMA, AOA

**NCQA Requirement**
- Not required
- (I & R) verify through specialty board, ABMS, AMA, AOA, state licensing board if documented
- May not use ABMS consumer website – must be subscription website
- (I & R) Lifetime certification must be documented – verify status not expiration dates
- 180/120 time limit

State License

**TJC, HFAP, DNV Requirement**
- PSV through state licensing board
- (I & R) PSV required at: Initial Appointment, Reappointment, Revision/Addition of privileges, Time of expiration

**NCQA Requirement**
- Statement on application regarding history of loss of license
- (I & R) PSV through state licensing board for all states where practitioner provides care
- License must be current when file is presented to the Credentials Committee
- Only use AIM DocFinder if directed to site by state board
- 180/120 time limit

DEA/Controlled Dangerous Substances (CDS)

**TJC, HFAP, DNV Requirement**
- (I&R) Applicant must provide info regarding previously successful or currently pending challenges or relinquishment of registrations
- (I & R) medical staff evaluates challenge and voluntary or involuntary relinquishment of registration
- PSV copy of certificate, NPDB, NTIS, AMA, AOA

**NCQA Requirement**
- PSV copy of certificate, NTIS, AMA, State CDS
- PSV required in each state where the practitioner provides patient care
- DEA/CDS not applicable to Chiropractors – CDS not applicable to Dentists
- 180/120 does NOT apply to this element – certifications must be current at time of review/approval and/or transmittal by CVO
**Malpractice History**

**TJC, HFAP, DNV Requirement**
- (I & R) applicant must provide info regarding claims history (at minimum include final judgments/settlements)
- (I & R) MS must evaluate evidence of unusual pattern or trend or excessive number of actions with final judgment.
- May verify with carrier or NPDB

**NCQA Requirement**
- (I & R) applicant must provide malpractice history for past five years.
- Five year history can be PSV through carrier or NPDB
- 180/120 time limit

**Ongoing Monitoring of Sanctions**

**TJC Requirement**
- Not addressed in standards
- Must have process to review complaints, concerns and allegations from patients/family and staff to assure credibility of complaints as part of QI function

**NCQA Requirement**
- P & Ps required
  - Medicare/Medicaid
  - License
  - Patient complaints (reviewed every 6 months)
  - Identified adverse events (reviewed every 6 months)
  - Monitoring occurs as information is published, reviewed at least every 6 months
  - Must be reviewed within 30 days of release of information

**National Practitioner Data Bank**

Organization MUST follow state/federal laws regarding querying and reporting!
Peer Recommendations

TJC Requirement

(I) required – must be within same professional discipline with knowledge of ability to practice, ability to work as a team and ethical behavior.

Recommendations should address the 6 General Competencies

(R) required only if there is insufficient practitioner specific data to be evaluated. May use PI Committee review, department chief, MEC.

Policies & Guidelines

Release language
- Absolute Immunity
- Release from liability
- Indemnify and hold harmless

Attestation questions to consider:
- Do you have a release agreement with any organization?
- Do you have a behavioral agreement?
- Have you ever had a time limited appointment?

Responsibility & Accountability

Responsibility - ALL USERS!

- Monitor data entry to ensure that the data remains clean – specific data audits
- Reporting issues – who in the organization is delegated – Super Users and Administrators
- Auditing to ensure all agreed organizational, regulatory and governmental standards are being met
Sequencing of Data

- **Credentials**: Medical School, Internship, Residency, Fellowship in chronological order. Professional Education followed by Graduate Education.

- **ID numbers**: License (APN, one associated with practicing specialty), DEA, and then NPI, any other states grouped together, historical on the bottom.

- **Hospitals**: Primary Scripps on top (even if applicant), any other Scripps facilities following. Next - other current hospitals with priors following chronological order.

Consider the downstream effect of your data

- Report generation
- Integration with Managed Care Enrollment
- Administrative Review Module implementation
- Direct data feeds, i.e., Doctor Directory
- HL7 interface with other systems
- Analytics

What makes a successful multi-entity process work

Communication between the corporation and each facility being brought into a centralized process:

- Buy in on authority, process and ownership
- Quarterly “refreshers and troubleshooting” are offered
- Monthly report goes to the Governing Board regarding the status process, audits, issues
- Strong relationships with not only the clients, payers, physicians and leadership but also with IT teams
Practices to Keep Data Clean

- Learn to love auditing
- Assign common reports to each member of the team to run, audit and send
  - Perspective of data to receiver
  - Accountable
  - Responsible
  - Educational
- Audit every initial application
- Incorporate audit outcomes in performance reviews
- Restrict table maintenance to a select few

Elements for Success

- Patience
- Never too soon to assess your current data
- Educate, educate, educate
- Review your policies to ensure they reflect the process
- Train new associates
  - Schedule close to final merge/Go-Live date
  - 1:1 computer time
- Continued support after merge
- Celebrate, celebrate, celebrate

Count on “do overs”
Looking Forward

- Acquisitions of groups and hospitals/clinics
- Community & Referring practitioners in our database…oh the HORRORS of HIE
- HR as an “organization/facility” to manage their RN licenses
- Ever growing list of people wanting “your stuff”
- Explore database capabilities and possibilities
- Achieving the dream! Multi-facility PCCB privilege forms
- Billing for services
- Extending services outside of the organization