

6 Critical provider credentialing issues and how automation can solve them in 2018

- Do you know that a poorly run credentialing process can cost your healthcare organization multiple millions of dollars in recovery audits?
- Are you aware that lapsed licensure is one of the most common reasons for [rejected claims](#)?
- Do you know that credentialing errors are considered a low-hanging fruit for recovery auditors as a provider without proper credentials cannot support claims?

Credentialing is mandatory for providers wanting to participate in insurance networks so they can treat patients and get paid for their services. With the cost of premiums and high deductibles and even higher Copays, participation with the insurance networks is almost a dire necessity for providers to acquire new patients.

Credentialing Issues: From Beginning to End

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The sooner a provider starts his practice or changes locations or joins another practice, it is imperative that he/she makes the commitment to notify all insurance carriers, including Medicare.

So often, we as the credentialers are not notified of these changes until 6 months or more after the fact. Usually a provider realizes that he/she should have acted sooner [to get paid](#). Contracts are tax ID and location sensitive! Ignoring the timeliness of credentialing is a compliance issue.

Quick list of the 6 critical credentialing issues faced by medical practices

1. Lack of Organization

Providers will either have a credentialing coordinator in house, or outsource the process to a reputable credentialing company. The coordinator has the duty of keeping up with expiring documents, reminding and requesting from the provider for current documents so that their online CAQH file can be updated and re-attested every 120 days. This process is extremely important to [ensure the provider continues to be paid in a timely manner.](#)



2. Lack of Timing

This is an important issue as so many practices are understaffed and maybe have one or two people wearing many hats on a day-to-day basis. Credentialing requests from insurance carriers have deadlines to receive information necessary to credential a provider.

If these are not met in the time allotted the provider can be termed and sometimes will have to wait as long as one year to [reapply for in-network status.](#)

3. Credentialing TAT for New Providers or Added Associates

Credentialing is one of the first applications all providers should start as soon as they know they are opening a new practice or a new associate position. Credentialing takes anywhere from 90 to 180 days, depending on the insurance company's agenda. Some states have an "any willing provider" status so there are never any "closed" panels in those states. Unfortunately, Texas does not have this amendment.



One of the largest issues with this regulation is that provider directories are not updated when a provider moves, quits practicing or passes away, there is a protocol established to remove these providers to make room for new ones. Sometimes it takes 2 or more times to get this problem resolved. Additionally, re-credentialing is mandatory everyone to 3 years depending on the carrier or hospital. Re-credentialing is critical to remain in the networks. When re-credentialing is requested from a carrier, it is imperative that the deadlines are met!

4. Common Information

All provider and credentialer information must be kept current. Any address changes, phone or email changes, need to be corrected and re-attested in CAQH as soon as they are known. Otherwise one call with a disconnected number or mail returned for address unknown can be a cause for terminating a contract.

5. Background Checks and Disclosures are essential!

When the credentialer is completing applications and history, it is standard and imperative procedure that each provider discloses any mal practice suit, board action against their license, or anything that has been reported to the NPDB, National Practitioner Database.



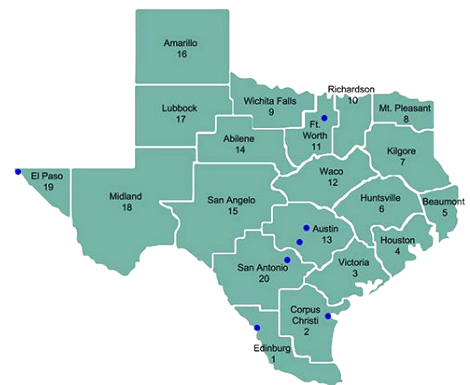
All information regarding law suits or board actions are automatically reported to this agency and part of the credentialing process by insurance companies and hospital agencies is to research to see if there is anything that a provider may have not reported. Non-disclosure is one of the main reasons a provider can be rejected by an insurance network.

6. State Compliance is a Must!

All states do not have the same regulations. It is important that your credentialer checks state regulations where your practice resides.

Some of the standard requirements are as follows:

- a) Current CV (resume) listing the last 10 years of education and work history, with addresses, phone numbers and start to end date in MM/YYRR format
- b) Letter giving your side of the story on any board orders or sanctions or malpractice suits along with the final outcome of the case.
- c) Copies of all diplomas and certificates, including current CME's



d) Current Peer References with current address phone and email. These references should be the same specialty and someone that knows your work and ethics.

Simplify the credentialing process through automation

2018 is going to be a rollercoaster year for healthcare organizations. It is important to get rid of manual, tedious processes to gain greater efficiency. There are several [provider credentialing solutions](#) that can help you perform online verification, manage and update provider details, resolve credentialing issues in real-time and manage access controls

About us:-

AnesthesiaBillingBridge is a revenue cycle management and medical billing company that specializes in offering technology enabled RCM services for anesthesia practices. Our [certified anesthesia coding experts](#) provide wholesome and result-driven coding solutions. Power your anesthesia practice with the right teams and technology.



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