Dynamic Chiropractic

YOUR PRACTICE

Everything You Need to Know About Insurance Credentialing

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There are so many things that can go sideways for a practice, all of which can impact cash flow, patient relationships, office systems and more. Of course, anything that interferes with the health revenue cycle system is going to have a downstream effect on many areas of the business. One of these interferences may be related to proper provider credentialing.

This matter has come across my own desk a number of times over the years and again several times recently. With that said, let's discuss the what, why and how for insurance credentialing as it applies to every DC, whether you've been in the insurance game or are just beginning.

What Is Credentialing?

Insurance credentialing is the process of applying and providing provider-related data for payers and payer plans, which enables a provider to accept particular insurances and ensure proper processing and reimbursement. More simply put, credentialing is the process required to certify a provider's qualifications and provider enrollment for payers or payer plans; as an individual provider or within a particular group/facility for which they will be treating patients and submitting claims.

Why Is Credentialing Necessary?

Health care provider credentialing is essential for proper insurance processing and reimbursement. Procrastination or haphazard credentialing management will result in claims rejections or denials, accumulating insurance accounts receivables, stifled cash flow, and disruption to practice-patient relationships.

Who Should Credential With Insurances?

- Established providers often see an opportunity with being enrolled under specific payers or plans in their region. To access network benefits, credentialing and enrollment are required.
- New providers getting started on their own or as an associate provider should always look at insurance credentialing necessities and options.
- Established providers who may be moving from one practice to another should also evaluate credentialing necessities prior to beginning with patient care in the new location.

Most providers accept some insurances – Medicare, the Veterans Administration, standard commercial payers and other local-type plans. Medicare, for example, requires chiropractic providers to be credentialed and enrolled with the Medicare program to even be able to provide care for patients with Medicare Part B coverage.

It is important to be aware of general payer guidelines for decision-making on credentialing and enrollment. Additionally, keeping a finger on the pulse of prominent payers in your general region will help determine if being credentialed and enrolled with particular networks is going to be financially advantageous and/or beneficial to the practice in other ways.

In other words, providers who may already been credentialed with some payers often find, over time, that there are other payers with whom credentialing would be a good business decision moving forward.

For example, you may find that a large employer in you region has changed to a new group insurance for their workforce. In order to best access those benefits and have the opportunity to build patient volume with that payer, credentialing and enrollment may be necessary.

Additionally, of course, provider re-credentialing is an ongoing requirement as well – thus, really all providers who are credentialed with payers should have a knowledgeable credentialing specialist in their contact list for questions and assistance with these processes.

What Is Needed for Credentialing?

Insurance credentialing is largely an online process requiring detailed disclosure of provider data, along with the inclusion of multiple supporting documents, such as current licensing information, malpractice coverage and more. This information, once completed and submitted to respective payers, is reviewed in detail and enables payers to do the following:

- Screen provider data, including history of billing for other payers, for potential risk of fraud, waste and abuse
- Establish complete provider identity for internal payer system setup so as to enable claims receipt and proper processing for coverage and reimbursement
- Provide current lists of in-network and out-of-network providers for patient reference, so they may be assisted in selecting health care providers on network-status for utilization of coverage and benefits

When Should You Credential?

In order to credential, specific information is necessary, including TIN, practice location, NPI data, etc. Given this, it is important for *newer providers* to be aware of what is required, so as to not spend unnecessary time starting a process they'll not be able to complete.

For *established providers or those moving from one location to another, or joining another group practice*, the credentialing process should be initiated at the earliest possible opportunity so as to minimize the impact to cash flow and patient relationships, along with other billing-related challenges.

How Do You Credential and How Long Does It Take?

As previously described, credentialing is managed through appropriate online portals, as well as by working with payer enrollment departments by phone. More often, due to the time spent to complete credentialing, and the detail and information that is required, along with the technical knowledge of individual payer and state rules related to credentialing, providers most commonly seek assistance from professional credentialing services.

As for how long it takes to credential, the average time frame for completion of required materials, payer review and approval of provider data is roughly 8-12 weeks. Note that should any information be missing or incorrect, any additional research or information be requested or any enrollment delays by the payer occur, this period can be extended.

Can You Submit Claims if Credentialing Isn't Yet Completed or Approved?

If credentialing has not been completed and submitted for review, any claims under the said

provider will be rejected / denied. This rejection or denial generally cites that the provider is not approved for submission with that payer or is not enrolled as a treating provider under the group practice through which claims have been submitted.

Note that if your business has perhaps moved to a new location, added a new provider or began submitting claims to payers for which you are unfamiliar or perhaps not enrolled with, it is highly recommended that you check electronic claims rejections (if you haven't done so already), as well as insurance "black hole"-type reports, to review lists of claims that may have not even made it out of your software.

In the event that credentialing data has been submitted and you are waiting for confirmation of approval, the general recommendation is that you should wait until confirmation of credentialing approval has been received. Approval is typically received via letter from the individual payers.

Note that if claims are submitted anyway, it is most likely those claims be rejected / denied until the payer has approved the credentialing application and enabled claims processing for the said provider and/or group.

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