

CASE STUDY

HOW A BEHAVIORAL HEALTH ORGANIZATION PROTECTED OVER \$47,000 IN REVENUE AFTER A MEDICAID PROVIDER TERMINATION

A Journey of Innovation and Success



OVERVIEW

A community-based behavioral health organization serving Medicaid beneficiaries discovered that one of its credentialed providers had been removed from a Medicaid managed care network. The termination immediately placed active claims, future reimbursement, and continuity of care at risk.

L&C Advanced Practice Management conducted a comprehensive credentialing and payer review, coordinated a multi-level escalation with the payer, and successfully supported the restoration of the provider's network participation.

As a result, more than 350 claims with an average reimbursement value of \$135.50 per claim, representing approximately \$47,425 in reimbursement, were protected from denial risk and made eligible for continued processing and recovery.

THE CHALLENGE

A behavioral health organization operating within a Medicaid managed care environment identified a serious payer enrollment issue involving one of its credentialed providers.

The organization discovered that:

- The provider had been removed from the payer's network.
- Active claims were exposed to denial risk.
- Future services could become non-reimbursable.
- Patient continuity of care could be disrupted.
- Leadership lacked visibility into the underlying cause of the termination.

At the time of discovery, more than 350 submitted and pending claims were potentially impacted.

Without intervention, the organization faced the possibility of losing reimbursement on services already rendered while also creating significant future revenue disruption.

OUR ASSESSMENT

L&C performed a detailed review of:

Credentialing & Enrollment Records

- Provider enrollment history
- Effective dates
- Recredentialing activity
- Network participation records

Payer Communications

- Termination notices
- Historical correspondence
- Credentialing records
- Network management documentation



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Revenue Cycle Exposure

- Claim inventory
- Submission timelines
- Pending reimbursement
- Future scheduling impact

Our investigation identified discrepancies that warranted immediate escalation and further payer review.

THE SOLUTION

Phase 1: Documentation Validation

Our team gathered and validated all supporting enrollment and credentialing documentation necessary to establish the provider's historical network participation.

Phase 2: Strategic Escalation

L&C coordinated communication across multiple payer departments, including:

- Provider Relations
- Credentialing
- Network Management
- Claims Operations

The objective was to identify the source of the termination and present evidence supporting reinstatement.

Phase 3: Revenue Protection

While the matter was under review, we monitored affected claims and documented reimbursement exposure to support future recovery efforts if necessary.

Phase 4: Resolution

Following payer review, the provider's termination was rescinded, and network participation was restored.

This allowed affected claims to remain eligible for processing and reduced future reimbursement risk.



MEDICAID PROVIDER TERMINATION



350+ CLAIMS AT RISK



\$47,425 REVENUE EXPOSURE



L&C ADVANCE PRACTICE MANAGEMENT INTERVENTION



REVENUE PROTECTED

RESULTS

- Revenue Cycle Impact
- 350+ claims protected from denial risk
- \$47,425 in reimbursement preserved based on average claim reimbursement values
- Reduced future accounts receivable exposure
- Maintained reimbursement continuity for active services



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RESULTS

Operational Impact

- Provider network participation restored
- Patient care continuity preserved
- Scheduling disruptions avoided
- Enrollment records corrected

Leadership Impact

- Improved visibility into payer enrollment management
- Stronger credentialing oversight procedures
- Enhanced monitoring processes
- Reduced organizational risk from future enrollment disruptions

LESSONS FOR PRACTICE OWNERS

If you cannot answer the following questions today, your organization may be exposed to similar risks:

- Are all providers actively showing as in-network with every contracted payer?
- Are payer rosters being monitored regularly?
- Do you have a process to identify unexpected network terminations?
- How quickly would you know if a provider was removed from a payer network?
- The cost of not knowing can be substantial.

KEY TAKEAWAY

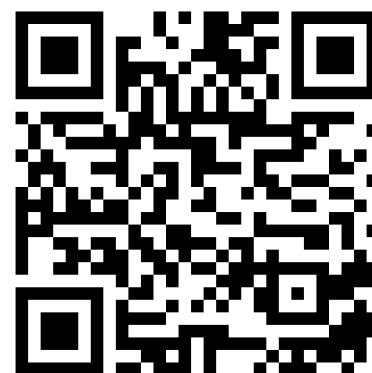
Credentialing does not end when a provider receives network approval.

Provider enrollment requires ongoing oversight, monitoring, and verification. A single payer roster error, enrollment discrepancy, or administrative oversight can expose thousands of dollars in reimbursement to denial risk and create significant operational challenges.

In this case, proactive credentialing management and strategic payer escalation protected more than \$47,000 in reimbursement while preserving access to care for Medicaid beneficiaries.



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