Provider enrollment – the nuances of credentialing

Healthcare provider credentialing and payer contracting are comprehensive, time-consuming processes but represent a critical component affirming requirements and qualifications necessary to deliver the highest level of patient care. They also are essential for insurance reimbursement.

The process of provider enrollment with an insurance network consists of two phases: credentialing and contracting. Credentialing can be defined as the process of obtaining, assessing and confirming the qualifications of a licensed or certified healthcare provider. The contracting phase is when the company issues a participating provider agreement that defines the terms of participation for receiving in-network reimbursement for claims. Payers may vary on which phase occurs first, but regardless of order, both phases are necessary steps in the provider enrollment process.

Providers starting out in a new practice who have previously worked for other groups still need to contact each payer to determine network status. It is not to be assumed if a provider is contracted in one office, he or she will have the same status in another. Typically, a new agreement will need to be signed to continue as an in-network provider with a particular carrier.

Keep in mind, unless otherwise allowed by state regulations, providers must be approved through both the credentialing and contracting processes before consideration and the ability to submit claims as an approved network provider.

CMS step-by-step process

CMS completes an extensive credentialing and application process for healthcare providers. The Medicare Enrollment Guide for Providers and Suppliers explains this step-by-step process at CMS.gov. Upon verification and depending on choice of participation, the provider is assigned a Unique Physician Identification Number and/or a Medicaid number – each is required to bill for Medicare and Medicaid services.

All managed care plans, including health maintenance organizations, other health insurance plans and some insurance companies also have their own exclusive and specific credentialing policies and procedures. Each credentialing program is developed in accordance with state and federal requirements and individual accreditation guidelines.

OMSs may want to work directly with a third-party payer via its application process or with a company that streamlines the process, such as the Council for Affordable Quality Healthcare (CAQH), which many medical and dental payers use to carry out their credentialing application process. CAQH simplifies the credentialing process so providers only need to submit their application and supporting documents once while allowing the ability to indicate which particular networks they wish to join. CAQH accomplishes this through its online database, the Universal Provider Datasource, which collects all information required for credentialing and makes it assessable to third-party payers. For example, Anthem Blue Cross Blue Shield and UnitedHealthcare link their credentialing process directly to the CAQH website.

Completing a credentialing application may take several hours, and it is not uncommon for the approval process to last up to three to four months. Therefore, to save time and ensure the application is complete, preparing a checklist can help compile all the required paperwork. Payers may vary based on the documentation required, although some common qualifications and supporting documents necessary to complete the credentialing process may include:

- Education, training and board eligibility or certification
- Work and medical staff history
- Clinical privilege history
- Names and emails of peers who can provide reference
- Clinical report cards and performance reviews

and contracting

- Malpractice insurance carriers and any claims history
- Explanations for any gaps of 30 days or more in education, training or work history
- Federal, state and professional licenses and registration

In order for healthcare providers to be able to report services for reimbursement on a medical or dental claim, the credentialing process should be started at least four months before the expected start date of seeing patients.

Rules for incoming provider

Oftentimes, the question may arise whether a provider that is new to the practice can see patients and report services under another provider's National Provider Identifier (NPI). Medicare and private payers have strict rules about billing for services performed by someone other than the treating provider. Services must be billed under the care-rendering provider's NPI, and it is inappropriate to bill a non-credentialed provider's services under a credentialed provider's NPI. This action may lead to a potential audit, fee recoupment and investigation by the insurance carrier. It also is a violation under the False Claims Act and can initiate exclusion of participation to all federal healthcare programs, including Medicare and Medicaid.

In addition, recredentialing occurs periodically and requires a provider to attest or renew the credentialing process. It is important to update provider profiles when changes occur and be aware of plan revalidation processes that may require affirming or updating information (e.g., license expiration, change of address or practice location).

AAOMS encourages members to discuss and review their contract negotiation with their practice attorney and thoroughly review and understand contracts before entering into an agreement with a third-party payer. ■