The Value of Medical Credentialing

Credentialing is Crucial for Healthcare Providers; Here's Why

Truth is, many patients know little more about their physician's qualifications than what they see neatly hanging from their office wall. While they're able to access in-depth background information about their auto mechanic, it's when they are at their most vulnerable, entrusting their family's health to a qualified healthcare professional, is when they must hope that there's more than meets the eye behind the sometimes bewildering abbreviations spread across those medical school diplomas.

That's why medical credentialing exists.

Put simply, **medical credentialing** is a process by which medical organizations verify the credentials of healthcare providers to ensure they have the required licenses, certification and skills to properly care for patients. It's an essential function for hospitals and others which precedes hiring or obtaining coverage by an insurance carrier. However, the procedure is anything but simple, as we'll soon discover.

Why is credentialing so important?

It might seem, at first glance, like credentialing is simply a paperwork chore, rather tedious and not nearly as essential as patient care, but it's an undertaking (with an urgency) that can't be taken lightly.

Medical credentialing provides quality assurance to the medical industry, which benefits everyone involved. Not only does it guard hospitals and other organizations from would-be lawsuits, it's a safeguard put in place to protect patients by supplying competent, high-quality healthcare providers.

More to the point, hospitals and clinics can be assured that the staff they hire will provide care at the standards demanded from them. Plus, insurance companies have an incentive to keep costs down

and therefore prefer to insure only those medical providers who demonstrate sufficient competence in practicing medicine.

Medical practitioners benefit from credentialing because once they receive privileges to accept clients from insurance companies, they can grow the number of patients who have access to them.

Finally, medical credentialing is perhaps most important because it's the one method that permits patients to place their trust with utmost confidence in their chosen healthcare provider(s). Through a standardized process involving data collection, primary source verification and committee review by health insurance plans, hospitals and other healthcare agencies, patients are confident in their healthcare professional's ability and experience.

Bottom line: The healthcare provider credentialing process works to make sure that everyone from doctor to patient, and everyone in between, is better off.

A bit of credentialing history

While most of us might think of medical credentialing as a present-day concept, it's been a part of physicians' livelihoods dating as far back as 1000 BC, at least in some rudimentary form. In ancient Persia, to qualify for licensure, a physician had to treat three heretics – if they lived, that qualified the physician to practice medicine for the rest of their natural lives. Sound simple enough?

By the medieval period, the credentialing process was becoming be more elaborate. In 13th century Paris, the **College de Saint Come** divided the barber surgeons (surgeons of the long robe) from lay barbers (barbers of the short robe). To become a member of the College, and therefore a surgeon of the long robe, one had to meet specific prerequisites for admission and pass an exam given by a panel of surgeons.

Fast forwarding to the U.S in the 1960's, the **Darlington v. Charleston Community Memorial Hospital** case established the duty of hospitals to verify their physician and other provider competencies. This landmark suit soon brought about the creation of a credentialing process as hospitals and other organizations sought to shield themselves from comparable lawsuits.

Prior to this case, the hospital contended that the attending physician was an autonomous contractor, exempt from oversight. Darling amended this tactic and set the stage for a consistent systematic evaluation of all physicians who asked to practice in the inpatient venue.

As such, the verification and evaluation of a physician's credentials became the standard before inpatient privileges would be accorded.

Again, moving forward, it was in the 1990's that national organizations devoted to the credentialing of medical providers came into being. The most well-known of these is **NCQA**, or the **National Committee for Quality Assurance**. This organization sets a range of standards that perform as a guide for **how to credential medical providers**, including the use of primary source verification which is the process of requesting and receiving verification of the provider's stated credentials from the college or other entity that issued the diploma or certificate. This includes board certification, education, training, malpractice claims and other factors that can have a bearing on patient care.

While credentialing has obviously changed over the years, the heart of the concept is identical– ensuring doctors practicing in a given state or city have obtained the required training and possess the know-how to safely and capably practice medicine.

How does the credentialing process work?

Basically, there are three primary stages:

1. In the **Initial Stage** (**credentialing on-boarding**), a healthcare facility or health insurance plan asks the medical provider for information on his or her background, including education, licensing, etc. Hospitals and similar healthcare organizations have a legal obligation to validate the provider's identity, education, work experience, malpractice history (if any), professional sanctions and license confirmations to safeguard patients from non-qualified providers. As a prime example, when a physician wishes to practice within a hospital, a surgery center or a physicians' organization, they are required to complete an application and grant permission to a credentialing authority to examine their professional documents. For a doctor, the **National Provider Identifier (NPI)****, **CAQH ProView**, professional licenses, diplomas, certificates and professional references are all considered as credentialing documents. Remember, the process of credentialing is to verify the accuracy and precise data in the physician's documents.** Every physician receives one **National Provider Identifier (NPI)** number in his or her lifetime. It is a 10-digit number given only to healthcare service providers. Each provider is then responsible to apply for and update the information associated with their NPI.
2. In **Stage Two**, this information is confirmed. This is the "background" work where the facility or insurance company will communicate with licensing agencies, medical schools and other such bodies to validate the provider's information. More recently, the Affordable Care Act substantially increased physician credentialing requirements for Medicare and Medicaid enrollment in an effort to reduce fraud and abuse.
3. **Stage Three** is where the provider is presented with credentials from a hospital or other healthcare organization after all required documentation is substantiated and no negative issues are found. The same with insurance companies who can decide to accept a provider as an in-network provider and will pay he or she for treating patients who have its insurance. Keep in mind that with Medicare and Medicaid, medical credentialing is not only concerned with guarding patients, but also deals with providers securing insurance reimbursements. Without insurance credentialing, providers cannot receive patients or clients that are covered by programs including **CMS/Medicare** and **Medicaid**, as well as most commercial plans.

Who are some of the other major players in medical credentialing?

Healthcare provider credentialing involves numerous parties and moving parts. Of course, as we've seen, the doctor—and other healthcare providers – all must prove they have the education, training and skills necessary to properly care for patients.

At the same time, healthcare oversight organizations monitor the work of hospitals and other healthcare providers to assure they are meeting the standards put forth. The federal **Centers for Medicare and Medicaid Services (CMS)** and the **Joint Commission on Accreditation of Healthcare Organizations** both require that healthcare providers be credentialed. Healthcare organizations that don't follow the CMS regulations are not eligible for Medicare or Medicaid reimbursement.

Most U.S. hospitals pursue the **Joint Commission** accreditation, which is also required for Medicare and Medicaid reimbursement eligibility. As such, the Joint Commission accredits only those who stick to its regulations

Other groups set standards on credentialing as well, and many healthcare organizations follow them to receive additional accreditation. These include the aforementioned **National Committee for Quality Assurance**, the **Utilization Review Accreditation** and the **Accreditation Association for Ambulatory Healthcare**.

Organizations that actually handle credentialing information include the **National Practitioner Data Bank** (information on license suspension, revocation ort medical malpractice claims), the **National Student Clearinghouse** (Information on education history), the **Federation of State Medical Boards** (information on medical professionals, including certifications, education, etc.), and the **American Board of Medical Specialties** (a way to check the Board Certification of physicians under review).

Add to this that all this reporting and monitoring must be continually checked by both the healthcare facilities that employ providers and by health insurance companies that want to issue an approved providers list.

Can the lengthy process of credentialing affect a medical provider's or healthcare facility's bottom line?

Keep in mind that credentialing can take anywhere from a few weeks up to 90 or, in some instances, 150 days, depending on the market. A drawn-out process can have a significant financial impact on both medical providers and healthcare facilities.

That's because when a provider is waiting for hospital credentials, he or she can't see patients at the hospital. Moreover, when a provider is awaiting insurance authorization, he or she won't be reimbursed by the insurance company for seeing patients who have that insurance.

"A physician's time is money," says one credentialing expert. He approximates that for "every day a physician isn't working, that's a loss of $7,000 for a hospital. You multiply that over six months, that's a big chunk of change."

That's why it's important that providers and hospitals ensure the process moves as efficiently as possible.

What are some of the obstacles that can be anticipated in the credentialing process?

This time-consuming procedure must be managed in the correct manner. If physicians are not fully enrolled or credentialed by their participating health plans, they will not get paid for rendering medical services. Not having admitting privileges will also impact their chances to attract more patients.

Moreover, as noted above, the credentialing process can take up to 150 days from beginning to end. This amount of time allows for some leeway with case verification entities who don't respond straightaway to requests of the credentialing authority or if the authority must look into inconsistencies for further clarification.

Remember, the credentialing authority has little control over the response time from outside sources who need to verify information. If they don't respond at first, the authority will make added requests, which can mean major holdups.

So, is it time to consider getting medical credentialing help?

You might decide, at this point, that going in-house for credentialing is not the best route forward. Fact is, health care providers often portray the procedure as "nightmarish" as the process rarely goes smoothly and many providers discover themselves resubmitting applications, battling enrollment denials and wasting a lot of time "on hold" with insurance companies.

It's also been found that in-house credentialing turns out to be problematic for many healthcare organizations either due to lack of dedicated staff, monetary restrictions or lack of required information resources. This is another reason why outsourcing is

becoming a preferred option.

Says one credentialing expert, "it's no secret that the process of medical credentialing isn't something many healthcare providers look forward to. In fact, it's a process that many shrink from."

For many healthcare entities, it just makes sense to employ a service such as **Medwave** to help with medical credentialing. Not only does a credentialing service ease the burden of the process, but using such a 3rd party service usually saves money.

Plus, a reliable service can be expected to have a higher success rate getting the credentialing completed expertly, indicating a physician can begin seeing patients with insurance, sooner rather than later.

What, then, are some of the favorable aspects of using a third-party credentialing service? In brief,

- ***You reduce application errors which could slow down the process considerably.***
- ***You save yourself and your staff time to see patients, cut paperwork and rid of frustration.***
- ***You free up schedule space for staff to work on other things.***
- ***You reduce overall operating expenses.***

We could go on, but we'd rather you give us a call to make an appointment so we can properly demonstrate what Medwave can do to streamline your credentialing process, saving you time and money, putting to bed those credentialing headaches.

Credentialing, **healthcare credentialing**, **medical credentialing**, **medical provider credentialing**