Navigating the Credentialing Process to Maximize Revenue and Minimize Denials

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Q. What is the best way to get my practitioners credentialed with various insurance companies and networks? It is frustrating to try and navigate this convoluted process. I am asked by each insurance company to complete a mound of paperwork and collect a stack of supporting documents for each practitioner. Then I wait *months* for approval notifications and effective dates. As a result, we end up losing some patients because they want to be treated at medical offices where their in-network benefits will apply. If we do treat patients with an out-of-network provider, claims will be either denied or paid at a reduced rate. We can't afford a loss in revenue and we can't afford to lose patients!

A. Credentialing can be a frustrating experience if you are not familiar with the process, especially with provider turnover in the urgent care setting. It is not just physicians (MDs and DOs) that must be credentialed in most cases. Depending on specific insurance company or network (payer) requirements, you might also need to credential advanced care practitioners (ACPs), chiropractors, and therapists including behavior health specialists. The National Committee for Quality Assurance (NCQA), an organization that manages provider and facility credentialing bylaws, states that an insurance company or network can require credentialing for any "...licensed practitioner certified or registered by the state to practice independently and provide care to members...." Alternately, the payer may, to your benefit, allow credentialing for your facility where all providers are covered under the contractual arrangement—generally not requiring a separate application process for your individual practitioners. It is advisable to verify the specific process with each payer entity.

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Documentation

The paperwork required for credentialing practitioners can be overwhelming, as the list of documents seems almost endless. Listed below is just a small sampling of the supplemental documents required to accompany a practitioner credentialing application before submitting to a payer:

- Copies of diplomas
- Curriculum vitae
- Copy of medical and Dangerous Substances certificates
- Work history
- Proof of professional liability insurance
- Negative actions (including investigation, charges, limitations, sanctions, etc.) against the provider's license or regarding DEA, board status, hospital privileges, medical society, faculty status, professional association, applicable narcotic registration, etc.
- Copies of current NPDB and HIPDB results
- Exclusions from Medicare and/or Medicaid
- Full description of clinical services that will be performed
- Accreditations and certifications
- Clinical Laboratory Information Act (CLIA) certificate

State- and Payer-Specific Requirements

Each state and payer has its own specific requirements that you need to know and understand. Caveat: Be prepared for the requirements to change, as the insurance companies have the right to change the process at will. Most changes occur without notification to the facility. Generally, you will discover a change in process when you try to credential your next new practitioner.

Medicare requires an online submittal process via the Medicare Provider Enrollment Chain and Ownership System (PECOS). Other payers may also offer similar systems or web

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portals for submitting credentialing applications, but most will require paper applications to be submitted via regular mail.

Once the credentialing application and required supplemental documentation have been received by the payer, the initial aggregation process will begin to ensure that all forms have been properly completed by the practitioner. This process usually takes place 30–45 days from the date the payer receives the credentialing application. However, if a discrepancy is discovered, usually meaning that supporting documents are missing or the application is incomplete, the payer has the right to (and in many cases will) return the application with all supplemental documents back to the provider to start the application process from scratch.

On average, the entire credentialing process will take anywhere from 3 to 6 months. Payer processing timeframes are regulated by NCQA, which allows 180 days to fully process a submitted and completed credentialing application and send the application off to a credentialing committee for approval or denial into the payer's provider network. Once the application is approved by the insurance company's credentialing committee, the provider becomes eligible for in-network reimbursement from the payer. However, payers are not diligent in notifying providers of their effective dates. NCQA requires insurance companies or payers to notify providers of the committee's decision no more than 60 calendar days as of the date a credentialing committee decision has been made. It is quite *rare* for an effective date or approval date to be retroactive, as that would result in back payment on claims for dates of service prior to the credentialing approval date. It is more likely that the effective date or approval date will be 30 days out from the credentialing approval date, but this varies greatly by payer.

Credentialing Denials

Keep in mind that not all practitioners receive approvals from the payer's credentialing committee. Once in a while you will get a denial, which also means the provider is a nonparticipating provider for an undetermined period of time. Any claims submitted under that practitioner's name will be denied. Common reasons for denials include:

- Payer credentialing verifications that do not match what was documented and submitted on the provider application
- Provider failing to release sanctions, limitations, or adverse actions
- Payer unable to verify completion of training program
- Medical malpractice cases showing a trend in clinical negligence
- On occasion there is a misunderstanding and the payer denies a practitioner by mistake

A knowledgeable credentialing professional will go beyond just filing the letter and accepting the denial. Know your provider's rights and each payer's appeals process. If the denial remains, the provider may be able to reapply in 1–3 years to be reconsidered into the payer's network.

Recredentialing

Medicare requires credentialing every 5 years. Most insurance companies and networks require credentialing every 2 years. NCQA requires insurance companies and networks to reevaluate a provider's credentials every 36 months at the very least. Credentials can be reevaluated sooner, but never later according to the NCQA bylaws; otherwise, payers can lose their NCQA accreditation. Some insurance companies will provide a recredentialing date in the approval letter, through other correspondence, or orally. The majority of insurance companies will not release recredentialing dates, and will require you to keep a look out for a notification email or letter to prompt the completion of the recredentialing process. If you do not respond to the payer's request for recredentialing in the required timeframe, the provider's credentialing file will eventually be terminated and claims will start processing as out-of-network until you complete the credentialing process again from scratch.

Storing Credentials

In addition to completing a payer-specific credentialing application, some insurance companies also require providers to

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maintain and store credentials in the Council for Affordable Quality Healthcare (CAQH) online data collection solution. The provider's uploaded credentials are then pulled by the insurance company to supplement any payer-specific forms that are required. If the credentials are not up to date, providers will be penalized by the payers and their participation will be terminated or suspended. CAQH requires provider information to be updated on a quarterly basis.

Utilizing Uncredentialed Providers

There are some ways you can utilize providers who are awaiting credentialing approvals. Educate your front desk staff on the importance of reviewing patient insurance information and knowing where each provider is in the credentialing process. Most credentialing companies will provide frequent reports detailing updates. If your urgent care center has more than one provider concurrently working in the clinic, then the staff can use this information to match noncredentialed providers with patients who are:

- Members of plans where the provider is credentialed
- Self-pay patients
- Occupational medicine clients
- Members of insurance plans that do not require an approval process prior to treating patients

Regardless of credentialing status, always be upfront with the patient. Depending on your situation, you could offer to work out a payment plan or some other option for those patients being seen by a noncredentialed provider. However, ensure the payer allows this type of arrangement and immediately notify your biller.

Have an In-House Expert

With the headaches, losses in revenue, and patient dissatisfaction at stake, it is highly recommended that you partner with a credentialing expert who can navigate this process. You will want someone who is familiar with the nuances of each payer, has personal contacts with each insurance company to solve problems quickly, and understands NCQA bylaws and provider rights. The alternative is to hire an employee dedicated to credentialing and ongoing recredentialing for your group of practitioners. Having a competent urgent care credentialing specialist handle the process will allow your practice to minimize delays, increase revenue, and raise customer satisfaction. ■