STREET *cred*

Smoothing bumps in the road to physician credentialing

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Getting your practice's providers credentialed with insurance plans doesn't have to cause dread and frustration. Learn the process and requirements to ensure that your organization gets paid for the care it provides.

How many times have health insurance plans denied your practice's claims for service, failed to authorize referrals, confused patients and made physicians unhappy because of credentialing? Most administrators would answer: "Far too often." Here's information about medical credentialing that may help you save money, time and effort.

A word with many meanings

"Credentialing" means different things to different people. For a hospital medical staff office, credentialing involves primary-source verifications. For medical office administrators, it means participating with a health plan to provide services to its subscribers. For billing office administrators, credentialing represents referral approvals, authorizations and payment for claims. Health plans use the word to indicate entry into their networks so approved physicians can see their subscribers. But for physicians, credentialing means tedious and seemingly needless paperwork.

Credentialing is the process of getting a physician approved by hospitals and health plans. These entities grant approval after reviewing and verifying the doctor's credentials.

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- mgma.com/payerperformance to compare your credentialing experiences with colleagues
- *Store*: Item 7001 for the *Health Care Credentialing Handbook*; E6852 for the electronic Information Exchange "Physicians – Credentialing Policies & Procedures" (6852 for the print version); 5098 for the *Medical Group Practice Legal and Administrative Guide*

If you learn the process and requirements, credentialing doesn't have to be a painful experience.

Earning hospital privileges

Hospitals grant privileges to physicians and other health care providers to use the facilities for patient care. Securing these privileges should be the first step in credentialing, as hospital privileges are a prerequisite for health plan credentialing. Since health plans maintain networks of physicians, labs, radiology facilities and hospitals, physicians must have privileges at a participating hospital or they will not be allowed to join.

Hospital privileges are specific to a physician's training, education and practice expertise. Before granting privileges, hospitals verify the primary sources for a physician's credentials according to the Joint Commission on Accreditation of Healthcare Organizations. This process takes anywhere from two to six months. When that's completed, the hospital's credentials committee reviews the information. An approved application goes to the hospital's medical executive committee and then to the board of directors for final endorsement (see flow chart, page 38).

Joining a health plan's network

Health plans — insurers — create networks of participating physicians, hospitals, labs, radiology facilities, etc., and offer services to their subscribers. Health plans do not grant hospital

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Keys to credentialing success

Heed these final recommendations for a painless credentialing process:

- The physician information must be accurate. A physician choosing a specialty not yet recognized by the American Association of Medical Specialties or the American Osteopathic Association may run into trouble getting credentialed.
- The physician's curriculum vitae (CV) must include month and year for all training and work history. Be sure the CV includes the start date at your practice before submitting it to the insurers.
- When considering a new physician for your practice, complete primary source verification of basic credentials to be sure no one is surprised by information discovered in the credentialing process. For example, a physician with numerous malpractice claims may trigger a thorough review by the health plans, delaying credentialing.
- Many health plans require that your practice have a copy of the physician's National Provider Identifier letter and Social Security card to initiate the credentialing process. You will also need:
  - Licenses (all current with correct address),
  - Drug Enforcement Agency (DEA) certificate and current list of controlled dangerous substances (required by some states, in addition to the DEA certificate for writing narcotic prescriptions);
  - Malpractice insurance face sheet (not the bill);
  - History of malpractice coverage;
  - Claims explanations;
  - Specialty board certificate(s); and
  - Copies of all training certificates.

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admitting privileges to physicians. However, the National Commission for Quality Assurance (NCQA) sets standards for approving the credentials of physicians who wish to join a health plan's network. NCQA requires primary-source verification of numerous credentials. After these are verified, the health plan's credentialing committee approves a doctor to join the network (diagram, page 40).

While each health plan has its own requirements for credentialing, all plans require that physicians provide their National Provider Identifiers (NPIs). The NPI is a 10-digit identifier obtained from the federal government. It replaces previous individual identifiers that varied by plan.

Next, physician data, such as office locations, tax identification numbers and specialties get added to the health plan's billing system. Wrong information here equals unpaid claims. For example, the system links physician specialties to current procedural terminology (CPT) payment codes. The health plan provides an approved codes list to each credentialed physician. If a physician submits a claim for a code not on the approved list, the plan will not pay the claim.

In addition, some savvy systems approve physicians only for certain locations. If the physician submits a claim for patient care rendered at Location A, but the network's system shows Location B, the claim is rejected.

As with hospitals, a health plan's credentialing process can take two to six months to complete for each physician. In addition, a health plan may require site visits by a provider relations representative before adding a location to its system. So, when adding a new physician and a new location to the system, make sure to do these processes concurrently.

Medicare: The mother of all credentialing processes

Hands down, Medicare wins the prize for the most difficult credentialing process. With the majority of physician payments coming from Medicare and many health plans basing their processes on Medicare's, we need to review nuances of this system.

For most physician practices, Medicare requires three basic applications:

- 855B – to establish or change a practice group number;
- 855I – to establish or reactivate a physician's individual number; and
- 855R – to link the physician's individual number to the group number.

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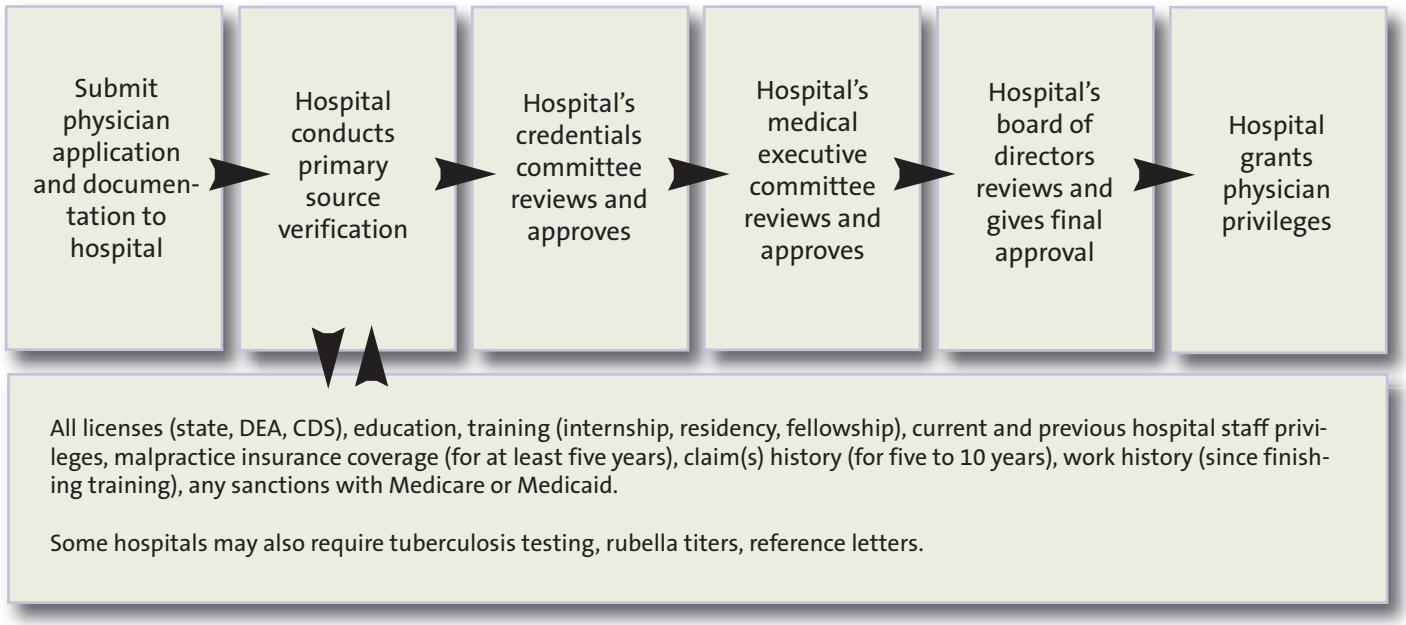
Hospital credentialing process



Problem areas associated with Medicare 855B

Issue	Explanation
Practice name	Practice must submit a letter to the IRS with the application to show its tax identification number. The name of the practice on the IRS letter (e.g., IRS CP 575) must match exactly the name of the practice on the application, the name of the practice on the group National Provider Identifier (NPI) letter and the name of the practice on the checking account. Because the IRS letter starts the process, use the exact same wording for the NPI letter and the bank account. For example: • The practice name: Eye Physicians and Surgeons does NOT match Eye Physicians & Surgeons. Also, the practice name Eye Physicians and Surgeons, PC does NOT match Eye Physicians and Surgeons PC (no comma). • If the practice has been calling itself "Special Eye Physicians and Surgeons," but the IRS letter does not reflect that name, Medicare will not process the application.
Bank account	A voided check or deposit slip must be submitted with the electronic funds transfer (EFT) form in the application. The EFT form must include the address of the bank you use, a contact name at that bank and the routing number for the account.
Contact person(s)	Most Medicare suppliers scan the application into their system for processing. Specialists can then obtain it for further review. When more than one contact person is listed with the application, the specialists may not be able to view all the pages and may refuse to speak with anyone other than the listed contact person.
Authorized official	For most physician practices, the physician owner(s) are the authorized official(s). An appointed official can be the chief executive officer, chief financial officer, general partner, chairman of the board or direct owner.
Delegated official	The authorized official delegates an individual to report changes and updates to the supplier's enrollment record. A delegated official must be an individual with an "ownership or control interest," or be a W-2 managing employee of the supplier. The practice administrator may or may not be qualified to be a delegated official based on his/her W-2 status.

How MGMA is working to make provider credentialing easier for medical practices

By MGMA Government Affairs, govaff@mgma.com

As a co-convenor of the Healthcare Administration Simplification Coalition (HASC), the Medical Group Management Association (MGMA) has strongly supported CAQH's Universal Provider Datasource (UPD). Formerly known as the Universal Credentialing Datasource, the UPD is an electronic tool to collect practitioner credentialing data. Practitioners enter their information into the system and then choose which health plans will receive their information, rather than completing separate applications for each health plan. More than 450 health plans rely on the UPD to collect credentialing data.

Each health plan with which you want to credential your physicians should give you access information for the UPD. For more info on the UPD, visit www.caqh.org/ucd.php.

MGMA has been working closely with the HASC and other provider organizations to encourage Medicare to create an interface with the UPD. This would reduce the administrative burden and costs of credentialing for medical practices. Additionally, the HASC will soon release a white paper on practitioner credentialing.

The Medicare program now has its own electronic credentialing application: Internet-based PECOS (https://pecos.cms.hhs.gov/pecos/login.do). Currently, it's available only to complete the CMS-855I application. The Centers for Medicare & Medicaid (CMS) plans to make it available to complete the CMS-855B application later this spring.

MGMA has also worked closely with CMS on the development of Internet-based PECOS. Association members tested the system in April 2008 and described their experiences to CMS staff. Additionally, MGMA and the American Medical Association have been engaged in ongoing discussions with CMS regarding Medicare provider enrollment. MGMA has been a vocal opponent of CMS' refusal to allow medical practice staff to use the Internet-based enrollment system on behalf of individual practitioners.

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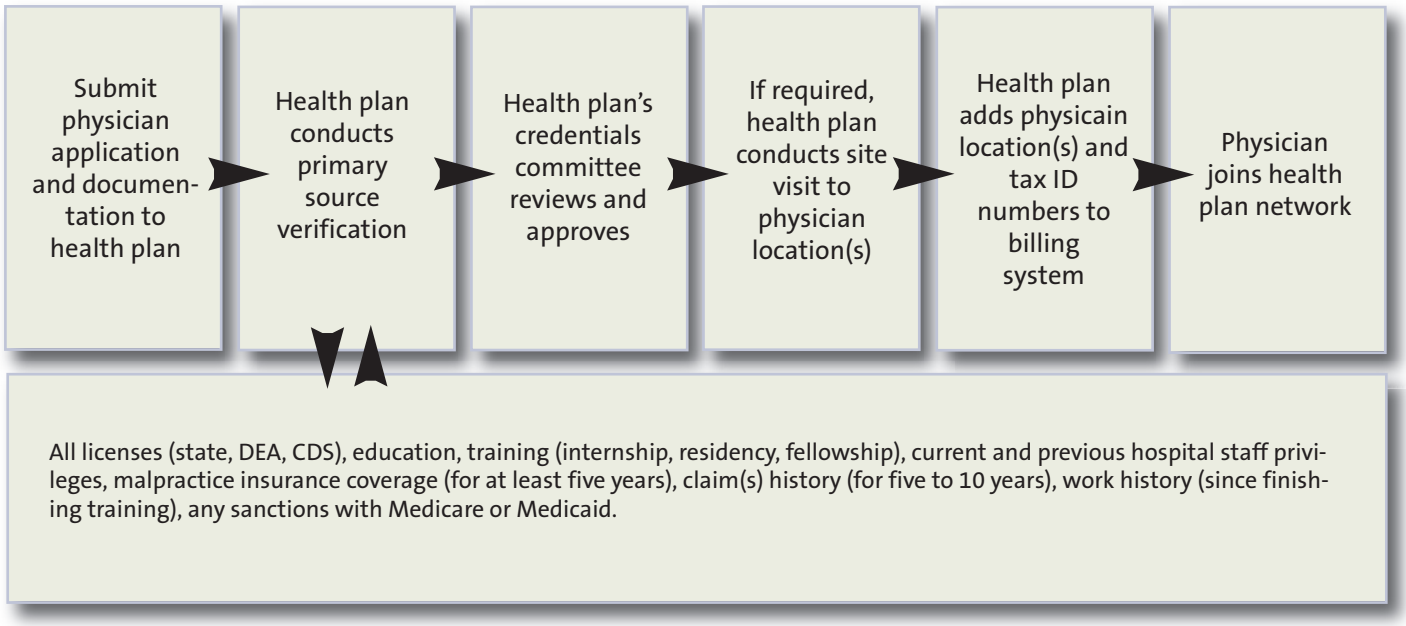
Health plan credentialing process



855B – Establish or change a practice group number

Physicians submit this 48-page Medicare application to obtain a group number for billing purposes. Groups already participating with Medicare use the form to make changes to physician listings, such as ownership, phone number, address and NPIs.

Most sections of the Medicare 855B application are well defined, with clear instructions. However, a few problem areas can derail an application's approval (table, page 39).

855I – Establish or reactivate a physician's individual number

This 29-page form is used to obtain a physician's Medicare billing privileges from the local Medicare administrator. These are *not* national billing privileges. For example, a physician who practices in Pennsylvania and New Jersey will obtain Medicare billing privileges from each state's or region's contractor. This application requires a copy of the physician's medical school diploma and NPI letter with his/her NPI number.

If the physician has not submitted an 855I application (obtaining the Medicare number before the form was created), Medicare will require an 855I application if any changes are made to the physician's file. In addition, if the physician does not bill Medicare for a 12-month period, Medicare will deactivate the number and require new 855I to reactivate his/her Medicare number.

855R – Link physician's individual number to the group number

This eight-page form is fairly self-explanatory. Just be sure your group's authorized or delegated official signs the form, in addition to the individual being linked to the group.

Getting the many pieces of the credentialing puzzle to fit together challenges every medical practice administrator. If you learn the ins and outs and develop a sound method, you'll succeed in the credentialing game. Most important, your practice will get paid for providing quality patient care.

join the discussion: What's your organization's process for getting physicians credentialed with health plans? Debate and discuss at mgma.com/ConnexionCommunity