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- Plan ahead to manage credentialing for new physicians while maintaining credentials for current providers
Physician Credentialing
A Guide for
Physician Office Staff

Veronica L. Rosas, CPCS
Reviewed by Valerie Handunge

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About the Author

Veronica L. Rosas, CPCS

Originally from southwest Kansas, Veronica L. Rosas, CPCS, earned a BS. in journalism from the University of Kansas in Lawrence, Kansas. She began her career in credentialing in July 2002 as an administrative support secretary for the CHRISTUS Santa Rosa Family Medicine Residency Program. After several years of proving her skills in coordinating the credentialing functions within the office, Rosas became credentialing coordinator for the residency program. In the summer of 2009, she became a Certified Provider Credentialing Specialist (CPCS) by the National Association Medical Staff Services (NAMSS).

For five years, Rosas served on the South Texas Association of Medical Staff Professionals (STAMSP) board of directors and served as president from 2013–2014. She is currently a member of the Texas Society of Medical Staff Services (TSMSS).

Rosas currently lives in San Antonio, Texas, and is working on other writing projects.
Welcome to the world of credentialing in the healthcare provider’s office!

If someone had asked me 12 years ago what I did for a living, I would have frozen. I would have bitten my lower lip and stared off in another direction. I wouldn’t have had the answer, because I didn’t know myself what I was doing. Credentialing was a whole new world. Like many others, I stumbled upon this profession. Credentialing was completely new to me; I had no prior experience or knowledge. I remember wishing I had a manual or some guide to assist me or orient me on the subject, but there wasn’t anything. There was no course I could take to learn about credentialing. I was on my own, and learning the credentialing process was very challenging when it came to figuring out the dynamics of credentialing a healthcare provider.

Because there continues to be more and more people falling into the credentialing profession by way of working in a physician’s practice as an administrative assistant or office manager, I wrote this book to serve as a guide for those who are new to the field. I divided the book into two parts. Part 1 focuses on the basics of the credentialing process, and Part 2 focuses on your role and duties within the provider’s office. Based on many years of experience, I provide some helpful tips on everything from initiating credentialing for a new provider to managing multiple credentialing-related tasks in the provider’s office. The primary focus of this book is to help newcomers in the provider's
Preface

Office understand the basics of credentialing so that they can successfully perform the necessary tasks to ensure the provider is approved to participate in the network of a managed care organization (MCO) and/or is approved for participation on a medical staff of a hospital.

There are two ways to use this book. It may be read straight through from beginning to end, or it may be used as a reference guide for particular topics you are unsure about or when you need some assistance on how to handle a task.

Again, this book is something I wish I had when I first started. Now it is available for you.

Good luck!
Introduction to Part 1

As a credentialing coordinator, office manager, administrative assistant, or related position in a group or solo practice, your role is to act as a liaison between the provider(s) and the managed care organizations (MCO) and hospitals when it comes to the credentialing process. This means you are providing administrative support for credentialing-related functions within the provider's practice. One of your primary duties is to submit the provider(s) application to MCOs and hospitals so the provider can participate in the network of an MCO and/or obtain clinical privileges at a hospital. It sounds simple, but it involves multiple steps both before and after you submit the application. You must review the application to ensure accuracy of the information on the application, prepare the application and required documents for delivery, and track the progress of the application after you submit it.

Here is a brief overview of your duties for credentialing in the provider's office:

- **Maintain the provider(s) credentialing applications.** (The number will depend on the number of providers in your practice.) It’s important to update the application on a regular basis with new information, such as new home or practice address, new expiration dates on licenses, controlled substances registrations, board certifications, etc.

- **Prepare the provider’s application for delivery to the MCOs and/or hospitals.** Attach the appropriate documentation (e.g., license, liability
insurance, etc.) with the application. Always follow the checklist provided by the MCO or hospital.

- **Follow up on the progress of the application until the credentialing process is complete.** The end goal is either that the provider is participating in the network of the MCO or has clinical privileges at the hospital to which he or she applied.

- **Maintain the provider’s credentials.** This includes updating professional licenses, controlled substances registrations, liability insurances, etc., to ensure they remain current and will not expire.

These are your primary duties in a nutshell. In Part 2, I will provide you with instructions on how to carry out these duties.

Even though you will not handle credentialing functions such as primary source verification and assessment, it’s beneficial for you to know what happens after you submit the provider’s application to the MCO and/or hospital. Chapter 1 is an introduction to credentialing, including its purpose and the basic process. In Chapter 2, I cover the credentialing application so you can understand (if you have never seen an application) what type of information is required of the provider. In Chapters 3 and 4, I go over the credentialing processes for MCOs and hospitals. Again, you will not be handling the credentialing functions of MCOs and hospitals. The staff members of credentialing departments and hospitals will carry out these functions, but it’s best for you to know the entire process of credentialing a provider.
1
Introduction to Credentialing

If you are new to credentialing in the physician’s office or even if you are just trying to explain your job to another individual, it’s best to start off with the simple scenario of a regular check-up or hospital visit.

We all go to our physician for regular check-ups or maybe have been admitted to a hospital to undergo a surgical procedure. We present our insurance card to the receptionist, and he or she will verify our benefits and take our copay. Have you ever looked at your insurance card? There may be several logos and phone numbers on the card, and one of those logos belongs to a network of a managed care organization (MCO).

A network is a group of providers (hospitals, physicians, and other healthcare providers, such as psychologists, dentists, etc.) that is contracted with an MCO to provide healthcare services to patients covered by one of the MCO’s health plans. The term “managed care organization” is a bit complex because there is not one standard definition. However, there is one key element common to each definition of an MCO—offering or delivering healthcare services via managed care plans, hospitals, etc. Generally speaking, an MCO is an organization that offers healthcare services to patients under specific health plans. As it is used in this book, a managed care organization is an entity that offers
healthcare plans and encompasses a network of healthcare providers (physicians, hospitals, psychologists, dentists, etc.) to provide healthcare services to the MCO’s members. In the chapter on contracts and fee schedules, I will go over the different types of managed care plans that MCOs may offer.

Let’s go back to your insurance card. Your insurance company has a contract with an MCO to use its network of providers, and the MCO must first approve your physician via “credentialing” in order to participate in the network and provide care to you, your family, and other patients. Depending on the type of insurance plan you have, you may have been assigned to a specific healthcare provider or were provided with a directory of providers for you to choose from for your care.

If you’ve ever been admitted to a hospital and/or had a procedure performed by a surgeon, your surgeon had to undergo a credentialing process to be approved in order to perform your surgery.

It may have never occurred to you how physicians became part of the medical staff. Sure, you know physicians have to go through medical school and become licensed, but you might not know this other process physicians have to go through to provide care to patients.

In this chapter, I will provide the definition of credentialing, the purpose of credentialing, and the basic steps of the credentialing process.
Credentialing

What is credentialing and why is it necessary? **Credentialing** is the process of obtaining, verifying, and assessing the qualifications of a healthcare provider to provide patient care services in or for a healthcare entity. A healthcare entity can be a hospital, ambulatory facility, long-term facility, acute-care facility, or a managed care organization. Credentialing is necessary for the following reasons: (1) to protect the public from incompetent healthcare providers, (2) to minimize legal risk, and (3) to meet regulatory requirements of accrediting agencies, such as The Joint Commission.

Within the definition of credentialing, there are three key words that describe the credentialing process: obtain, verify, and assess. These three words capture the basic steps of the process. There are additional aspects, but for now it is important to know the basics before learning about the extra components, such as approval from committees and medical directors. I will go over these extra steps in Chapter 3. First, let’s take a closer look at the three basic steps.

**Step 1: Obtainment**

In order to credential a provider so he or she can provide healthcare services, MCOs and hospitals must **obtain** the required documentation to initiate the credentialing process. These documents consist of the credentialing application and copies of the healthcare provider’s CV, license to practice, controlled substances registrations (if applicable), postgraduate training certificates, and professional liability insurance. Once all of these are in order and the provider has signed off on his application, you will submit these documents to the MCO and/or hospital.

Once the MCO and/or hospital obtains the provider’s credentialing application and copies of his certificates or credentials, the credentialing department will first review the documents to ensure the application is complete, signed, and dated. The credentialing department will also ensure the required credentials are current. This step is known as the “prescreen” step and is conducted to
ensure the provider’s application is complete and can proceed to the next step: verification.

**Step 2: Verification**

Verification is the step in which the information on the provider's credentialing application and his or her credentials (licenses, certificates, training, etc.) are verified with the primary source. A *primary source* is the original source of a specific credential that can verify the accuracy of a qualification reported by an individual healthcare provider.\(^3\)

Examples of primary sources include medical schools, graduate medical education programs, and state medical boards. You will often hear this process called "primary source verification."

Listed below are the types of information verified by the credentialing departments of MCOs and medical staff offices of hospitals:

- Medical school
- Educational Commission for Foreign Medical Graduates (ECFMG) (for graduates of foreign medical schools)
- Medical/professional license(s)
- DEA certificates and other controlled substances registrations
- Postgraduate training (internships, residencies, fellowships, teaching appointments)
- Board certifications
- Work history
- Hospital affiliations
- Professional liability insurance and malpractice claims history

Note

Some MCOs and hospitals may require a provider to complete a “pre-application” before submitting a credentialing application. The purpose of the pre-application is for the MCO to determine whether or not the provider is eligible to apply for participation in the network. It is the same scenario with a hospital. The medical staff office at the MCO or hospital may require a pre-application to determine eligibility before sending an application packet to the provider.
• Peer references
• Criminal history

Once the credentialing departments and/or medical staff offices verify all of the information, the provider’s application proceeds to the last step: assessment.

Step 3: Assessment

During the assessment phase, the provider’s application is reviewed by a credentialing committee(s) in the MCO setting and by the credentialing committee, medical executive committee, and the governing board in the hospital setting. These committees are necessary to determine whether or not to approve the provider for participation in the MCO’s network or to grant the provider clinical privileges at a hospital. Once the provider is approved to participate in the network or is approved for hospital privileges, he or she will receive notification from the credentialing department of the MCO’s network or hospital. The notification is referred to as a “welcome letter” and includes the provider’s effective date of participation in the network. The notice from the hospital is referred to as a “letter of appointment to the medical staff” and also includes an effective date in the form of a date range. For example, Dr. Jones was approved for privileges to the medical staff, and his appointment will last from July 1, 2012, to June 30, 2014 (see sample letter in Chapter 4, Figure 4.2).

To summarize, credentialing is the process of obtaining, verifying, and assessing the qualifications of a healthcare provider to provide patient care services for a healthcare entity. Credentialing is performed to protect patients, to reduce legal risks, and to meet regulatory requirements of accrediting agencies. Lastly, there are three basic steps in credentialing—obtain, verify, and assess—and, as you can see, the verification step takes up the majority of the process.
Chapter 1

References

2. Joint Commission. The Joint Commission is an independent, nonprofit organization that accredits and certifies more than 20,500 healthcare organizations and programs in the United States.
3. Professional Development for Medical Services Management, National Association Medical Staff Services (NAMSS), February 2009.
Credentialing providers in a physician practice is a confusing and time-consuming process that can seem daunting to even the most seasoned professional. Between managing the credentialing of new physicians to the mandatory recredentialing that must be undertaken every few years, it is imperative that practice-based credentialing coordinators are on top of their game.

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