

# Provider credentialing vs. provider enrollment:

**DIFFERENCES & SOLUTIONS**

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**INTIVA HEALTH**

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## Excutive summary

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This white paper is an overview of the required credentialing process that a medical provider must complete and how it is distinct from the enrollment procedure that facilitates eligibility to accept patients and receive payments through a commercial insurance provider or government health plan. Provider credentialing and provider enrollment are two essential processes that must be completed in order for a health care provider to begin working in the industry and receive reimbursement payments from a health insurance plan.

While they are similar in that each process can be considered a form of accreditation, their respective purposes differ. Nevertheless, it is common for workers in the health care industry to either confuse the two courses of action or be unaware of their differences. Both processes are fundamental functions of the health care industry. Therefore, it is important to understand the distinctions with respect to how each procedure plays a role in authorizing a health care worker to begin their duties. While the processes are separate, their underlying co-dependency showcases a compelling argument to consider a single platform that accomplishes both tasks and eliminates the redundancy of manually collecting and inputting practitioner data into a multitude of documents.



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# The basics of health care provider credentialing

Provider credentialing is the process of organizing and verifying a provider's professional records and reputation for the purpose of working at a facility. The credentialing process in the health care industry is foundational for the success and reputation of facilities and also to ensure the highest level of patient care. Health care facilities have a legal responsibility to verify a provider's identity, education, work experience, malpractice history, and license status to protect patients from unqualified caregivers.

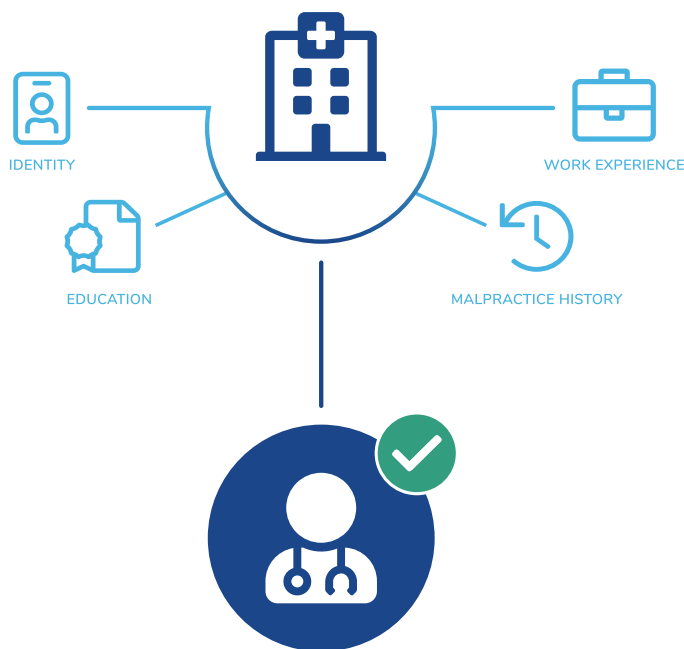
In the United States, government agencies grant and monitor licenses and professional organizations certify practitioners. A certification can either be a prerequisite for licensure or, in some cases, an alternative. To get certified or licensed, practitioners must meet specific education, training, or practice standards. Professional organizations in some complementary health professions offer certification examinations to graduates of accredited education and training programs. Certification may play

a role in qualifying graduates for state licensure (<https://nccih.nih.gov/health/decisions/credentialing.htm>).

When a health care worker applies to practice within a facility, he or she is asked to complete an application and allow a credentialing entity to procure and verify any applicable professional documents. It can take anywhere from a few weeks to six months to get credentialed. For physicians, that's a minimum of three hours spent submitting approximately 20 different credentialing forms, according to a study in the New England Journal of Medicine (Cutler et. al 2012). Then, facility staff spends an additional 20 hours on each physician's forms. If any elements are missing from the application, or if a school, employer, or reference doesn't swiftly respond to verification requests, it can add weeks or even months to the process. All of this time spent waiting on credentialing is precious time lost that could be utilized focusing on patient care, and ultimately represents a loss of revenue for the health care facility.

The credentialing process must be re-done every two years in addition to fulfilling continuing medical education (CME) requirements. In combination with other non-clinical paperwork, this administrative burden takes up nearly nine hours a week for the average doctor, according to a study published in the International Journal of Health Services (Woolhandler & Himmelstein 2014).

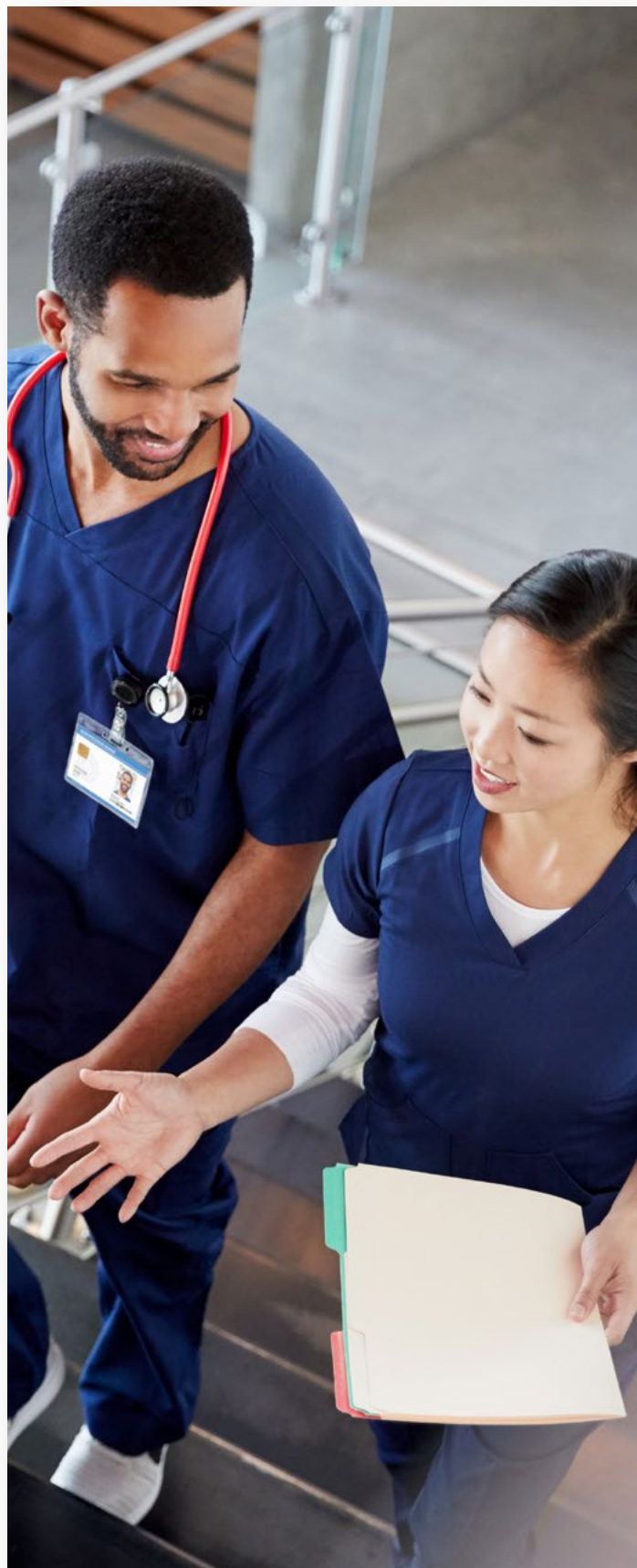
For a physician, the National Provider Identifier (NPI), licenses, certifications, diplomas, and professional references are all considered credentialing documents. Credential management is the process of verifying the relevance and accuracy of specific data in their documents. The credential management process helps




assure both the patient and the facility that the provider is able to work in the health care industry in the capacity and quality that is expected. At a minimum, the physician will be requested to submit a copy of their National Practitioner Data Bank (NPDB) file and possibly undergo a criminal background check.

The credential management process also conducts what is known as primary source verification (PSV). A health care organization performs PSV of the provider's education, training, certificates and licensure from the original source and maintains the information on file. Some examples of primary source verification include: National Provider Identifier (NPI), federal and state sanctions, state medical board, DEA permits, and medical licensures. The sum total of these licenses, certifications, background checks, and insurance documents furnishes necessary and sufficient evidence that the provider is certified to administer the level of care required by governing bodies. In turn, proactive attention to credential management maintains a positive reflection on the reputation of the facility and the quality of service patients can expect. The credentialing process helps assure both the patient and the facility that the provider is able to work in the health care industry in the capacity and quality that is expected. An appropriate, methodological credentialing process can prevent admission of fraudulent health care workers with questionable qualifications, which yet again ensures a better quality of patient care and protects the reputation of the health care institution.

The procedure involving new hires of health care workers at a facility and letting them get to work does not stop with credentialing. Once the credentialing process is completed, the process of granting or denying privileges begins (Matthews et. al 2017). According to the American Medical Association's (AMA) Principle of Medical Ethics, the purpose of privileging is to improve the efficiency and quality of



patient care in the hospital. The AMA states in their Code of Medical Ethics Opinion 9.5.2 that the process can be divided into two categories: what to base privilege decisions on and what to avoid basing privilege decisions on:



**Base privilege decisions on the:**

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Candidate's training, experience,  
demonstrated competence

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Availability of facilities

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Overall medical needs of the community,  
the hospital, and especially patients



**Avoid basing privilege decisions on:**

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Numbers of patients  
the candidate has admitted to the facility

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Economic or insurance status of  
patients admitted by the candidate

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Personal friendships, antagonisms,  
jurisdictional disputes, or fear of competition

Standards set by recognized accreditation bodies, including the Joint Commission on Accreditation of Healthcare Organizations (JAHCO), National Committee for Quality Assurance (NCQA), and Accreditation Commission for Health Care (ACHC) mandate a considerable effort to properly evaluate the credentials of health care providers. A collaboration of employers and health insurers led to the formation of the NCQA, which is now the most widely known accrediting organization for credentialing with health plans. The credentialing process can be time-consuming and cost facilities thousands of dollars in revenue if not executed properly. Since it is a necessary step in the enrollment procedure, it carries even more weight. Intiva Health's Ready Doc™ credential management platform reduces the credential management process timeframe significantly. This allows the provider to complete enrollment, treat patients, receive payments, and start the flow of revenue for a facility even quicker.

## Health care provider enrollment

Enrollment refers to the process of a health care provider requesting participation in a health insurance plan network. It can also be the validation of a provider in a public health plan such as Medicare or Medicaid and the approval to bill the agency for services rendered. It is important to note that enrollment is entirely independent from credentialing, yet the latter is a prerequisite for the enrollment process to occur. Therefore, credential management directly affects a provider's enrollment options and outcomes.

“Therefore, credential management directly affects a provider's enrollment options and outcomes.”



The enrollment process differs depending on the private insurance plan, the level of network the provider is seeking to become a part of, or if the provider is enrolling in a government insurance plan such as TRICARE, Medicare, or Medicaid. The only difference with plans governed by the Centers for Medicare & Medicaid Services (CMS) is that the government plans have set fee schedules and therefore do not need to contract directly with the practitioner or practice.

For a provider to become enrolled in a commercial insurance network, the process involves two steps:

**1. Credentialing:** The provider request to join an insurance company plan must be supported by a credentialing process, which can vary from completion of a credentialing application specific to the insurance company, usage of a CVO, or acceptance of a state standardized credentialing application. Either of these methods will involve the stringent process outlined in the previous section, some to a higher degree of detail than others depending on the insurance plan. On average, the entire credentialing process will take anywhere from three to six 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 (Journal of Urgent Care Medicine).

**2. Contracting:** Following the approval of a credentialing committee, the second phase of the process begins: contracting. The contracting phase of the enrollment process is when the provider's credentials have been accepted and a contract for participation is offered. It is common for commercial insurance networks to have staff

dedicated to the contracting process and it is separate from, but dependent on, the credentialing stage. In the contracting phase, the provider reviews the contract, reimbursement rates, and participation responsibilities. This is also when the provider begins negotiating reimbursement rates. This may mean a delay in the overall credentialing and contracting process as the negotiating process can take up to 6 months. Once the agreement is signed and returned to the insurance network, the provider is given an effective date and identification number to begin billing the plan and receiving reimbursement for any claims.

## Enrollment in government health plans

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The process for a health care provider to enroll in Medicare, Medicaid, TRICARE, and other government health programs differs somewhat. Each of the programs have standard forms that must be filled out and sent to



MEDICARE



MEDICAID



TRICARE

the agent that handles the administrative paperwork for the program. The application is reviewed against strict enrollment standards.





If a provider would like to enroll in TRICARE, they must complete a Network Provider Participation packet, approximately 30 pages in length, which includes a provider information form as well as specific credentials required by Health Net Federal Services. If a health care provider wants to enroll in Medicare, they must complete the following steps:

1. Get a National Provider Identifier (NPI)
2. Enroll in Medicare Provider Enrollment, Chain, and Ownership System (PECOS)
3. Respond to Medicare Administrative Contractor Requests
5. Complete and sign application forms.

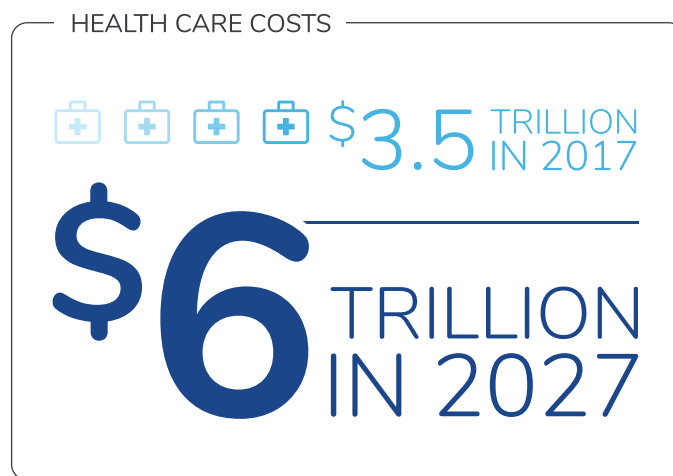
The application forms can range between 25 pages and 54 pages in length. The time it takes to manually complete the entire process could be up to 90 days. If a health care provider wants to

enroll in Medicaid, the process is similar but slightly more complex since the program is administered by the state but partially funded by the federal government. Thus, it is important to note that enrollment in Medicare does not guarantee enrollment in Medicaid. Consequently, a provider must re-enroll in Medicaid each time they choose to move or practice in a different state. The Centers for Medicare and Medicaid Services (CMS) provides oversight for each state to adhere to federal regulations for enrolling providers in Medicaid, Medicare, and Children's Health Insurance Programs (CHIP). The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP).

## Patient implications

The ease of the enrollment procedure can directly impact the number of patients a health care worker can treat on a routine basis, which in turn affects the amount of revenue produced for a facility. No matter the level of care administered by the provider, personal connection and trust bestowed in them by the patient, or long-standing history of treatment; the rising cost of healthcare ultimately the decision of where to seek care will be based upon acceptance of health insurance plans. The greater

number of health insurance plans offered by a facility results in a more extensive opportunity for patients to obtain services. In April of 2019, CMS published a report projecting national health care spending. The report indicates that total health care spending in the U.S. will continue to grow at an alarmingly high rate. According to their



findings, overall health care costs, including private and public spending, are anticipated to rise by an average of 5.5 percent per year over the next decade — growing from \$3.5 trillion in 2017 to \$6 trillion by 2027. Spending on health care is projected to grow faster than the economy, increasing from 17.9 percent of the GDP in 2017 to 19.4 percent of the GDP in 2027 (<https://www.pgpf.org>). Taking into account these expenditure figures, it is imperative that health care providers are able to easily enroll in the most beneficial health plan for their patient demographic. The existence of this mutualistic patient-provider relationship has a positive reflection on the reputation of the facility as well as the revenue stream.



# Summary

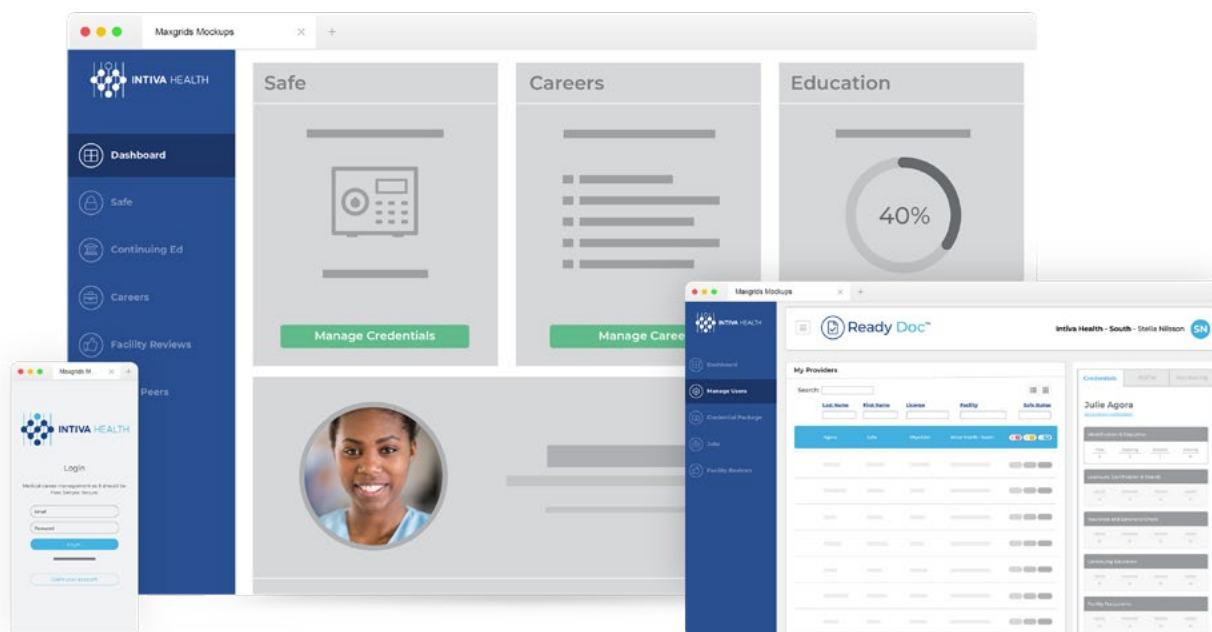
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No matter what type of health plan a provider chooses to enroll in, they will have to complete the credentialing process as a necessary first step. This requires the collection, storage, curation, and management of a myriad of documents for each provider and each application. A manual approach to this process yields an overwhelming amount of paperwork for both the provider and the health care facility. Further, communication and management of credentials by health insurance companies will cost additional time and money during the health plan enrollment process. Those who are involved with the enrollment process in health plans at the federal, state, and commercial level should consider accomplishing both tasks with one streamlined, simultaneous platform. This implementation would avoid redundancy of credential management efforts, drastically cut down on administrative burden, and ultimately boost productivity within the office space and allow health care providers to begin working and receiving payments exponentially quicker.

## Ready Doc™: A solution to both credentialing and enrollment

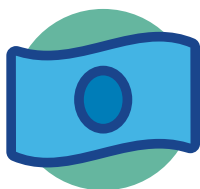
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Intiva Health has built a revolutionary proprietary platform offering a variety of tools which reduce the time it takes to complete burdensome credential management and administrative tasks from months to minutes. Ready Doc™ utilizes blockchain technology to immutably and securely digitize both the credentials of a provider and the verification of the credentials – i.e., creating a digital notarization – which drastically reduces the credential verification timeline.



After a health care professional's credentials are uploaded and verified in Ready Doc™, they can share their digital documents with any medical facility and obtain near-instant privileges at that facility. Ready Doc™ also facilitates compliance by automatically monitoring the expiration of credentials and alerting medical professional and facilities in advance. This solution allows all credential compliance to occur on the same platform, dramatically increasing efficiency and reducing the risk of lapses in compliance.

Though a provider may have the proper credentials to work at a facility and been granted privileges, they still cannot be paid until the enrollment process is complete. As detailed above, this process can be just as time intensive as traditional credential management methods. However, with the digital notarization of verified documents, electronic signature capabilities, OIG exclusion database access, and CAQH monitoring available within Ready Doc™, the platform can be used to expedite provider enrollment as well. There is no need to duplicate any data collection, verification, or entry efforts into the array of forms involved with enrollment. Once all of the provider data and credentialing documents have been uploaded into Ready Doc™, the credential management process and enrollment process can each be completed hassle-free.



**Save**

millions in lost revenue



**Cut**

administrative work



**Boost**

security & compliance



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