



Whitepaper

The Provider Guide to
Medical Credentialing

Medical credentialing is a critical process for healthcare providers that ensures they meet the necessary standards to offer care within specific networks or systems, such as insurance carriers and Medicare.

This guide provides a clear overview of the credentialing process, answers common questions, and outlines essential documentation requirements. Understanding these processes can help streamline your interactions with insurance and healthcare agencies, ensuring you can focus more on patient care and less on administrative burdens.

Understanding Medical Credentialing

Credentialing is essential for:

- Maintaining compliance with both federal and state regulations.
- Ensuring the quality of care delivered in medical practices.
- Facilitating the reimbursement process as insurance providers require proper credentialing for billing.

Key Players in Credentialing

Medical Staff:

Include all licensed providers such as physicians, dentists, nurse practitioners, and physician assistants.

Credentialing Staff:

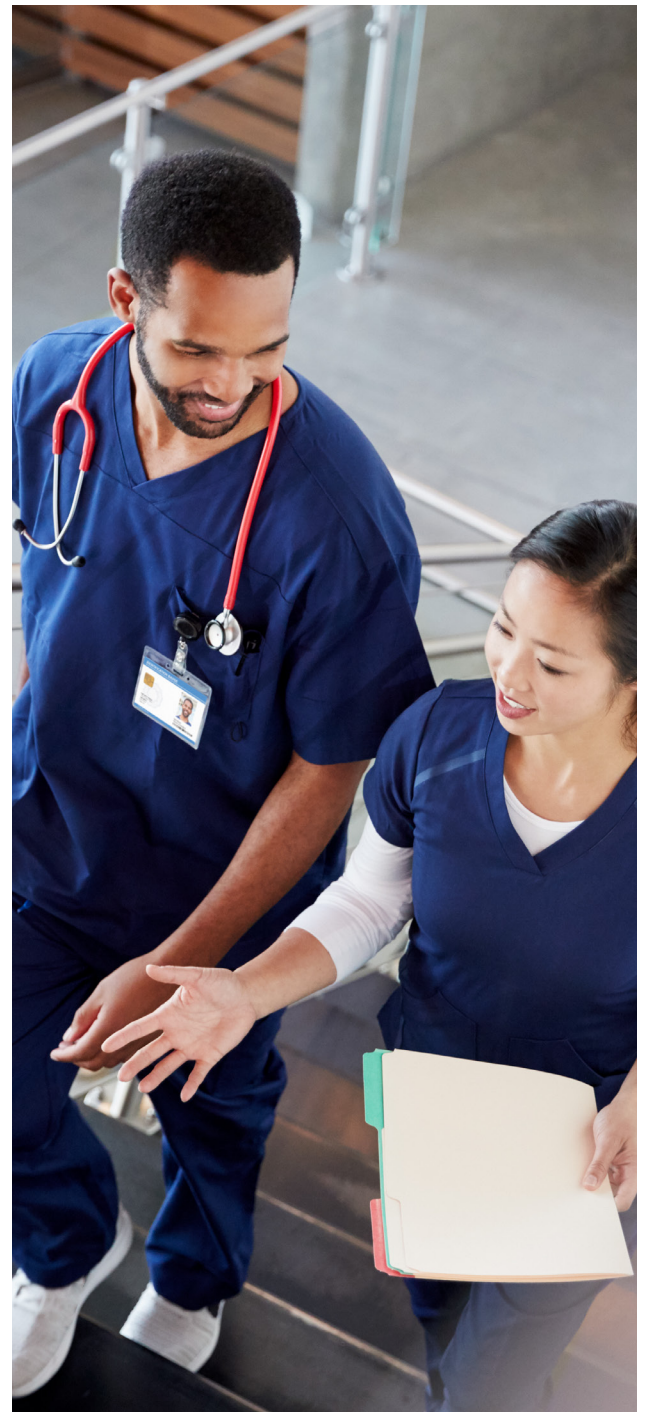
These are the professionals responsible for verifying qualifications and handling the documentation required for the credentialing process.

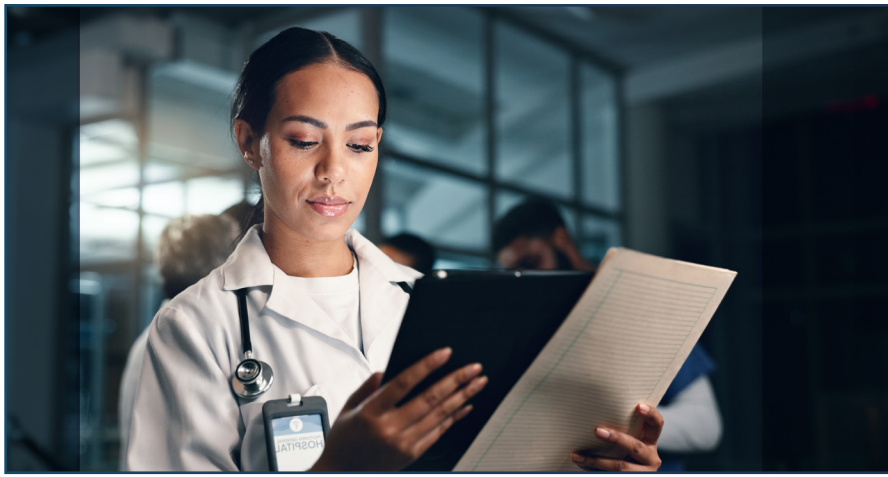
Healthcare Administrators:

Oversee the overall credentialing program, ensuring it aligns with organizational policies and compliance requirements.

Legal and Compliance Officers:

Ensure that the credentialing process adheres to all applicable laws, regulations, and guidelines, thus protecting the organization from legal issues.





The Credentialing Process

Step-by-Step Process

01 Gathering Required Documentation

Collect relevant documents including but not limited to:

- Diplomas and certificates from medical training
- State medical licenses
- Board certifications
- Proof of malpractice insurance and claim history
- Updated CV detailing all work history

02 Submission to Credentialing Bodies

Documents are submitted to relevant bodies, including insurance panels and hospital credentialing committees.

03 Verification of Documents

Each piece of documentation is verified for authenticity by contacting universities, previous employers, and relevant authorities.

04 Committee Review

The credentialing committee reviews the verified documents to assess the provider's eligibility to provide care.

05 Approval and Re-credentialing

Following approval, the provider is credentialed with the organization and re-credentialing dates are scheduled, typically every 2 to 3 years.

06 Timeline

Typically, the credentialing process can take anywhere from 60 to 120 days, depending on various factors including the responsiveness of third parties and the completeness of the submitted documentation.





Best Practices in Credentialing

Organization

Use digital tracking systems to keep documents organized and easily accessible.

Communication

Maintain open lines of communication with credentialing bodies and respond promptly to any requests for additional information.

Technology

Implement credentialing software that helps streamline the process and reduce manual errors.

Common Challenges and Solutions

Delayed Processing

Ensure all documents are complete and accurate before submission to avoid delays. Regular follow-ups can help keep the process on track.

Documentation Errors

Double-check all entries and documents for accuracy. Consider having a second set of eyes review everything before submission.

Compliance Issues

Stay updated with the latest healthcare regulations through regular training and subscriptions to industry publications.

Efficiency Tip

To help streamline and accelerate these processes, practices should consider outsourcing credentialing workflows and tasks. Schedule a free consultation with a CureMD Credentialing expert at curemd.com/credentialing.





Medical Credentialing Q&A

What is the difference between credentialing and privileging?

Credentialing verifies the qualifications of a healthcare provider, while privileging grants specific clinical rights in a healthcare facility based on their credentials and performance.

How often do I need to undergo re-credentialing?

Generally, re-credentialing occurs every 2 to 3 years, but this can vary by state and insurance provider.

Can I expedite the credentialing process?

Expedited processes may be available in urgent circumstances, but typically the process cannot be rushed due to thorough verification needs. CureMD enhances efficiency by managing applications and follow-ups, thus minimizing delays caused by common errors during self-management.

Do I need a service location to begin credentialing?

Yes, a physical service location is necessary to initiate the credentialing and contracting processes. A home address cannot serve as a clinic address but can be used for billing and correspondence. Keep in mind that CureMD credentials in every state and for every specialty.

What happens if I switch practices or specialties?

You will need to undergo credentialing again to ensure all qualifications for the new practice or specialty are verified and approved.

How does credentialing affect billing and reimbursement?

Without proper credentialing, a provider may not be recognized by insurers, potentially leading to denied claims and lost revenue.



How long does it take to enroll with Medicare?

Enrollment with Medicare generally takes 60 to 90 days, with certain provisions allowing retroactive billing from the application's receipt date.

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) experience longer turnaround times due to additional scrutiny and required site visits.

How do I complete Medicare revalidation?

Revalidation must occur every five years (three years for DMEPOS suppliers), using the CMS855I Medicare enrollment application for individual providers and the CMS855B application for groups, with the necessity of setting up electronic funds transfers.

Which Medicare application is used for provider enrollment?

The CMS855I is used for individual provider enrollment. Depending on the provider's status, additional forms like CMS460 or CMS855R may be needed.

What is a CP575?

The CP575 is an IRS-issued letter confirming the receipt of an employer identification number. This, or a replacement letter 147C, must be included in Medicare applications.

Conclusion

Navigating the complexities of medical credentialing can be challenging but understanding the requirements and processes involved can significantly ease the burden.

This guide aims to equip providers with the knowledge needed to manage their credentialing tasks more effectively, leading to improved operational efficiency and better patient care outcomes. Schedule a free consultation with a CureMD credentialing expert at curemd.com/credentialing

Additional Resources

National Practitioner Data Bank (NPDB)

<http://www.npdb.hrsa.gov>

Federation of State Medical Boards (FSMB)

<https://www.fsmb.org>

Centers for Medicare and Medicaid Services (CMS)

<https://www.cms.gov>

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

<https://www.jointcommission.org>





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