Credentialing The Borders
NYSAMSS

Brett Wolfson
Vice President, Operations
Med Advantage
Why “Credentialing the Borders?”
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<td>Provider Enrollment</td>
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Definitions

- **Credentialing:**
  - The process of gathering and evaluating the qualifications and practice history of a licensed or certified healthcare provider.

- **Privileging:**
  - The process of authorizing a licensed or certified healthcare provider’s scope of clinical practice.

- **Provider Enrollment:**
  - The process of registering with a commercial or government insurer to become a paneled provider. This is the precursor to credentialing.

• Why is Credentialing performed?
  – CVOs verify the qualifications of doctors and other health care practitioners with whom an HMO, PPO or other Client contracts. The purpose of the standards is to ensure that the managed care organization includes only properly qualified health care practitioners in its network. The credentialing process has long been valued as an important way to protect patients and to minimize legal exposure for health care organizations due to malpractice claims.

• How is Credentialing performed?
  – This process includes a review of a provider’s completed education, training, residency and licenses. It also includes any certifications issued by a board in the provider’s area of specialty.
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Process

Credentialing Process

PREPARATION
• Receive Provider Data from Client
• Populate and Send Application

Screening & Data Entry
Primary Source Verification

Set Next Credentialing Date
Archive Final Verifications Report

CVO Quality Review
Release To Client

Multiple Outreach Attempts
• 10 criteria
  – Written Policies and Procedures (Core)
  – Protecting Credentialing Information (Core)
  – Verifying and Reporting Licensure
  – Verifying and Reporting DEA or CDS Certification
  – Verifying and Reporting Education and Training
  – Verifying and Reporting Work History
  – Verifying and Reporting Malpractice History
  – Verifying and Reporting Medical Board Sanctions
  – Verifying and Reporting Medicare/Medicaid Sanctions
  – Processing Application and Attestation
  – Application and Attestation Content
  – Ongoing Monitoring of Sanctions
• CVO has a written contract with each organization that specifies the activities for which each party is responsible.

• CVO provides at least semi-annual reporting to organization.

• Organization maintains right to approve/terminate practitioners, and maintains oversight responsibility of delegated agency, unless agency is certified.
• **Organizational Requirements**
  – CVO - 1 - Organizational Requirements
  – CVO - 2 - Policy and Procedures

• **Credentials Verification Process**
  – CVO - 3 - Credentialing Application
  – CVO - 4 - Confidentiality
  – CVO - 5 - Review of Credentialing Information
  – CVO - 6 - Communication Mechanism
  – CVO - 7 - Primary Source Verification
  – CVO - 8 - Credentialing Time Frame

• **Data Integrity**
  – CVO - 9 - Data Integrity

• **Credentials Verification Communications**
  – CVO - 10 - Credentials Verification Reporting

• **On-Site Review**
  – CVO - 11 – On-Site Review Inclusions
  – CVO - 12 – On-Site Reviewer Requirements
  – CVO - 13 – On-Site Review Recredentialing
  – CVO - 14 – On-Site Review Deficiency Requirements
• CVO has a written contract with each organization that specifies the activities for which the CVO is responsible.

• CVO maintains documentation of the sources used to verify credentials. Credentialing applications must be comprehensive, to include information on accessibility, education and training, work history, state licensure or certification, liability insurance information, liability claims history, a history of adverse actions taken against the applicant and a release of information waiver.

• CVO maintains written policies and procedures governing the reporting of findings to the organization, attempts to retrieve information and the status of the practitioner in the verification process.

• CVO maintains a written quality improvement plan that includes evidence of routine inspections of data and databases, annual random sampling of staff activities and improvements in areas of concern.
What do we Primary Source Verify (PSV)?

- Board Certification
- DEA/CDS
- DHHS
- Education (Highest level or board certification)
- Insurance (OK by attestation)
- License
- Litigation
- NPDB
- Privileges (OK by attestation)
- Professional References
- Work History, 5 years (Not PSV)
<table>
<thead>
<tr>
<th>Element</th>
<th>NCQA</th>
<th>URAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attestation</td>
<td>305 @ CVO</td>
<td>120 @ CVO</td>
</tr>
<tr>
<td></td>
<td>365 @ Committee</td>
<td>180 @ Committee (Initial Only)</td>
</tr>
<tr>
<td>Board Certification</td>
<td>Required; 120 @ CVO, 180 @ Committee</td>
<td>Required; 180</td>
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<tr>
<td>CME</td>
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<tr>
<td>DEA/CDS</td>
<td>Required by PSV or cert copy; Current @ CVO return &amp; Committee</td>
<td>Required by cert copy or attestation; 180</td>
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<tr>
<td>Education</td>
<td>Highest level (Residency) or board certification</td>
<td>Required if not board certified</td>
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<tr>
<td>Hospital Delineations</td>
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<tr>
<td>Hospital Privileges</td>
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<tr>
<td>Insurance Coverage</td>
<td>OK by attestation, Current at Committee</td>
<td>Required</td>
</tr>
<tr>
<td>License</td>
<td>Required; 120 @ CVO, 180 @ Committee</td>
<td>Required; 180</td>
</tr>
<tr>
<td>Malpractice Claims</td>
<td>5 yrs Required; 120 @ CVO, 180 @ Committee</td>
<td>Required; 180</td>
</tr>
<tr>
<td>NPDB</td>
<td>Acceptable source for license and Medicare/Medicaid sanctions, malpractice history; 120 @ CVO, 180 @ Committee</td>
<td>Acceptable source for Medicare/Medicaid Sanctions; 180</td>
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<tr>
<td>Post Grad</td>
<td>Required if not board certified</td>
<td>Required if not board certified</td>
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<tr>
<td>Professional References</td>
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</tr>
<tr>
<td>Sanctions</td>
<td>Required; 120 @ CVO, 180 @ Committee</td>
<td>Required; 180</td>
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<tr>
<td>Work History</td>
<td>Collection of 5 years required but PSV not required; 365 @ Committee</td>
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CVOs follow organization’s guidelines, but no specific certification/accreditation for CVO. Instead, JC outlines the following requirements when utilizing a CVO:

- CVO informs organization what data and information it can provide
- CVO provides documentation to the organization describing how its data collection, information development and verification processes are performed
- CVO provides organization with clear information on any limitations of information available
- CVO provides organization an overview of quality control processes for data integrity, security and transmission accuracy
- Organization and CVO agree on the format for the transmission of credentials information
- Organization can easily discern which information from CVO is from a primary source
- CVO provides the date information was last updated from the primary source
- The organization can engage the quality control processes of the CVO when necessary
Credentialing JC

- What to Primary Source Verify (PSV)?
  - Board Certification
  - DEA/CDS
  - DHHS
  - Delineations
  - Education
  - FSMB
  - Insurance ➔ If required by Client’s P&Ps
  - License
  - Litigation
  - NPDB
  - Professional References
  - Work History ➔ Not addressed, but typical is 10 years (Not PSV)
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<tr>
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<td>Not Addressed; Typically 305 @ CVO, 365 @ Committee</td>
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<td>Insurance Coverage</td>
<td>Only if required by the client’s P &amp; P</td>
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Still with me?
• Provider Enrollment:
  – The process of registering with a commercial or government insurer to become a paneled provider. This is the precursor to credentialing.

• What is involved and how much time does it consume?
  – National Provider Enrollment company commissioned a survey to look at these questions from the provider’s perspective
Role in credentialing process

- 34.05% I am solely responsible
- 17.56% I am partially responsible
- 15.05% The person(s) responsible works for me
- 19.00% Outside company manages it for my practice
- 9.32% I do not manage it but am familiar with credentialing
Number of providers in office credentialed with payors

- 1: 42.19%
- 2-4: 41.77%
- 5-7: 6.75%
- 8-10: 6.75%
- 10+: 2.53%
How much of your office’s time does credentialing consume?

- 10% of my time: 52.34%
- 10% - 25% of my time: 29.79%
- 25% - 50% of my time: 2.98%
- 25% - 50% of my time: 9.36%
- My whole job: 5.53%
- None: 2.98%
What does CAQH do for your office?

- Provides credentialing services: 32.03%
- Stores my providers information only: 13.52%
- Enrolls me in health plans: 22.78%
- Completes credentialing applications for me: 19.22%
- Keeps me current in health plans: 12.46%
What is your perception of CAQH?

- 34.65%: We are not a subscriber to CAQH
- 25.25%: We were, but are no longer a subscriber to CAQH
- 11.39%: CAQH requires a lot of work to enroll and maintain
- 23.27%: CAQH has significantly reduced our credentialing efforts
- 3.96%: CAQH gives me significant value beyond credentialing
- 11.39%: I am not familiar with it
- 0.50%: POOR customer service
- 0.50%: Not certain
- 0.50%: Not certain
Provider Enrollment - Saving Time

• Major Considerations
  o Complete full application
  o Ensure application is correct and current
  o Provide clear copies of all supporting documents
  o Maintain CAQH application and supporting documents ongoing for organizations that leverage CAQH
    ➢ Do not just re-attest
  o Sign and date application
    ➢ No stamps
Questions?