



THE IMPORTANCE OF PROVIDER CREDENTIALING AND ENROLLMENT – ELIMINATE ENROLLMENT DENIALS



ArchProCoding

RURAL & COMMUNITY HEALTH

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Over 20 years of experience in healthcare billing, coding, credentialing, enrollment and documentation auditing. Academic background includes a Bachelors in Business Administration (BA), Certified Professional Medical Auditor (CPMA) through the National Alliance of Medical Accreditation Services (NAMAS), a certified Community Health Coding and Billing Specialist (CH-CBS) by the Association for Rural Health Professional Coding (ARHPC).





Goals and objectives

- ▶ Understand the difference between enrollment and credentialing
- ▶ Understand Payer Requirements
- ▶ Identify solutions for more efficient enrollment processes



Credentialing

Provider credentialing in healthcare is the process by which medical organizations verify the credentials of healthcare providers to ensure they have the required licenses, certifications, and skills to properly care for patients.

Vs

Provider Enrollment

Enrollment refers to the process of requesting participation in a health insurance network and submitting required documentation to third party payers to gain approval into payer networks and allow providers to bill for services.

PAYERS:

Entities other than the patient that finance or reimburse the cost of health services:

- Commercial: Health Plans, Managed Care Organizations
- Federal/State: Medicare, Medicaid, Tricare
- Health Plan Sponsors: Employers or Unions



Why do Payers Credential?

- Ensure practitioner has legal authority and relevant training and experience to provide quality care
- Legal Precedent
- Accreditation/Regulatory Requirements such as NCQA, URAC, CMS
- Internal Policies and Procedures





UNDERSTANDING PAYER REQUIREMENTS



What do YOUR payers require?

- In what networks are your providers participating?
-
- What accreditation standards do they follow?
- What additional requirements do they have?
- Who is your point of contact?



It is important to remember ongoing payment requirements after initial enrollment:

- Reporting
Demographic changes, TIN updates, terminations
- Recredentialing/Re-enrollment
Commercial payers at least every 36 month
- Revalidations
Medicare – every 5 years or upon request
Medicaid – 5 years



COMMERCIAL PAYER TIMELINE

CONTRACTING – 30 TO
90 DAYS

CREDENTIALING – 30 TO
180 DAYS

THESE PROCESSES MAY
OCCUR IN PARALLEL



Items checked during Credentialing

-
- License
 - Application/Attestation
 - DEA
 - References
 - Education and Training
 - NPI
 - NPDB
 - Sanctions
 - Professional Experience
 - Board Certification
 - Malpractice



Additional Items Plans may Verify/Request

1. Social Security Death Master File Verification
2. Hospital Affiliation Verifications
3. CLIA Certificates and Verifications
4. State specific Patients Compensation Fund Verification (if applicable)
5. National Student Clearinghouse Contractual Relationship Verification
6. Medicare Opt-Out Verification
7. Collaborative Practice Agreements
8. W9



PROVIDER ENROLLMENT CHALLENGES:

- Volume
- Payer Requirements
- Provider Information
- Timeliness
- Communication
- Resources



THE RESULT OF ALL OF
THESE CHALLENGES IS
DELAYED OR LOST
REIMBURSEMENT !!



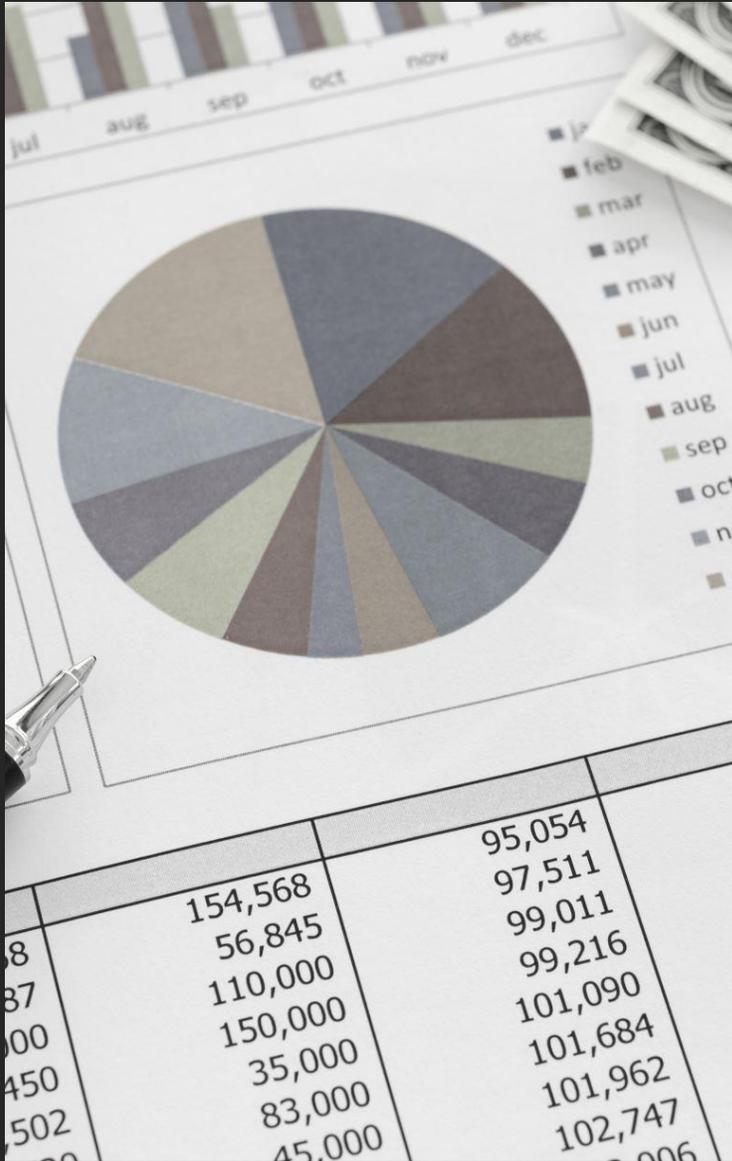
It is very important to make sure your application is complete. Some items to consider are:

Application/Attestation with current signature and date

Work History needs to be in mm/yy format

Malpractice History must be included

Disclosure Questions. Explanation for any YES answers must be provided.



Five of the most common mistakes to avoid:

-
- Incomplete Information
 - Lack of follow up
 - Letting CAQH Lapse
 - Poor Planning
 - Not understanding the standards and guidelines of payers



DO NOT WAIT!

-
- Regardless of who is handling your provider enrollment applications, the primary thing to consider and always keep in mind is DO NOT WAIT! The process is very lengthy and you won't receive "in-network" reimbursements until your contracts are in effect.
 - Credentialing your providers is labor intensive, with few shortcuts. Trying to take short cuts will lead to problems every time!



Follow up guidelines:



1 week after submission,
confirm they received



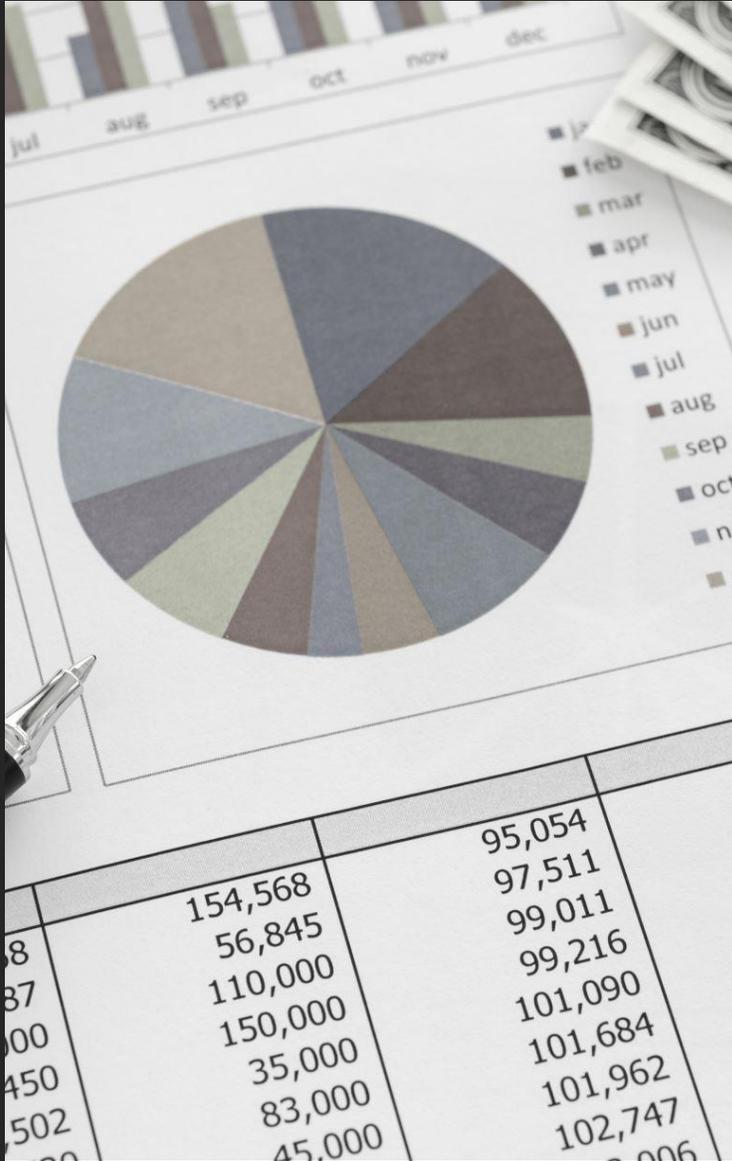
Give 30 days and follow up



Follow up every 2 weeks after



They will tell you to wait the 30 or 60 days. They will tell you they have a process. We in turn tell them we also have a process and that is to follow up every 2 weeks. You don't want to wait 60 days to know that they are missing a document or that you filled out the wrong application.



Payer Repository That Includes at a Minimum:

-
- Payer Name
 - Contract Date
 - Average Turn Around Time for Enrollment
 - Contact Info
 - Plan Specific Requirements



Using Technology to Streamline Enrollment

-
- CAQH – used by over 900 Healthcare Organizations
 - Commercial Software
 - Enrollment and other functions
 - Online collection of provider data
 - Application pre-population
 - Potential integration with CAQH

Using Technology to Streamline Enrollment

- CAQH must be up to date at all times. Even if it is not time to re-attest, if anything changes, CAQH must be updated. You have to attest each time you change anything.
- Don't get confused if you see information on there that does not relate to your group. Many providers are associated with multiple groups.
- As soon as provider gets Medicare/Medicaid ID, update that info in CAQH before trying to enroll with plans that pull info from CAQH.
- As of 2019, **Almost 90 % of all National Health Insurance Companies use CAQH** as their primary database for provider information. This includes over 900 health plans, hospitals, and healthcare organizations.





- USING TECHNOLOGY TO STREAMLINE ENROLLMENT WITH MEDICARE

- PECOS

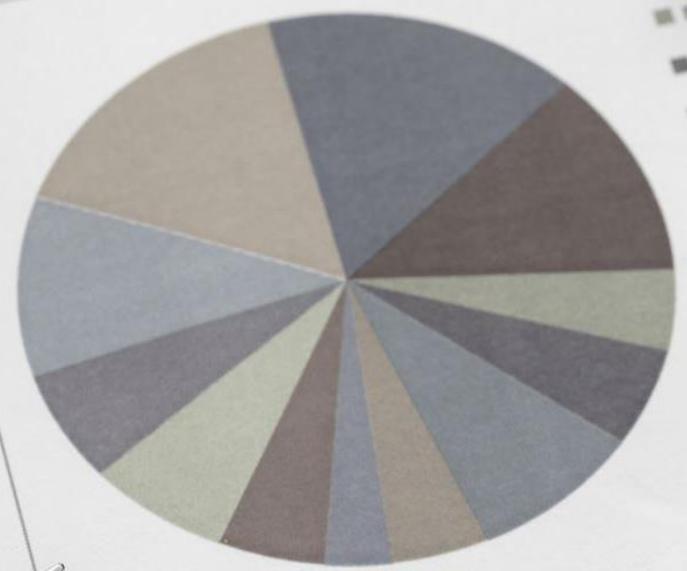
- Initial enrollment averages 45 days vs 60 days for paper
- Status, changes and revalidations
- Identity & Access Management System
- Surrogate Registration

- Revalidations

- Download report and track <https://data.cms.gov/revalidation>
- Use PECOS or revalidations



- **CMS specifically prohibits you** from using your provider's PECOS (Provider Enrollment, Chain and Ownership System) login to manage, verify, update or authorize their Medicare enrollments.
- Instead, the Agency wants you to set up a PECOS Surrogacy enrollment account which allows you to work on your provider's behalf using your own login. Failing to comply with these rules, means that you are NOT in compliance with CMS requirements – not somewhere you want to be.



125,058	154,568	95,054
125,487	56,845	97,511
124,000	110,000	99,011
105,450	150,000	99,216
86,502	35,000	101,090
	83,000	101,684
	45,000	101,962
		102,747
		2,006

154,568
110,000
89,000
50,000
68,700
123,000

The Surrogate Process



Login to I&A

nppes.cms.hhs.gov/IAWeb/login.do

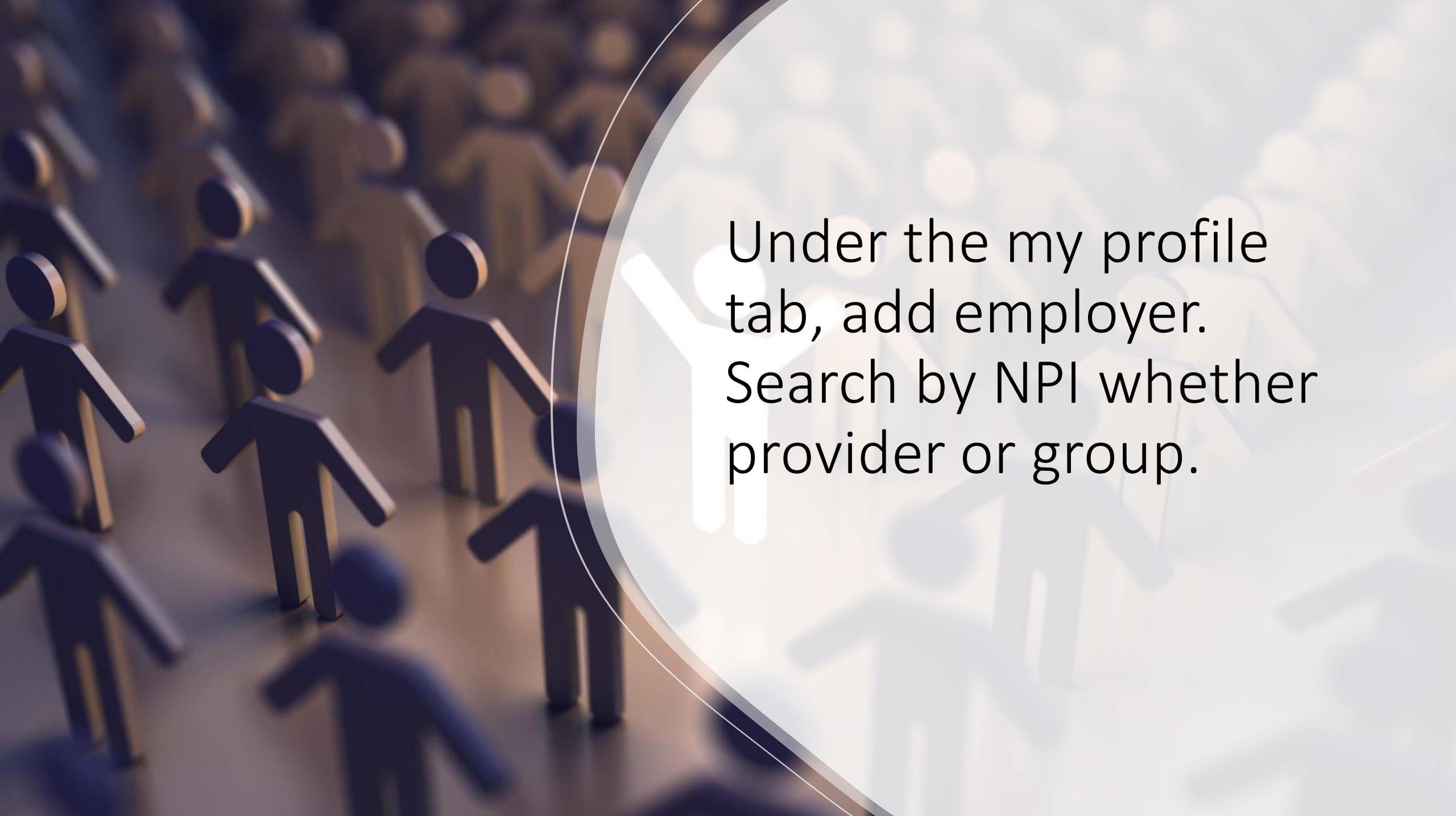


I&A - MFA Verification



I&A - My Connections

Find Provider
Request Surrogacy Approval



Under the my profile
tab, add employer.
Search by NPI whether
provider or group.



Email Communication Sample

Us: I am just checking in to see if you have an update. (October 12)

Plan: Your request is under review. Please standby for an update. Thank you! (October 12)

Us: Just following up on this request. We hope to hear from you soon ! (October 21)

Plan: Please standby for a response. I understand that you're eager to contract. I'm reviewing network need at this time. I'll get back to you soon with an update.

Us: Just following up on this request. We hope to hear from you soon! (November 17)

Plan: Thanks for the follow up. Is your intent to contract for ALS and BLS transportation? Please advise. Thanks! (November 17)

Email Communication Sample:

- Plan: Last ask. May you send me something the verify your Medicare Star status? Thanks! (December 2)
- Plan: My apologies, I just learned that Humana does not pursue direct agreements with transportation providers. The vendor for these services is LogistiCare. Please visit www.logisticare.com for information on obtain a contract with them and how to opt in to service Humana members. (December 7)
- Plan: I just received word that Logisticare only handles non-emergent transportation for Humana. Please return the attached with a W9. Thank you for your patience. (December 9)
- Plan: I'm unable to weigh in on an effective date as that is determined by leadership. The delay here is partially due to network analysis and some miscommunication about how ambulance providers were handled. (April 7, 2022)
- Plan: Pardon, I got your service confused with another ambulance provider. You may view your company out on the Humana website. (April 13, 2022)





Make sure enrollment staff have access to the sites they need to do their jobs efficiently and effectively:

- I&A Account - MFA
- Availity Account – MFA
- CAQH info for providers
- PECOS – must have providers link themselves to group.

125,058	154,568	95,054	124,500
125,487	56,845	97,511	125,000
124,000	110,000	99,011	154,000
105,450	150,000	99,216	95,000
86,502	35,000	101,090	154,200
	83,000	101,684	110,000
	45,000	101,962	89,000
		102,747	50,000
			68,700
			123,000



Getting started tips:

- Step 1: Gather all documents
- Step 2: CAQH Access and update and attest
- Step 3: Medicare/Medicaid apps
- Step 4: Apply to all plans that pull from CAQH
- Step 5: Apply to all other plans

- Make sure all documents get uploaded with application.
- Some, like Humana, you just complete an interest form so you can't send documents with interest form.
- Cigna is done over the phone to initiate application. Then they come back and ask for things.
- When you get documents from providers, load into CAQH so that plans have access to it. As you know what plans require, be proactive and update CAQH with any documents plans ask for.

Some documents plans ask for:

- Hospital admitting arrangements.
- Protocol agreements.
- DEA
- Malpractice COI
- Medicare approval letters
- Collaborative agreement
- CLIA



Helpful hints:

- You must be organized
- You must follow up relentlessly
- You may get different answers from different customer services reps. Not everyone at their current job knows what they are doing, and many will say anything just to get you off of the phone.
- Don't accept "still in process". Ask WHY? WHAT IS MISSING? CAN WE ESCALATE THIS?
- Acronyms and terms – be familiar. If you aren't sure what something means..ASK...do not ignore
- Know what stages mean – credentialing, loading, contracting. What do these mean? How long does each stage take? And what point is the provider effective?
- Some plans used Vendors...Aperture is one of those. They may ask for things the payer doesn't ask for. Many requests will give deadlines for getting documents in before application is denied and you have to start over.
- Sometimes panels are closed. Plans evaluate network needs and organizations/providers standing before deciding to extend an agreement.



NC Medicaid

[Provider Enrollment | NC Medicaid \(ncdhhs.gov\)](https://www.ncdhhs.gov/provider-enrollment)



NC Tracks Enrollment/Re-Enrollment Application Processing Turn Around Times –

Feb.

11.34 Days

March

10.92 Days

April

11.88 Days

These processing times are for clean applications where the application is error-free and complete, and includes any/all required supplemental information at the time of electronic submission.

[Credentiaing | American Dental Association \(ada.org\)](http://ada.org)



Powered by CAQH ProView®, this service helps you share your credentials with multiple dental plans quickly and easily.

BCBS Medical and Behavioral Health

Directs you to go through CAQH:

- ▶ [Step 1: Providers can submit their application online via CAQH](#)
- ▶ Blue Cross NC is working with the Council for Affordable Quality Healthcare (CAQH) to make the application process easier. This means you don't need to fill out and send multiple applications.
- ▶ By applying online:
 - You can submit your information online easily
 - You can change your information yourself to make sure it's up-to-date
 - We can access your information whenever you've given us approval
 - We can verify and review your credentials to make sure they meet Blue Cross NC requirements
 - Your information is stored securely and you can access it whenever you want on your schedule
- ▶ [Please follow these steps:](#)
 1. Make sure you are a [CAQH member and get a CAQH provider number](#) (only for providers who aren't already registered with CAQH)
 2. Apply for credentialing/recredentialing using the button below
 3. Return here and email us at credentialing@bcbsnc.com to let us know you've completed your online application and we can start our review process
 4. Make sure your application status show the "Completed" stage before emailing us
- ▶ [Start the CAQH Application Process](#)
- ▶ Need more information?
- ▶ To learn more about CAQH and the CAQH UCD, you can [visit their website](#) to watch an online demonstration. Or read our [frequently asked questions](#) for more information.





- BCBS- Dental

<https://www.bluecrossnc.com/providers/dental-providers/dental-enrollment-and-credentialing>



BCBS UPDATED DEMOGRAPHICS – PMF (PROVIDER MAINTENANCE FORM)

The *Provider Maintenance Form (PMF)* is an online form used to request demographic and practice profile changes to Anthem contracted physician, practitioner, and professional provider records.

Online PMF submissions allow us to update your provider information in a more accurate, expeditious manner. Using the online PMF helps to get your updated provider information to our Provider Directories quicker.

Examples of changes to report on this form include practice or provider name changes, address changes, tax ID changes, opening or closing practice locations, provider leaving a group practice, etc..

This form may not be used to add new providers or to request participation with Anthem. New providers joining an existing group and providers wishing to join the Anthem network should complete the Add-a Doc\New Add Provider Maintenance Form.



UHC Medical

Here's what to have handy as you get started:

- Tax Identification Number (TIN)
- CAQH (Council for Affordable Quality Healthcare) ProView Account Number – make sure the account is up to date and authorize UnitedHealthcare to access your data



UHC –<https://www.uhcprovider.com/en/resource-library/Join-Our-Network.html>

Request should be submitted through RFP Portal

- A representative will start the process with you.
- You'll be registered in UHC system (if you're not already).
- You'll receive a confirmation of your participation request – this usually occurs within 5 business days.
- We'll quickly review your application – and if we're not accepting new applications for your area or specialty, we'll let you know.



UHC – if unable to complete through one of the previous methods

Call UnitedHealthcare at 877-842-3210

Enter your Tax Identification Number

Select Credentialing, then Medical, then Join the Network.



UHC – Behavioral Health

<https://www.uhcprovider.com/en/resource-library/Join-Our-Network/join-get-started.html#item1542649855503>

- If you work in this specialty area, you'll contact Optum Behavioral Health Solutions, which handles credentialing and contracting on behalf of UnitedHealthcare.
- To get started, go to [providerexpress.comopen in new](#) (look under "Our Network" for specific instructions) or call 800-817-4705.
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UHC - Dental

<https://www.uhcdental.com/content/provider/dental/dental-join-our-network.html>

1. Use the regional map to find your state and identify the correct regional location of your practice
2. Use the following list to select the appropriate region and contact us to request a provider packet
 1. West region: [Contact us](#)
 2. Central region: [Contact us](#)
 3. Southeast region: [Contact us](#)
 4. Northeast region: [Contact us](#)
3. Fill out the email completely. Consultants should attach their signed Letter of Authorization (LOA) indicating they are representing the practice(s).
4. Send to our team. Be sure to indicate your State and County in the email subject line.



UHC – Joining a practice with an existing United Healthcare group agreement

- You'll need to submit your request through the RFP portal or Onboard Pro. Even though you are joining a practice that has a UnitedHealthcare agreement in place, you'll still need to complete the credentialing process before you can see patients as an in-network provider.
- We're transitioning participating groups from the RFP portal to Onboard Pro, our improved credentialing tool in the UnitedHealthcare Provider Portal. Open the [RFP portal open in new](#) and enter your TIN. You'll either be rerouted to Onboard Pro or you'll complete your request in RFP. Learn more about [Onboard Pro](#).



Cigna

[Cigna Medical Network Credentialing | Cigna](#)

- Pre-Application
- Before starting the application process, we'll need some information from you to confirm that you meet the basic guidelines to apply for credentialing.
- Please call Cigna Provider Services at **1 (800) 88Cigna (882-4462)**. Choose the credentialing option and a representative will assist you. In most cases, you'll be informed on this call if you meet the basic guidelines to apply for credentialing.
- If you are a facility or ancillary provider, we'll need more information from you than is on the Provider Information Form. Please call 1-800-88Cigna (882-4462), choose the credentialing option, and the representative will tell you the next steps in the application process.



Cigna

[Cigna Medical Network Credentialing | Cigna](#)

- Submit your application
- If you meet the basic guidelines to apply for credentialing, you will receive an email with an application packet and all the information you'll need to get started.

- If the application information already exists on the Council on Affordable Quality Healthcare® (CAQH) website or the One Healthport/Medversant® website, with your permission we will access it electronically to gather most of the information we need. As a third option, if it's required by the state in which you practice, we'll accept a state application that you complete, sign, and mail to us with the required documentation.



Cigna Behavioral Health

[Evernorth Provider - Resources – Credentialing](#)

- Complete the [Evernorth Behavioral Health Provider Information Form](#).
- Evernorth Behavioral Health will respond by email within 20 business days after reviewing your form.
- The email will be sent to the email address that you list in the "Contracting/Credentialing" field under the Professional Contact Information section.
- The entire credentialing process typically takes 45-90 days to complete.
- During this time, you'll also receive emails from us to:
 - Confirm your application was received.
 - Request any missing documentation or application information. If we do not receive missing information, we'll send you an email notification that we closed your application.
 - Keep you updated on where your application is in our credentialing verification process, including any delays that may cause the credentialing process to extend past the standard 45- to 90-day turnaround time.
 - Confirm you have been approved and credentialed as a network-participating provider with your effective date, or notify you that you have not been approved
 - If you have been approved, we will upload your provider information into our directories and claim systems which typically happens within 10 business days.



Cigna Dental

[Cigna Dental Network Credentialing | Cigna](#)

1. Call or email Cigna

To start the online application process, call at 1 (800) Cigna24 (244-6224) or 1 (800) 280-9622, or send an email with your name, office name and office address to dentistenrollment@cigna.com.

2. Provide your credentials

You can submit your credentials electronically using the Council for Affordable Quality Health Care (CAQH) Universal Credentialing DataSource, One Healthport/Medversant, or Cigna's e-onboarding tool. If your application already exists in CAQH or One Healthport/Medversant, with your permission we will access it to gather most of the information we need:

1. W-9 form
 2. Current dental license
 3. Current drug enforcement agency (DEA) certificate (not required for orthodontists)
 4. Certificate of specialty training (if applicable)
 5. Current professional liability policy declarations page
3. As another option, if it's required by the state in which you practice, we'll accept a state application that you complete, sign, and mail to us with the required documentation.



Multiplan

Go to
<https://www.multiplan.com/nominate/nominate.cfm?type=join>

Fill out the request to join form and submit

Notate Processing number

Check status of request on the same website with the processing number

You should receive an application from Multiplan to your email

Fill it out and submit

Continue to check status on website with the processing number until approved



Aetna-First Health/Coventry - Medical

<https://www.aetna.com/health-care-professionals/join-the-aetna-network.html>

Choose Medical

Click Medical Request for Participation

Fill out form

Click Submit

Once Credentialing is complete, you will receive written notification. You will be contacted by network management and they will assist you in completing the contracting process



Aetna-First Health/Coventry - Dental

<https://www.aetna.com/health-care-professionals/join-the-aetna-network.html>

- Dentist - Dental Maintenance Organization (DMO[®]) and managed dental products and/or Preferred Provider Organization (PPO) plans* application request.

- Please complete the Dental Request for Participation form to get an application to join Aetna's Network.



Aetna-First Health/Coventry – Behavioral Health

<https://www.aetna.com/health-care-professionals/join-the-aetna-network.html>

Helpful Tips to consider before completing request for participation:

- If you're a Behavioral Health professional, including those joining a medical group, you should complete this Behavioral Health Request for Participation form.
- If you need more information about our application and credentialing process, use the link below. You will also find the information on Council for Affordable Quality Healthcare (CAQH) ProView[®] and Medversant/ProviderSource[™].

Please ensure that your CAQH ProView applications is complete to avoid delays in the Credentialing process.



Cigna Health Spring – (Known as Cigna Medicare HMO Plan A 360 Comprehensive Program)

Must Call 800-882-4462

Choose the credentialing option

The representative will gather the following information and begin the process

Providers name

DOB

NPI

TAX ID of group

Location

Specialty

Start Date

The representative will provide a reference number.

You can check the status on

Onboardingstatus@Cigna.com

Group must elect to use Arcadia and utilize the HMR (Health Maintenance Record)

Verify your group has Cigna Health Spring Claims first



Humana

Go To:

<https://www.humana.com/provider/medical-resources/join-humana-network>

Click on Apply to our Network

Pick I will file my claims to Humana using an EIN or TID number

Fill out request to participate form and submit



Humana Military

Go To:

<https://www.humanamilitary.com/provider/access/become-a-tricare-provider/>

Click on Get Certified

Click on Practitioner Certification Applications

Choose What type of Provider

Fill out the form

Return by fax to 608-221-7535

Once approved then can apply for participation



Georgia
Primary Care
Association



ArchProCoding
RURAL & COMMUNITY HEALTH

