Elements of Provider Credentialing

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by Patricia Nelson, MEd, RHIT (formerly ART)

HIM professionals manage patient information. But in the provider credentialing process, another kind of information management is necessary -- handling the varied and important information compiled on doctors throughout the country. Here's how the credentialing process works.

Traditionally, health information professionals manage patient information. But in the world of physician credentialing, information managers keep track of data on the doctors. Credentialing certifies that physicians have the appropriate knowledge and experience to provide care to patients. It is also a measure that allows organizations to determine whether physicians should be hired, have hospital privileges, or be able to participate in managed care contracts.

HIM professionals may be only peripherally aware of the credentialing process in their daily work, but credentialing is of interest in more ways than one. Some interesting parallels can be drawn between the two professions in terms of information management principles and related skills.

Credentialing and the Rise of the CVO

Regulatory agencies such as the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance (NCQA), and the American Accreditation HealthCare Commission/ Utilization Review Accreditation Commission (URAC) require a peer review process for staffing privileges in compliance with quality improvement standards. At first, this process mostly applied at a hospital level. Now, managed care organizations, health maintenance organizations, independent practice associations, preferred provider organizations, and other healthcare organizations also mandate peer review through a credentialing process.

This peer review process is part of a healthcare organization's quality management process, which emphasizes the criteria for clinical appointments to provide continuous quality improvement of patient care in an efficient and cost-effective manner. The Joint Commission and NCQA require that every two years, all providers with clinical appointments must participate in a credentialing process commonly referred to as recredentialing.

During the credentialing process, areas of the provider's background and training are verified through various primary sources. The process can be laborious, paper intensive, and time consuming without the proper procedures, software, and trained staff. For these reasons, many healthcare organizations have elected to outsource the credentialing and recredentialing process to a credentials verification organization (CVO).

While only a handful of CVOs existed at the beginning of the decade, they are now numerous. Hospitals, HMOs, and other employers of physicians typically contract CVOs to credential all their physician employees. Physicians can also contract directly with CVOs to check their own credentials.[1]

Checking the Checkers: Accrediting CVOs

URAC and NCQA both accredit CVOs. Both agencies require two-year accreditation periods. Many CVOs acquire dual accreditation from both agencies to effectively compete for credentialing contracts.

URAC initiated a CVO accreditation process in April 1998. The agency places much emphasis on the credentialing operational process. URAC's accreditation standards emphasize the development and implementation process regarding on-site provider audits. This is attributable to its history of working with PPOs, IPAs, and workers' compensation programs.

URAC's CVO accreditation standards provide benchmarks for:

- a CVO's organizational integrity and structure, including the training of credentialing staff
- information collected from practitioners for credentialing
- methods of verification of information collected from providers
- time frames for consideration of credentialing information
- security and confidentiality of credentialing information
- procedures for on-site reviews of provider offices[2]

NCQA, possibly the better-known accreditation agency, began certifying CVOs in 1996. NCQA seeks to verify that a CVO has demonstrated and provides sufficient protection (confidentiality) required by NCQA standards; that it has developed a sound management structure; and that it continuously monitors and improves its quality of service.

The major components of an NCQA CVO certification survey are:

1. Determination of compliance with CVO standards, which include a review of an organization's:
    - polices and procedures for credential verification
    - mechanisms for maintaining data integrity and confidentiality
    - capabilities for ongoing data collection
    - internal quality assurance processes
    - physician application components
    - reporting of physician disciplinary actions
2. An audit of completed credential files to determine compliance with NCQA's credentialing standards.[3] During the audit process, credentialing files are reviewed for 10 elements:
    - licensure
    - hospital privileges
    - Drug Enforcement Agency (DEA) registration
    - medical education and/or board certification
    - malpractice insurance
    - liability claims history
    - National Practitioner Data Bank (NPDB) queries
    - medical board sanctions
    - Medicare/Medicaid sanctions
    - provider application[4]

The Credentialing Process: How It Works

The credentialing process starts with the provider application. An application provides a mechanism by which essential information about current licensure, relevant training or experience, current competence, and health status is verified for each specific provider. Not all information on the application is applicable to all types of providers (e.g., dentists, podiatrists, mental health professionals, nurse practitioners). For this reason, the credentialist must carefully review the application for completeness and accuracy. The application must include a signed and dated attestation to verify completeness and accuracy and an information release and immunity statement, which authorizes the reviewer to verify the validity of the information.

Discrepancies or incomplete information can relate to the provider's professional history, which addresses any licensure restrictions or revocations, felony convictions, Medicare/Medicaid sanctions, reports to the NPDB, chemical dependency or substance abuse, or physical or mental conditions that might limit the provider's ability to provide covered services. All information on the application is verified through primary source verification. If any discrepancies are noted on the application, the provider must provide written clarification, including date and signature, which becomes an addendum to the application. All incomplete applications are returned.

The credentialist must obtain primary source verification, which can be obtained either in written or verbal format. If the information is obtained verbally, written documentation must appear in the credentialing file as to the contact person in the

agency, the information obtained, and the date and time of the verification, which is then signed and dated by the credentialist.

All 10 credentialing elements as addressed by the NCQA standards should be verified via the mandated primary source agencies (see table below).

Where Does Source Verification Come From

Element	Primary Source	Verification Format
Licensure	State board of medical examiners	Written or verbal report
Hospital privileges	Hospital staff services department regarding active status in good standing	Written or verbal report
Drug Enforcement Agency Registration	Current copy of registration to include number and expiration date	Current copy of registration
Medical education*	Medical school and/or program	Written report indicating dates of graduation from school and/or program
Board certification*	Issuing specialty board	Copy of American Board of Medical Specialties or American Osteopathic Association board certification directory
Malpractice insurance	Malpractice carrier	Written report indicating the dates and amount of coverage
Liability claims history	Malpractice carrier	Written report indicating number of claims within a five-year period from the date of credentialing
National Practitioner Data Bank queries	NPBD Query for Practitioners (QPRAC)	Written report
Medical board sanctions	State Medical Board of Examiners	Written report
Medicare/Medicaid sanctions	QPRAC	Written report
Provider application	Provider	Actual signed application

*Highest level of education is verified starting with medical school graduation, internship, residency, and fellowship and ending with Board certification. If the provider is board certified, it is not necessary to verify the other forms of education since this has already been verified by the certifying Board.

The credentialist must complete the credentialing process within 120 days of the date of the signed attestation statement. The clock does not stop ticking until the healthcare organization, or client, has a copy of the completed file for review by its credentialing committee. The client then has another 60 days to review the completed file. The provider cannot receive clinical or contract privileges until the credentialing committee reviews the provider credentialing file. If the file is not completed and reviewed within these stated time frames, both the CVO and healthcare organization are out of compliance, for the information will not subsequently be considered current. If the CVO exceeds the 120-day time frame, the attestation statement must be re-signed and dated in order for the credentialing process to be continued. In light of these time constraints, a credentialist must demonstrate good organizational skills to retrieve all primary source information within the required time period.

Peer Review

Peer review is the review of a provider's professional behavior, educational background, and experience as a provider. Once the credentialing process is complete, the information is sent to the client's credentialing committee, which serves in an advisory capacity regarding peer review. The committee holds the right, as directed by the organization's board of directors, to make the final decision of acceptance or nonacceptance into the organization's provider network. It is important that, during the peer review process, explicit criteria be developed to avoid discrimination during the selection process, and that only providers who have demonstrated their commitment to quality and who have the necessary background needed by the healthcare organization are selected for the provider network.

As with any decision-making process, the organization must have a written appeal process that allows the provider due process by providing a fair hearing to address adverse decisions regarding initial credentialing, recredentialing, disciplinary action, and termination. The committee has the authority to render a decision supported by all rules and regulations regarding educational

background and training, experience, professional behavior, and appropriate use of resources in providing high-quality patient care.

How CVOs Monitor Their Own Performance

Common goals of a credentialing program include improving profit and revenue by reducing risk, errors, waste, and inefficiency; increasing the client's level of satisfaction, which may lead to increased referrals; and responding promptly to problem situations before customer relationships can be compromised. Like any organization, a CVO must implement a continuous quality improvement process to ensure accuracy and compliance regarding the credentialing process and to determine if processes need to be improved regarding efficiency, quality of service, and customer satisfaction. It is important that established performance standards are monitored, problems investigated, and preventive action taken.

These processes include the development of realistic, measurable, and goal-oriented performance and incident monitors. These monitors have certain parameters defining their measurement and thresholds for acceptability. The standards are communicated to all whose performance will be monitored or to those affected by the monitors. Monitored areas are added and deleted as deemed necessary to meet the quality goals of the CVO.

Monitors may include:

Performance Monitors

- policies and procedures are followed
- clients are satisfied
- turnaround is timely
- proper consent obtained
- correct information sent to the proper client
- correct fee charged

Incident Monitors

- error rates
- legal/risk situations
- down time
- lost applications
- unexpected loss of client
- complaints

Monitors help determine if thresholds are exceeded or if a problem exists. The problem is then investigated and a decision is made as to whether immediate or preventive action is needed.

The plan of action is documented and communicated to all parties involved. A summary of the reported findings is submitted to the CVO's quality improvement committee on a quarterly or as-needed basis. The summary should include documentation of corrective action taken when performance monitor thresholds were exceeded, description of what immediate actions were taken, and what preventive measures should be taken.

Privacy and Confidentiality Issues

In dealing with any health information, confidentiality is a primary concern. Considering the sensitive background information that is obtained about a provider (history of substance abuse, chronic communicable diseases and license sanctions, etc.) confidentiality is critical and must be a priority for all CVO employees. CVOs must develop policies that control access to credentialing files to ensure confidentiality of all information and to protect the content of the file from unauthorized access and tampering. The original file remains the property of the CVO and must be protected. At no time should the original credentialing file leave the premises unless required by a court order.

A provider has the right to control disclosure of personal information. Prior to any type of primary source verification of information, a provider must sign an information release and immunity statement, which allows for primary source information to be released to the CVO. A copy of this statement must accompany all primary source requests. The provider and client shall have access to the content of a credentialing file for review purposes only. At any time, either may schedule an appointment to review the file. But at no time can the provider review confidential information contained in the credentialing file as it relates to references, personal observations, or comments regarding the provider from primary source verification agencies. CVO staff must be familiar with state laws regarding immunity from civil liability for the purpose of healthcare quality assurance review and understand what information is considered confidential and protected from discovery proceedings.

Only authorized CVO personnel should have direct access to credentialing files. All employees should sign a confidentiality statement if they have access to the information in the credentialing file or database. All files should be maintained in locked cabinets with keys available to authorized personnel only.

The healthcare organization (client) receives a copy of the credentialing file, including the application and all primary source verification information, including all disciplinary actions taken against the practitioner, unless the contract or federal or state law precludes this disclosure. Federal law does prohibit the copying and release of NPDB materials, which includes the Medicare/Medicaid sanctions report to the client. A summary sheet should be provided to the client indicating that the NPDB was queried, including the date and the number of sanctions reported.

To maintain confidentiality, copies of information/correspondence containing any provider's identifying information or signature should be destroyed. It is important that a CVO establish a destruction policy determining the length of time that credentialing files must be maintained and how the information will be destroyed after the retention period has expired. The most common means of destruction is shredding.

A CVO should also create a disaster recovery plan. The plan should identify the type of computer system, both hardware and software, and security issues, including passwords and employee orientation. It also should include disaster recovery team duties, an emergency telephone list, and notification procedures. The CVO should identify the types of information maintained (e.g., credentialing, financial, personnel records) and prioritize those necessary to keep the organization functioning. Then a plan should address the recovery operations and salvage procedures. The most critical point, for all types of information, is that it should be backed up regularly.

Conclusion

Credentialing is an important and necessary process in today's healthcare environment. From a risk management perspective, a healthcare organization is responsible for protecting patients from any unreasonable risk of harm, and that process starts with the provider selection process for clinical staff privileges. In today's increasingly complex healthcare environment, credentialing is gaining increased recognition as a critical step in the process. HIM professionals looking for a career change may want to investigate this field, as it offers considerable opportunity.

Notes

1. Glabman, Maureen. "Physician Credentialing Heats Up." *ACP Observer*, 1997. Available at http://www.acponline.org/journals/news/apr97/credentl.htm.

2. American Accreditation HealthCare Commission/URAC. "Credentials Verification Organization Standards." Washington, DC: 1998.

3. National Committee for Quality Assurance. "1998 Standards for Certification of Credentials Verification Organizations." Washington, DC: 1998.

4. Ibid.

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