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By: Jeanne T. Connelly, RN, MBA, CPC, FACMPE

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Should the Insurance Credentialing Process be Standardized by the Healthcare Industry and Government Mandates?

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Jeanne T. Connelly, RN, MBA, FACMPE, CPC
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Executive Summary

Many processes are frustrating in the healthcare arena. The provider credentialing process with hospitals and insurance carriers is one of these frustration points. This historical paper presents the timeline of events that has created the need for credentialing and the proposed changes that may be required in the future. The documents reviewed during this research provided multiple points of inconsistency. The trigger points for the evolution of the credentialing legacy that is in place today are substantiated through a review of the history of health insurance, medical education quality improvements, shifts in population sentiment towards hospital systems, and rising healthcare costs. Case law reviewed supported the need for credentialing validation and standardization, but government entities have been reluctant to enforce any national standards that have fully met this need. The enactment of the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Care Quality Improvement Act of 1986, and the additional amendments to these acts, have laid groundwork for patient rights and industry responsibilities. The National Provider Databank is one of the positive outgrowth from these government interventions. Additional patient rights have been assigned with the enactment of the Patient Protection and Affordable Care Act (PPACA) in 2010. Legislative bodies at the state level have also attempted to streamline insurance processes in general. Additionally, independent agencies, including the Medical Group Management Association, are working collaboratively through the Healthcare Administrative Simplification Coalition (HASC) and have created basic recommendations for the industry. Nevertheless, the credentialing process remains arbitrary within the context of a technologically advancing industry. This affects the
bottom line of the medical practice and diverts healthcare dollars, which could be utilized more efficiently. Government intervention is required to create meaningful standardization.
Introduction

Credentialing is “the process of review and verification of the information of a health care provider who is interested in participating with a managed care organization (MCO)” (Sobelman, 2001). The MCO has a duty to its plan participants to ensure that the providers meet the standards of their organization. The required information and documentation can differ greatly from MCO to MCO. Time requirements to complete the credentialing process can also vary from weeks to 6 months. There is no set standard to date for completion of this required paperwork. The redundancy of this process is time consuming and costly to the providers.

This paper will attempt to identify the challenges that both the healthcare provider and MCO face in the credentialing process and the common areas that could be consolidated to a uniform process. This will be accomplished through review of current literature and case law.

History of credentialing process

Before health insurance, there was no need for credentialing. The Yale Journal of Medicine and Law relate that the first form of a health insurance plan, The Franklin Health Assurance Company was established in 1850 in Massachusetts. This plan would cover injuries related to travel on railroads and steamboats. Coverage for illnesses and injuries evolved from this plan, but the first “modern health insurance plans were not formed until 1930.” (Zhou, 2009)

Historically, people who were sick stayed home to recover. Until the early 1900’s, there was a distrust of hospitals and medical technology. Health care costs were minimal. As technology and treatment plans improved, the utilization of healthcare resources became more accepted in society. In 1904, the American Medical Association created the Council on Medical Education, “which developed standards for medical licensure. In 1913, the American College of
Surgeons was founded to oversee the accreditation of medical schools”. (Zhou, 2009). This accreditation process decreased the number of medical schools from 131 to 95 over the course of 5 years. This early form of accreditation or credentialing proved the positive impact objective standards could have to improve the quality of a system. The subsequent decrease in physicians, increase in quality of care, and increase in demand for utilization of resources by the general public caused healthcare costs to rise. Patients did not stay home to recover. They wanted to go to the hospital. These increasing medical costs “prompted the development of modern day health insurance” (Zhou, 2009).

In 1929, Dr. Justin Ford Kimball of Baylor University Hospital identified a need for school teachers to have help with paying their medical bills. He began to offer the Baylor Plan, whereby the teachers would pay fifty cents a month for a guarantee of up to 21 days of medical care in a given year. As the Depression began, other hospital systems latched on to this concept. But these single-hospital plans changed the economics of supply and demand again, and price competition began to impact the basic premise of the plans. The community hospitals began to work together and in 1939, the American Hospital Association (AHA) used the name of Blue Cross to establish that a health care plan met the AHA standards. These individual plans merged into one Blue Cross organization in 1960. It was organized under the AHA and was therefore considered a nonprofit organization, exempt from taxes, and allowing low premiums. This was another moment in healthcare history where standards were established to ensure quality and allow for participation in a system. While the hospitals were working together in 1939, there were also physicians working together in California. The California Physician Services was a pre-paid plan that would cover physician and surgeon fees. Additional physician insurances developed
and these groups merged together in 1946 to form the Blue Shield organization. Blue Cross and Blue Shield would later merge into one company in 1971.

While the hospitals and physicians were developing their insurance plans, there was a concurrent development of private commercial plans. In the 1930’s life insurance plans began to offer health insurance packages. These plans were for serious medical emergencies only. The life insurance plans used the same actuarial statistical analysis to identify health premiums that were used to identify risks associated with life insurance. Sick people or the elderly paid more for their healthcare insurance. Blue Cross and Blue Shield had previously charged a flat rate fee, but had to start assigning premiums in a similar fashion to remain competitive. Employers began to offer plans during the 1940’s and 50’s. World War II wartime wage controls limited how much an employer could pay an employee, so insurance benefits became a recruitment and retention tool. These payments were also not taxable which increased the desire for employers to offer this benefit (Zhou, 2009).

Up to this point, the success of the health plans precluded the need for any government intervention and regulation. However, in 1954, “Social Security coverage included disability benefits for the first time and 196 Medicare and Medicaid programs were introduced.” (Zhou, 2009). During the 1970’s and 80’s healthcare technology advances began to drive up healthcare costs. In order to try to control utilization and quality, Health maintenance organizations (HMO) were developed. Employee benefit plans became Managed care organization (MCO). Each type of product developed their own network of healthcare providers who were required to be verified as quality providers, accept the fees being offered, and follow the guidelines established by the HMO or MCO. Quality of providers and verification of credentials became a priority in the marketing of these plans. The development of this gatekeeper strategy slowed the growth of
healthcare costs but did not stop it (Zhou, 2009). It did however increase the responsibility for the healthcare organizations to ensure the providers and networks that they were offering met or exceeded the standards of the organization. Under the legal concepts of respondeant superior and vicarious liability, the organization could be held responsible for the misdeeds of it credentialed providers (Showalter, 2011). Credentialing became a priority in the networks.

As networks developed, each plan maintained separate credentialing requirements and standards. Hospitals also maintained individualized requirements and standards. In order to provide the best for their participants, hospitals were obligated to develop what they believed were the best standards. Credentialing Committees would painstakingly review documentation. During the early days of Medicare, it was not uncommon for a 20 page form to be returned to a practice because there was an error on page 3. The error would be corrected by the practice only to have the form returned again because there was an error on page 8. And so, the process would continue until all documentation supplied was accurate and verified. Many smaller physician practices would fumble through these processes with multiple carriers. Nevertheless, it was the right of the carrier to mandate these formats because the carrier held a higher responsibility to plan participants than to the providers. “Credentialing is a multi-step process that protects the public from providers who lack proper qualifications, health care organizations from liability of using under qualified providers, and providers from unfair or arbitrary practice limits, which helps maintain their general reputation and respect” (Mejia, 2009).

The provider starts the credentialing process by requesting and completing a professional history application. The completed information is then verified by the credentialing committee at the insurance carrier. There can be primary source verification, such as specialty boards, professional references, and medical schools. Affiliations with hospitals and surgical centers are
confirmed. The National Provider Data Bank (NPDB) (defined in Government regulation below) is accessed to ensure the veracity of reported information in regards to malpractice or other professional sanctions. Some insurance organizations will require criminal background checks. This process “will reveal Medicare/Medicaid sanctions, state license disciplinary actions, and malpractice claims”.

As computer technology allowed, some carriers automated their processes to allow for form completion on line. These forms would need to be printed and personally signed by the providers. In 2002, The Council for Affordable Quality Healthcare (CAQH) developed the Universal Provider Datasource (UPD) to address the following:

• **Redundancy**: Providers are asked to complete multiple forms essentially requesting the same information.

• **Follow-up**: Omitted and illegible responses require significant resources and result in processing delays.

• **Misalignment**: Different credentialing cycles exacerbate the problem requiring providers to complete the process at different points in time.

• **Off-cycle updates**: Follow-up required to maintain accurate data between credentialing events so that provider directories, referrals, claims, and other provider and member services are in agreement.

• **Turnaround**: Providers are frustrated with time between application submission and when a decision is finally communicated.” (Davis & Mattingly, 2010).

This system provided a single source for submission of information and scanned documentation. The provider would complete the application and select carriers that would be allowed to access the information to complete the credentialing process. This was not a
mandated process so there is no legal requirement for insurance carriers to subscribe to this service. In their 2010 conference lecture, *Defining Quality: The Universal Provider Datasource Data Quality Task Force*, Davis and Mattingly reflected on the accuracy of the information being entered into the database. They found that the integrity of the information held true. “Two categories of errors are notable: –7.3% of providers re-attesting to their information failed to update expired state licenses. –2.7% of providers had contradictory responses to related questions; for example, answering “No” to accepting new patients, and subsequently answering “Yes” to accepting new Medicare patients. Study results indicate that the UPD provider data is 92.3% (absolute) to 93.9% (functional) accurate (Davis & Mattingly, 2010).

The database process also has its flaws. Once the provider completes the forms, they must still notify the carrier of their desire to credential with the carrier. If the provider is changing locations or groups, the linkage to those entities could be completed on the CAQH website, the carrier website, or on a specific paper form. A hand signed contract is always required. Many carriers actually require the ink utilized be blue to ensure it is an original signature.

Medicare also developed an on line process for documentation and information. The Medicare Provider Enrollment, Chain and Ownership System (PECOS) is similar to UPD but is only utilized to credential Medicare providers.

**Industry Adoptions**

Hospitals have maintained credentialing process since the early 1900’s. Insurance carriers did not formalize credentialing processes until the late 1980’s. Prior to that time, managed care organizations were regulated by state insurance laws which did not address quality or regulations associated with contracted providers (Freed, Dunham, & Singer, 2009). In order to
assure an appropriate credentialing process, HMO’s, MCO, and some physician/hospital
organizations (PHO), preferred provider organizations (PPO) and independent practice
associations (IPA) began to seek accreditation with one of the managed care accrediting
organizations. The ones that are best known are National Committee for Quality Assurance
(NCQA), the Joint Commission on Accreditation and Healthcare Organizations (JACHO), the
American Accreditation Healthcare Commission (AAHCC), or the Medical Quality Commission
(MCQ). These accreditation processes proved the policies and procedure that follow meet the
standards established by these industry watchdogs. NCQA and JACHO began accrediting
MCO’s in 1991 and 1994 respectively. Additionally in 1996, the Utilization Review
Accreditation Commission (URAC) expanded its utilization review services to include the
accreditation of health plans (Freed, et. al. 2009). Accreditation is not mandated by legislation in
every state. It is utilized by different carriers in different ways. There is no standardization as to
why some MCOs are accredited with JACHO and others with AAHCC. The standards associated
with the credentialing process differ by organization.

Health plans will utilize accreditation status as a marketing tool for both subscribers and
providers. Some providers utilize accreditation assignations as a way to determine if they want to
apply for participation with an insurance plan (Sobelman, 2001).

A study, done by Freed, Dunham, and Singer (2009), audited the use of board
certification of surgeons and nonsurgical specialists in contracting policies. The study identified
board certification as an available tool to assess competency of a provider. They then randomly
sampled the credentialing criteria of 223 health plans. Less than 40% of respondents reported
they “ever require surgical specialists, general surgeons, and nonsurgical subspecialists to obtain
board certification at some point in time during their affiliation with the plan. Board certification
requirements did not vary significantly by reported NCQA accreditation status. Only one third of NCQA accredited health plans reported that the require board certification at some point for general surgeons (33%), surgical specialists (33%) and nonsurgical subspecialists (35%)”. The study concluded that it does not appear that health plans view board certification as an important tool for assessment of physician competency. The study also reported that a 2003 Gallup Poll of the general public went against the views of the health plans. Of the Gallup Poll respondents, 98% believed physicians should go through the board certification process and 78% felt that recertification was also important (Freed et. al., 2009).

There has been some outsourcing of portions of the credentialing process. Credentialing Verification Organizations (CVO) gathers information from the primary sources and maintains this database. Through the CVO, this database can be accessed by “multiple organizations as a credentials source for information on a particular health care provider. All information is held in strict confidence and only released to organizations after obtaining the provider’s permission.” There is immediate relief of some of the redundancies and form processing when a CVO is utilized (Mejia, 2009).

**Federal and State Regulations**

There were regulations established at both a state and federal level to mandate certain processes when dealing with insurance carriers, employer offerings of healthcare, and how data is distributed. “The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.” (Department of Labor, 2012). Features of this Act identify the fiduciary responsibility of those who are overseeing the funds, as well as regulations regarding the need for plans to provide plan benefit information to the
subscribers. It mandates an appeal process be identified for any grievances “and gives participants the right to sue for benefits and breaches of fiduciary duty. There were a number of amendments to ERISA, expanding the protections available to health benefit plan participants and beneficiaries. One important amendment, the Consolidated Omnibus Budget Reconciliation Act (COBRA), provides some workers and their families with the right to continue their health coverage for a limited time after certain events, such as the loss of a job. Another amendment to ERISA is the Health Insurance Portability and Accountability Act (HIPAA) which provides important new protections for working Americans and their families who have preexisting medical conditions or might otherwise suffer discrimination in health coverage based on factors that relate to an individual's health. Other important amendments include the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, and the Women's Health and Cancer Rights Act.” (Department of Labor, 2012)

According to the American Medical Association, “The National Practitioner Data Bank (NPDB) is an electronic repository of all payments made on behalf of physicians in connection with medical liability settlements or judgments as well as adverse peer review actions against licenses, clinical privileges, and professional society memberships of physicians and other health care practitioners. The NPDB was established by Congress as part of the Health Care Quality Improvement Act of 1986. By federal law, information on all medical liability payments and on certain adverse actions must be reported to the NPDB. In turn, the NPDB is required to make this information available to hospitals, state licensure boards, some professional societies, and other health care entities under certain circumstances. The information is considered confidential and is released only to the eligible entities or to physicians and other health care practitioners who wish to conduct a self-query.” (AMA, 2012)
Several States attempted to regulate the credentialing process. Through the works of the Washington Credentialing Standardization Group, Washington State has a standardized credentialing application that is utilized by most of the carriers in the state. However, this is a voluntary program (Mejia, 2009). Colorado and Ohio took standardization one step further by enacting laws to mandate compliance. In 2008, The Ohio Healthcare Simplification Act (HB125) was signed by Governor Ted Strickland. The basis of the act was to protect physicians and medical practices from “unfair practices and minimize administrative complexity by addressing transparency in contracting, contract fairness, and standardization of physician credentialing” (Johnson, 2008). The four points that were key to the provision included;

- Assurance that fee schedules would be provided so contracting physicians would know how they would be reimbursed for services.
- “Ban on selling or renting of a physician’s contract to another company unless the rental is disclosed to the provider” and all original contract terms are honored (Johnson, 2008). This is also referred to as “ghost contracting” within the industry
- All insurers must use the same standard credentialing form and process must be completed in 90 days
- “A prohibition against insurers using predatory clauses, such as “most-favored nation” clauses, in physician contracts that force doctors to provide services at lower rate than originally called for.” (Johnson, 2008)

In 2010, the State of New Jersey was also attempting to pass Bill A589, which would create similar standards regarding contracting, simplification of the credentialing process, fee schedule disclosures, and standardization of the appearance of patient ID cards (MGMA, 2012).

On January 2, 2010, President Obama signed the Patient Protection and Affordable Care
Act (PPACA). This Act mandates improvements in healthcare coverage, seeks to improve quality of care, and expands and preserves coverage for all individuals. In the 960 page document explaining all the varied components of the plan, administrative simplification is addressed but the term credentialing is only used once in the entire document (HR 3590).

**Legal Implications of Credentialing Process**

Respondeat superior is Latin for “let the superior answer”. According to Showalter (2011) it is a “doctrine in the law of agency that provides a principal- the employer (superior) - is responsible for the actions of his/her/its agent (employee) done in the course of employment.

This is similar to vicarious liability, which is defined as “attachment of responsibility to a person whose agent caused the plaintiff’s injuries” (Showalter, 2011).

Most provider insurance contracts have several similar clauses. There is a clause that states that the provider is not an employee of the insurance organization. There is a clause that states either party may terminate the contract after a period of time with a certain notification time frame, typically 90 days, without any cause. There is another clause that either party may terminate immediately upon identification of cause. These three clauses are the basis of several lawsuits levied by provider against carrier, and patient against provider and carrier.

“Under the theory of negligent credentialing, MCOs are responsible and can be held liable for exposing an injured subscriber to an unqualified provider by failing to conduct a proper credentialing review” (Sobelman, 2001). There are risks associated with malpractice claims where a patient is injured and they place blame not only on the physician but on their MCO that offered this physician as an in network provider. “Effective credentialing and fair hearing processes all provide several advantages…include: risk management, accreditation, immunity from provider’s lawsuits under Health Care Quality Improvement Act, positive marketing to
those seeking to purchase health care policies, consumers and potential member providers”
(Sobelman, 2001)

Lawsuits

There are many legal proceedings that challenge the credentialing process and responsibilities healthcare organizations initiated by both subscribers and providers.

In the case of Dykema v. King, the U.S. District Court for the District of South Carolina “remanded to state court a suit alleging that negligent credentialing by the administrator of an employee welfare benefit plan and malpractice by doctors associated with the plan led to the death of a participant from failure to diagnose his pulmonary embolism. The court rules that the Employee Retirement Income Security Act (ERISA) not preempt state law claims involved in the suit” (Health Law Week, 1997). The defendants contended that Companion Healthcare created a network of providers. Mr. Dykema was a subscriber to the plan and followed the plan guidelines when seeking care over the course of several days, both through their PCP and hospital network emergency room. Neither of these locations diagnosed his pulmonary embolism and he died due to the delay in diagnosis. Dykema’s estate sued Companion, the physicians, and the hospital for wrongful death medical malpractice. “The lawsuit alleged Companion negligently selected and credentialled” these entities. The suit also alleged that “Companion could be held vicariously liable for the alleged negligent acts of the hospital and the providers”. Companion attempted to remove the case to Federal Court claiming ERISA “displaced the estate’s wrongful death medical malpractice claim.” The District Court denied this claim as ERISA speaks to benefits and plan rights, the claim was focused on quality issues not the administrative issues afforded by ERISA. The claim fell outside the scope of ERISA and therefore was remanded back to State court (Health Law Week, 1997).
The credentialing and grievance process was placed under scrutiny in the case of Harper v. Healthsource N.H. Inc. Dr. Paul Harper was a board certified surgeon contracted with Healthsource as a surgeon and a primary care provider since 1985. In 1989, Healthsource re-enrolled Harper but only listed him as a primary care provider. He was not listed as a surgeon. This error on the part of Healthsource caused Harper to appear to be failing to maintain certain Healthsource quality standards. Dr. Harper realized in 1994 that “Healthsource was manipulating and records of treatment he had provided to several of his patients and that such inaccuracies adversely affected subsequent reports. After Harper notified Healthsource of is concerns about the accuracy of his patients’ records, Healthsource informed him that its credentialing committee was recommending that his contract be terminated because he had not satisfied its recredentialing criteria.” (Health Law Week, 1996) Harper appealed through the clinical quality assurance committee of Healthsource. The committee “affirmed the decision to terminate Harper for cause but also decided to terminate him without cause.” Harper appealed through the executive management team at Healthsource’s, which upheld the termination without cause but decided not to terminate with cause. Harper then looked for legal assistance stating the decision to terminate was in “bad faith and violated public policy”. New Hampshire has a statute, N.H. Rev. Stat. Ann. 420-C:1 (1991) that holds a preferred provider agreement must be fair and in the public interest. “Under this standard a terminated physician is entitled to review of a termination decision, whether the termination is for cause or without cause. However, if a physician’s relationship is terminated without cause and the physician believes that the decision is made in bad faith to based on some factor that would render the decision contrary to public policy, then the physician is entitled to a review of the decision.” The case was remanded for further judicial review (Health Law Week, 1996).
Discussion Regarding the Standardization of Process

In 2005, the Healthcare Administrative Simplification Coalition (HASC) was formed under the collaborative efforts of the Medical Group Management Association (MGMA), the American Academy of Family Physicians (AAFP), and the American Health and Information Management Association (AHIMA). The goal of the coalition was to bring together key industry stakeholders to “move forward to leverage health information technology, and the use of industry standards to streamline critical areas of healthcare administration”. (HASC report, 2009) In 2008, Dr. William Jesse, CEO and President of MGMA, reported that MGMA data indicated that “an average 10 physician practice spends $247,500 a year on complex, wasteful, duplicative administrative tasks that add no value to a practice or its patients. The same study also found that such practices spend, on average, $4262 on physician credentialing process and $33,800 per year on negotiating insurance contracts. MGMA members spend an average of five and a half hours negotiating each insurance contract; medical groups often have agreements with more than 20 health plans.” (Johnson, 2008).

The HASC (2009) reported their recommendations for four areas that would benefit from simplification: Practitioner Credentialing Process, Healthcare Insurance Eligibility Process, Prior Authorization Process, and Standardized, machine-readable Health Identification Cards. The challenges associated with credentialing were targeted as the need for practitioners to complete separate credentialing processes for several different carriers each year. They acknowledged the verification process of practitioner’s qualifications and history was “critical, but costly and time consuming”. (HASC report, 2009) The designated opportunity for improvement was
encouragement of universal use of UDB and the development of an electronic data interchange between Medicare’s PECOS database and UPD. Additionally, all Medicaid agencies would be allowed access to exchange information.

If these recommendations were adopted voluntarily there would be a four-fold benefit extending from providers, to carriers, to subscribers, to employers. Providers would benefit through the “simplification of the credentialing process; fewer errors; lower practice costs; shorter wait times for practitioners to begin to treat patients; increased patient satisfaction (as a result of ability to obtain an appointment more quickly with new practitioner); simplification of recredentialing process because only information that has changed since initial credentialing would need to be completed.” (HASC report, 2009)

Health plans and administrators would benefit because of reduction in time and costs “associated with developing an individualized credentialing application; reduced the number of errors and costs associated with errors made by practitioners and their staff then completing the applications; lowered costs associated with the collection of data because costs are amortized over a large number of organizations, including hospitals, health’s insurance plans, and others; increased number of providers participating in networks (reduction in paperwork makes participation in multiple health plans easier and more appealing); increased likelihood that practitioners will update their credentialing information within required timeframes, while decreasing costs associated with recredentialing.” (HASC report, 2009)

According to the HASC report, subscribers would “benefit from reallocation of funds and time to patient care; access to new practitioners more quickly; increased access to practitioners disinclined to participate in certain health plans because of the burden associated with credentialing; consistent and timely data that can be used to update and maintain payer
provider directories.” And finally, employers would benefit from “decreased administrative costs associated with health care, which would translate into decreased administrative costs; decreased employee complaints regarding data accuracy of payers’ provider networks.” (HASC report, 2009)

**Conclusion**

There are many factors that affect the need for credentialing. The carriers hold a responsibility to plan subscribers to ensure the practitioners who are allowed to participate with the plan network uphold the standards, which the carrier identified as values for their organization. As identified in the 2009 study regarding the requirement for Board certification, each organization is within their rights to establish their own criteria for participation. The legal case of Dykema v King enforced the concept of vicarious liability and the need for carriers to ensure the quality of the providers and network that they have established. Would it be appropriate to mandate participation in a process that may not hold the same values as the insurance carrier?

The redundancies within the credentialing process are felt more strongly by the practitioners. Multiple forms or access points through internet sites have both streamlined and confused the process. The costs associated with the process are escalating as reimbursement from carriers is decreasing. There are credentialing companies or software packages that specialize in completing these processes, but they also come at a cost.

National regulations have improved some aspects of the credentialing process. ERISA established a mandated grievance and appeal process as it relates to benefits. HCQI formulated the National Practitioner Data Bank, which have greatly improved the identification of problems with credentialing for both the practitioner and the insurance carriers.
Regulations at the state level have been more successful in promoting a unified credentialing system. Washington State has been marginally successful in identifying a voluntary standard format for the credentialing process. But since this is not a law, it is not universally used by all carriers in the state. Ohio, New Jersey, and Colorado all had recent successes in mandating simplification steps associated with the credentialing process. The Ohio regulation is the most encompassing by regulating the standardization of forms, 90 day deadlines, elimination of ghost contracting, mandating fee schedule provisions, and prohibition of predatory clauses. But even with state laws becoming more encompassing, you begin to have issues with carriers who work across state lines. Each carrier would be required to accept several credentialing documentation in different formats from different states. This could cause a barrier to identifying all the correct quality features if the states decide that they value points differently than the carrier. Also, with the adoption of telemedicine, there will be practitioners who will be affected by state licensing and insurance credentialing across state lines. This will eventually add another dimension to the credentialing process as telemedicine utilization becomes mainstreamed (MedCity News.com, 2012).

The Healthcare Administrative Simplification Coalition brought together three very powerful organizations in the healthcare industry. The coalition’s goal is to simplify the credentialing process and to improve the quality of these administrative processes for all the stakeholders. The final report offers additional voluntary suggestions regarding not only the simplification of the credentialing process, but regarding the administrative processes associated with healthcare in general. These include the creation of an electronic data interchange with PECOS through CMS.
Should the insurance credentialing process be standardized by the healthcare industry and government mandates?

The industry self regulated with accreditation processes, voluntary participation in process improvement, form development, and some standardization in processes. Regulatory mandates included ERISA, utilization of the NPDB, HCQI, COBRA, and HIPAA. The PPACA has addressed many other concerns regarding healthcare but is not focused on the credentialing aspect of the business. The evidence shows that the industry should continue to evaluate and adapt certain standards. The establishment of these standards should not place a carrier in jeopardy of vicarious liability through negligent credentialing. State regulations will improve the process within that area, but it may compound the process as each state develops their unique processes. It will take an Act of Congress to allow for an electronic data interchange between PECOS and UPD or any other electronic repository. Therefore, regulations from the Federal government will be necessary to establish the appropriate guidelines to put into motion, on a national level, all the conclusions that were suggested by HASC.
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