Credentialing Resource Center Journal

Comparing competencies in credentialing and in provider enrollment

At its most basic, credentialing is the verification of healthcare practitioners' education, training, and current competency. Depending on the specific items that need to be verified, this process can be lengthy.

Provider enrollment, however, casts an even wider net. When practitioners and provider organizations seek to join health plans to treat insured patients and receive in-network reimbursement (which is higher than the alternative), they must go through a credentialing process for each health plan with which they wish to partner.

The average provider is enrolled into 18–30 different plans, each of which requires compliance with federal regulations and accreditation standards, as well as with a litany of other requirements determined by the plan, state, and/or membership population. Although credentialing requirements levied by the National Committee for Quality Assurance—the primary accreditor in the space—are less stringent than their hospital-focused counterparts, individual health plans might impose additional requirements, such as querying the Social Security Death Master File, or more rigorous varieties, such as receiving office visits. All told, enrollment with a government or commercial health plan can take as long as seven months: 7–30 days to obtain all of the practitioner's credentialing data and another 30–180 days for the health plan to complete the credentialing and approval process. Application denials can add even more time.

Source: News & Analysis