What is Credentialing?

Credentialing is done before a health care professional joins a MHP network. It is a separate process from network contracting.

Credentialing involves collecting and verifying information about a provider's professional qualifications. This includes, but is not limited to:

Training and Education

- Practitioner degree (MD, DO, DPM), post-graduate education or training
- Details of medical or professional education and training
- Completion of residency program in the designated specialty

Licensing and Certification

- Current license or certification in the state(s) in which the care provider will be practicing (no temporary licenses)
- National Provider Identification (NPI) number
- Active Drug Enforcement Agency (DEA) number and/or Controlled Dangerous Substance (CDS) Certificate or acceptable substitute (if required)
- Medicare/Medicaid participation eligibility or certification (if applicable)

Work History Details

- Five-year work history
    - If there are any gaps longer than six months, please explain.
- Statement of work limitations, license history and sanctions.
  The statement must include:
    - Any limitations in ability to perform the functions of the position, with or without accommodation;
    - History of loss of license and/or felony convictions; and
    - History of loss or limitation of privileges or disciplinary activity.
- W-9 form
- Hospital staff privileges

Insurance

- Active errors and omissions (malpractice) insurance or a state-approved alternative
- Malpractice history

Other

- Other Credentialing requirements such as AMA profile or criminal history review as required by Credentialing Authorities

- Notification if this provider has ever been a delegated provider prior to this credentialing application
- Plan/Insurer may require the use of a current CAHQ profile in conjunction with its credentialing and/or re-credentialing process

Credentialing Timeline

NCQA guidelines allow for 180 days to credential providers, our Medicaid Health Plans agree to 60 days to complete the credentialing process once all required credentialing documentation has been received. The 60 day time frame may be exceeded in such cases where credentialing has identified issues that may have a bearing on the standard of care the applicant may provide to members. These applicants will require further review by the Credentialing Committee, which is a peer review committee that has the authority to approve or disapprove providers for participation.

Contracting Timeline
Medicaid Health Plans agree to 90 days to complete the contracting process once all required documentation has been received.

What is the difference between "being credentialed with" or "being contracted with" health plan/insurer?

- Contracting
  – Contract between insurer and care provider for services rendered; the application includes providing basic information of license, education, national provider identifier (NPI) number, including state regulatory requirements, to become an approved provider of a specific health plan/insurer.

- Credentialing
  – Includes contracting application agreement in addition to liability protection for the health plans constituents; includes providing full background of professional work and liability history, education, state regulatory requirements, citizenship, etc. The health plan/insurer is verifying to their members that the contracted professional has met the requirements of licensure, expertise, professional history, and liability.
  - Credentialing is an extra step required in the contracting process, providing liability protection for both the insurer and the insured. - From the business/financial view point of the provider, being contracted with a health plan/insurer is just as beneficial as being credentialed with the health plan/insurer.