Credentialing from the Inside Out

Provider · Payor · Credentialing · Automation

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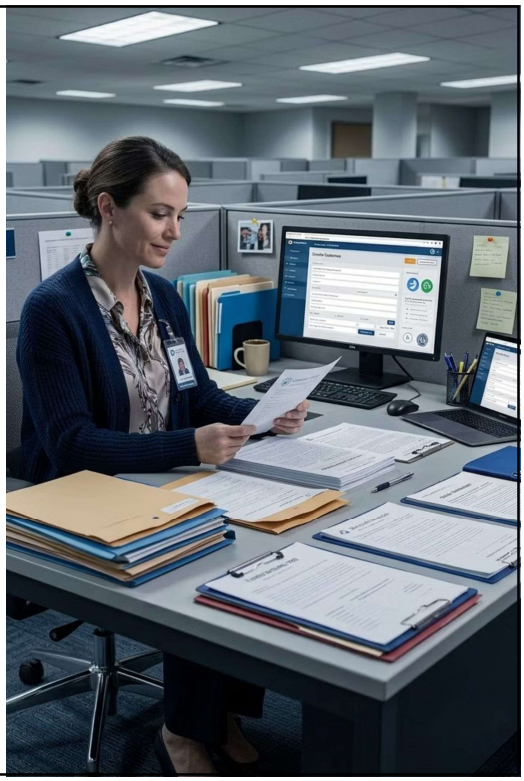

1

Why We're Telling This Story

1. We were a New Provider
2. Massive hiring Spree
3. Recruiting + Credentialing + Contracting at the same time
4. Learned the hard way: missed deadlines, delayed revenue, and avoidable rework
5. Missed Revenue Opportunities

That rough start is exactly what makes this perspective valuable — we've lived it

What You'll Walk Away With

- Appreciation for the role of credentialing
- Provider and Payor Perspectives
- Practical strategies that worked for us
- Real automation examples built without a large IT team or enterprise budget

2

The Timeline Nobody Talks About

The full credentialing cycle runs **60 to 180 days** — and your organization collects **$0 in-network revenue** for every day a provider sits in pending status. This is why timelines aren't an administrative nuisance. They're a revenue management problem.

1 **Document Prep**

2–6 weeks

Portal Access, Gathering licensure, DEA, malpractice, training records, references — before a single application is submitted.

2 **Payer Review**

60–120 days

The black hole. Applications sit in queues with little visibility. Follow-up cadence is the only lever you control.

3 **Final Enrollment**

2–4 weeks

Credentialing approval → contracting → system loading → first clean claim. Each step has its own delay risk.

180

Maximum Days

Worst-case full cycle when applications stall at payer review with no follow-up system.

60

Best-Case Days

Achievable with complete intake, proactive follow-up, and clean CAQH attestation.

3

The Cost

These aren't projections. This is what credentialing delays are costing healthcare organizations right now.

⚠ 43% of healthcare organizations lose $50,000+ per month in unbilled claims due to credentialing issues. That's not an administrative problem — that's a revenue strategy problem.

$7,500

Lost per physician per day

During credentialing delays

$122K

Total revenue loss per provider

Over a full delayed credentialing cycle

$1M+

Lost annually per 1 in 5 hospitals

Due to credentialing delays

90–120

Average credentialing timeline

Under traditional manual workflows (days)

Sources: MedWave 2025, Sutherland 2026, Medallion 2026 State of Credentialing Report, Intelliworx 2026

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It All Starts With the Contract

Before a provider sees a patient or a claim gets paid, three things must happen — in order.

Step 1 — Contract

The agreement between the healthcare organization and the payer. Sets the rates, terms, and network participation rules. This contract stays in place and renews — it is the foundation everything else is built on.

Step 2 — HR Function: To Be Able to Pay the Provider

W-9, payroll setup, employment agreements.

HR must close this before credentialing opens.

Step 3 — Provider to Perform Services

Hospitals verify provider qualifications to grant clinical privileges. Governed by Credentialing Agency, CMS, and medical staff bylaws.

Step 4 — Company to Get Paid

Insurers verify providers before approving in-network participation. No approval = no in-network billing.

5

The Credentialing Lifecycle

01

Recruit

Background checks & offer letter

02

HR Onboarding

W-9, payroll, agreements

03

Collect Documents

Licenses, DEA, malpractice, certs

04

CAQH

Load profile and attest

05

Send to Payer

CAQH link, licensure, DEA, payer forms

06

PSV

Verify against original issuing bodies

07

Follow-Up

Call, check portals, escalate

08

Submit to Payer

Full package with PSV and attestation

09

Exclusions

OIG and SAM screening

10

Enrollment Confirmation

Confirm in-network, load into billing

11

Monitor & Maintain

Track every expirable

6

Credentialing → Contracting: What I Learned Starting Out

The contract determines every dollar you collect from that payer for the next 2–5 years. Here's what I wish someone had told me before I signed the first one.

Starting Out

When you're new, Size Matters

Redlining has gotten harder. The back-and-forth that used to move rates is slower and more bureaucratic than it was even a few years ago.

The real unlock was getting a person on the phone — not a portal, not a generic provider relations line. A specific contact who could actually move something. That came from relationships.

We didn't get top-tier rates. But we held the floor: no contract came in below CMS rates. For a new operation, that's the win.

Five Clauses to Read Before You Sign

1. **Asymmetry in Assignment Rights** — Payor and provider should be on equal terms. Watch for one-sided assignment language.
2. **Termination Without Cause** — 90 days is standard. 30 days is a red flag.
3. **Timely Payment** — 30 days for clean electronic claims. Verify the penalty structure.
4. **Clean Claims Definition** — Payer-specific. Their definition of "clean" directly affects your denial rate.
5. **Retroactive Audits** — Look-back period and recoupment limits. Unlimited lookback = unlimited risk.
6. **Carve-Outs** — Services excluded from the contract rate. Know exactly what's carved out.

The Relationship Layer

Relationships matter. Payer reps, provider relations contacts, and MSO liaisons can move your application faster than any portal.

Straight talk works. Be direct about your timeline, your provider's start date, and what you need to get to yes. Payer reps respond to specificity.

[Placeholder — expand with personal story or example]

7

Our Experience: Real Pain Points from the Trenches

Before we talk solutions, let's be honest about the problems. Ask yourself which one hits hardest at your organization.

Manual Re-Entry Everywhere

The same provider data entered into CAQH, then each payer portal, then your internal system. Every re-entry is a new error opportunity — and someone's afternoon.

The Follow-Up Black Hole

Applications submitted and then… silence. No status visibility, no payer callback, no escalation path. Staff follows up manually — when they remember.

Expirable Blindness

Licenses, DEA registrations, malpractice coverage, and board certifications expire on unpredictable schedules. A single missed expiration can suspend billing overnight.

Revenue Leakage You Can't See

Claims denied, written off, or delayed because a provider wasn't fully enrolled. The damage is often discovered weeks or months after the fact — if at all.

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Payer Rules: A Moving Target by Design

Payer credentialing requirements change constantly — forms, timelines, documentation standards, portal logins, re-attestation windows. Keeping up is a full-time job on top of the full-time job. And here's the honest truth: we get it. Payers aren't being difficult for sport. They have a legitimate obligation to ensure every provider in their network is thoroughly vetted, actively licensed, and safe to practice. The rigor exists for a reason.

Why It's Exhausting

- Requirements vary by payer, plan type, and state — sometimes by product line within the same payer
- Portals change without notice: new logins, new forms, deprecated fields, broken uploads
- Re-credentialing windows shift — 2 years, 3 years, rolling attestation — and payers don't always notify you
- CAQH attestation requirements updated mid-cycle, invalidating in-progress applications
- Delegated vs. non-delegated credentialing rules differ and aren't always clearly communicated

Why It Makes Sense

- Payers are gatekeeping a network patients depend on — the bar should be high
- Sanctions, license lapses, and malpractice history must be caught before a provider sees a single patient
- Frequent rule updates reflect real-world changes: new fraud schemes, new license types, new state laws
- A well-credentialed network protects patients, providers, and the payer alike
- We'd rather do this right than fast

The frustration isn't with the standard — it's with the lack of consistency and communication around how that standard changes. That's the gap automation and good workflow design can close.

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The Disappearing Phone Call: When Relationships Go Digital

Direct communication with payer reps, once a cornerstone of efficient credentialing, is rapidly being replaced by digital gatekeepers. This shift isn't just an inconvenience — it's a significant barrier creating delays and revenue risk.

The Human Touch (Then)

- Personal relationships with dedicated payer reps often meant faster resolutions and informal escalation paths.
- Goodwill and familiarity with your organization could move applications forward.
- Nuanced problems were resolved quickly with a single 10-minute phone call.

Navigating the Digital Wall (Now)

- Automated portals, chatbots, and ticketing systems are now the primary contact methods.
- Credentialing issues can get stuck in queues for days or weeks without human intervention.
- Meticulous documentation of every interaction is crucial for tracking and disputes.
- New strategies are needed: identify and cultivate the few remaining human contacts, understand formal escalation processes, and know when to relentlessly push for live support.

⚠ The challenge isn't automation itself, but the loss of nuanced problem-solving. An issue that used to take 10 minutes now takes weeks, directly impacting your bottom line.

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Our Credentialing North Star: Where We're Headed

Our journey towards credentialing excellence involves building a robust, adaptable system that minimizes administrative burden and maximizes revenue capture.

Rigorous Auditing

Continuous internal and external checks ensure compliance and data integrity, reducing risk.

Streamlined Workflows

Optimized and automated processes reduce manual effort and accelerate credentialing timelines.

Proactive Change Management

Agile systems in place to quickly implement payer rule changes and regulatory updates.

Strategic Delegation

Achieving delegated status with eligible payers to minimize direct credentialing burden.

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TO GET THERE·YOUR CREDENTIALING QUEUE IS A FINANCIAL INSTRUMENT

> "Every week a credentialing application sits in a queue is a week the payer retains revenue it is contractually obligated to release. Whether that outcome is intentional or incidental, the incentive structure rewards delay."
>
> — Kevin W. Barron, FHFMA, FACHE

Source: Kevin W. Barron, FHFMA, FACHE — "Drew's Credentialing Queue Is a Financial Instrument. His Payer Knows That. Does He?" LinkedIn, July 23, 2026. linkedin.com/posts/kevinbarron_managedcare-healthcarefinance-payerrelations-activity-7486042654577729536-bR7D

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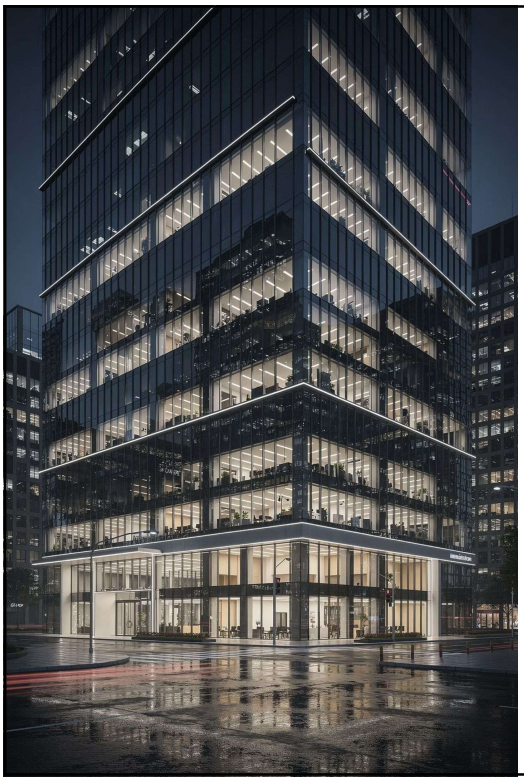

SECTION 02 OF 03

Payor-Side Credentialing

We've been looking at credentialing from your side of the desk. Now let's flip the perspective — and understand what actually happens inside the insurance company when your application arrives.

Understanding the payer's internal process is the fastest way to reduce application errors, accelerate timelines, and stop wondering why applications disappear.

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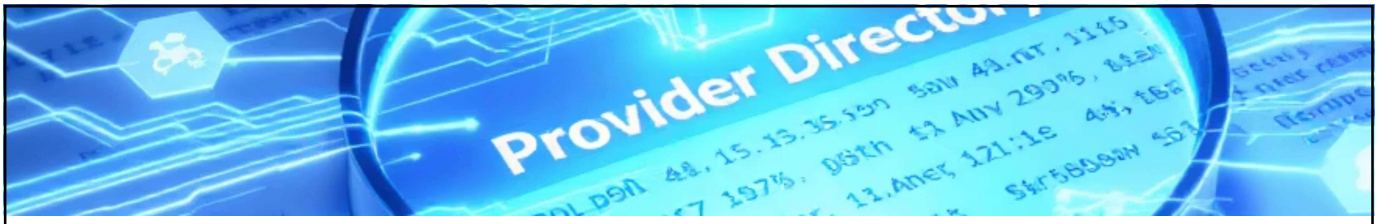

CMS Final Rule: Provider Directory Accuracy (CMS-4208-F2)

> "MA plans must directly disclose their provider directories on Medicare Plan Finder for 2027 open enrollment, and annually attest to the accuracy of provider directory data submitted to CMS — cracking down on 'ghost networks' and improving beneficiary access to accurate in-network provider information."
>
> — CMS Final Rule CMS-4208-F2, *Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program... Finalization of Format Provider Directories for Medicare Plan Finder*
> Federal Register Vol. 90, No. 180 · Published September 19, 2025 (90 FR 45140)

This rule was published **September 19, 2025**, with an effective date of **November 17, 2025** and applicability beginning **January 1, 2026**. It requires Medicare Advantage plans to surface accurate, up-to-date provider directories directly on Medicare Plan Finder ahead of the 2027 open enrollment period.

The mandate aims to give beneficiaries reliable access to current in-network provider information, support informed plan selection, and eliminate ghost networks that expose patients to unexpected out-of-network costs.

Source: Federal Register Vol. 90, No. 180 (Sept. 19, 2025) | CMS-4208-F2 | 90 FR 45140

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What Payers Actually Do With Your Application

There is a critical distinction that most billing staff — and many credentialing specialists — conflate: **credentialing approval and enrollment are two separate processes.** A provider can be credentialed and still not enrolled. Both must complete before a clean claim can be submitted and paid.

Credentialing vs. Enrollment

Credentialing	Enrollment
Payer verifies qualifications, licensure, malpractice, and sanctions. Committee review and approval. This is a clinical vetting process.	Provider loaded into payer claims system with correct NPI, taxonomy, location, and effective date. This is an administrative processing step.

Both must complete before a clean claim can be submitted and paid.

Direct vs. Delegated

Direct credentialing means the payer runs their own verification process — your application goes directly to their credentialing committee.

Delegated credentialing means the payer authorizes a third party (large health system or MSO) to credential on their behalf. The delegate must meet NCQA standards and report back.

Delegated arrangements can cut timelines dramatically — but only if the delegate's process is as rigorous as the payer's.

Pre-Delegation Audit
Before delegation is authorized, payer evaluates the delegate's policies, procedures, file documentation, and committee structure. A sample of files is reviewed. If the delegate fails, delegation is denied. NCQA requires ongoing annual audits after delegation is granted.

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What Every Credentialing File Needs

This is the pre-flight checklist. **Do not submit a payer application until every cell in this table is complete and verified.** Incomplete submissions don't pause the clock — they restart it.

Identity & Licensure	Qualifications	Compliance & Risk
Government-issued photo ID	Medical school diploma	OIG LEIE exclusion check
NPI (Type 1 & 2 confirmed)	Residency/fellowship certificates	SAM.gov exclusion check
State medical license (all active states)	Board certification (ABMS verified)	Malpractice claims history (10 yr)
DEA registration (if applicable)	Work history (10 yr, no gaps)	Malpractice certificate of insurance
CAQH ProView ID + current attestation	Professional references (3 minimum)	Medicare/Medicaid sanction history
PECOS enrollment status confirmed	Hospital affiliations & privileges	State license verification (primary source)

⚠ Malpractice gaps are the #1 application rejection cause at major payers. Verify coverage dates before submission — not after the denial.

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What Payers Need From You — And Why It Matters

The payer's credentialing team is not your adversary. They're processing hundreds of applications. Providers who make their job easier get through faster — every time.

Complete & Accurate Applications

Missing fields, outdated licenses, or unsigned forms don't pause the clock — they restart it. A complete application on first submission is the single biggest thing a provider can do to accelerate credentialing.

CAQH Attestation — Keep It Current

Payers pull directly from CAQH. If your attestation is expired or your information is stale, the payer cannot process your application. Re-attest every 120 days — don't wait for a rejection.

Respond to Requests Quickly

When a payer sends a deficiency notice or requests additional documentation, every day of delay is a day of lost revenue. Designate someone to own payer communications and respond within 48 hours.

Notify Payers of Changes

Address changes, new practice locations, malpractice carrier changes, license updates — payers must be notified. Failure to update can result in claim denials or termination from the network.

Engage in Re-Credentialing Proactively

Re-credentialing isn't something that happens to you — it's something you participate in. Providers who engage early and submit complete files re-credential faster and with fewer disruptions.

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Triennial Re-Credentialing: Don't Miss the Clock

NCQA mandates re-credentialing every 36 months — this is an accreditation standard, not a payer preference.

What's Required

Must include: updated PSV, sanctions screening, and peer review. Every active provider in your network must complete this cycle on time — no exceptions.

What Happens If You Miss It

Missed deadlines can trigger provider termination and accreditation findings. A lapsed provider cannot be billed as in-network until re-credentialing is complete — restarting the revenue clock.

Best Practice

Flag providers 90 days before their triennial deadline — not at expiration. Build automated alerts into your tracking system. Manual calendaring is how deadlines get missed.

Flag providers 90 days before their triennial deadline — not at expiration.

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Building a Workflow That Actually Works

The core principle: **collect once, deploy everywhere.** A single standardized intake form feeds every downstream system — CAQH, payer applications, your tracking dashboard, and your automation layer. No duplication, no drift.

The Six Pillars

1. **Intake Standardization** — One form, every provider, no exceptions
2. **Tracking Dashboard** — Real-time status per payer per provider
3. **Expirable Calendar** — Automated 90/60/30-day alerts
4. **Payer Follow-Up Cadence** — Defined touchpoints, not reactive calls
5. **RPA Integration** — Automate repetitive portal tasks with UIPath
6. **Modio OneView** — Centralized credentialing lifecycle management

Why Standardization Comes First

You cannot automate chaos. Before any bot touches a portal, your data needs to be clean, structured, and consistent. Automation amplifies whatever process it connects to — good or bad.

When intake is standardized, every downstream step — CAQH load, payer app, tracking update — becomes a copy-paste or bot operation, not a judgment call.

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Delegated Credentialing: On Our Radar

We haven't pursued delegation yet — we're still building the foundation. Here's why it's worth understanding now.

Pros

- Faster provider onboarding
- Full control over the process
- One workflow, multiple payors
- Reduces portal dependency

Cons

- You own all liability and errors
- Requires NCQA/URAC audit readiness
- High infrastructure and staffing cost
- Not all payors offer it

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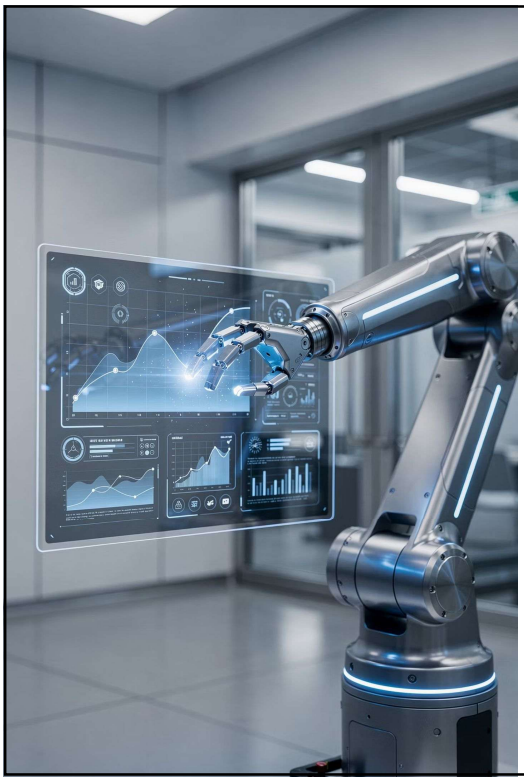

SECTION 03 OF 03

AI & Automation in Action

The next three slides cover production automations — not proofs of concept, not sandbox demos. These bots run on a schedule, handle exceptions, and produce documented output that goes to leadership.

Everything in this section was built lean — no enterprise IT team, no six-figure software budget. These are practical automations built by operations staff using tools already available to most healthcare organizations.

Built on UIPath and integrated with Modio OneView. Every automation started as a Monday morning task someone hated doing manually.

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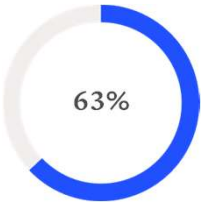
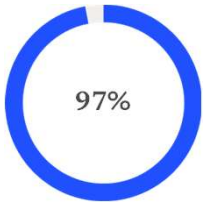
The Automation Opportunity Is Real — and Largely Untapped

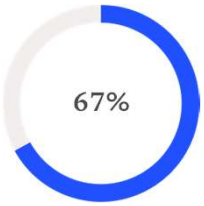
The data shows automation works. The problem is most organizations haven't moved yet.



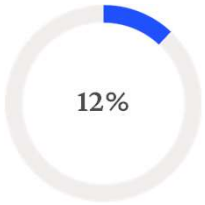
Of healthcare organizations that adopted automation reduced credentialing turnaround time (MedWave, 2025)



Of credentialing professionals report some level of burnout (QGenda, 2025)



Of credentialing teams are still mostly or entirely manual (QGenda, 2025)



Only 12% of credentialing teams have real-time visibility into their own timelines (QGenda, 2025)

77% of credentialing professionals believe enhanced technology can significantly reduce workload and burnout. The tools exist. The question is whether your organization is ready to use them.

Sources: QGenda 2025 Credentialing in Focus Report, MedWave 2025

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5 Principles for AI in Credentialing

Not all AI is created equal — especially in regulated healthcare workflows. Before we walk through our three production bots, here's the framework I use to evaluate whether any automation is actually worth building or buying. These come from real operational experience, not vendor marketing.

Purpose-Built AI

Designed for credentialing workflows specifically, not repurposed general automation. Must handle NCQA, CMS, payer-specific requirements.

Human Oversight

AI supports your team; it doesn't replace accountability. Your organization owns the outcome, not the vendor. Committee review, red flag interpretation, and final determinations stay human.

Security & Governance

Provider data is sensitive. Understand whether your data trains the model, who has access, and what the incident response looks like.

Audit-Ready Accuracy

Every output must be traceable back to source documentation. If you can't prove it in an audit, it didn't happen.

Operational Outcomes

Measure speed, burden reduction, and revenue impact. Automation claims mean nothing without measurable results.

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Automation 01: Provider Chat Bot

Every Monday morning, a staff member would spend 2.5 hours logging into UHC's provider chat portal, querying application statuses one by one, and manually updating a tracker. That routine is what triggered this build.

What the Bot Does

- Launches UIPath sequence on scheduled trigger (Monday AM)
- Authenticates into provider portal via secured credentials
- Iterates through the full application queue, querying each status
- Handles CAPTCHA challenges via exception routing (human-in-loop fallback)
- Outputs structured results to Excel — status, date, notes
- Sends automated email alert when any application status changes

2.5hr

Before Automation

Manual Monday morning routine, every week, per analyst.

12min

After Automation

Full queue processed, output delivered, alerts sent.

That's a 92% time reduction — and the output is more consistent than any human process we ran before.

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Automation 02: Provider Enrollment Portal RPA

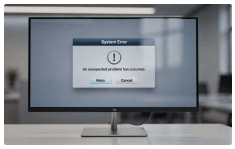
The Aetna bot handles the full application submission loop — from standardized intake form to portal entry to screenshot audit trail. The lesson learned here is the most relatable moment in this section.

Intake → Portal

Bot reads structured intake form data and maps fields to Aetna portal inputs. No re-keying, no field mismatches — assuming the UI hasn't changed since last week.

Screenshot Audit Trail

After every submission step, the bot captures a timestamped screenshot. This creates a defensible audit trail — useful when a payer claims they never received your application.



The Lesson Learned

Provider's portal UI changed without notice. Selectors broke, the bot failed silently, and we had a week of missed submissions before anyone noticed. **Build selector validation layers.** Test weekly, even when nothing should have changed.

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Automation 03: Modio OneView Compliance Reporting Pipeline

The goal was simple and painful to admit: leadership was getting a 40-row spreadsheet of credentialing data and not reading it. We needed to turn that into a one-page risk summary they'd actually act on.

The Pipeline

The Output: Risk Tier Summary

Every provider is automatically classified into one of three risk tiers based on expirable status, attestation currency, and exclusion screening results:

Critical

Expired credential or active exclusion flag. Requires immediate action before next billing cycle.

At Risk

Credential expiring within 60 days or CAQH attestation overdue. Proactive remediation window.

Compliant

All credentials current, attestation complete, no exclusion flags. No action required.

Report auto-emails to leadership the first Monday of every month. No one has to ask for it. No one has to build it.

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What I'd Tell My Past Self

I did not understand until I lived it

1

Standardize Before You Automate

A bot running on inconsistent data creates consistent errors at scale. Get your intake form locked down and your naming conventions agreed upon before UIPath touches anything.

2

CAQH Is Your Foundation — Treat It That Way

Every payer uses it. Every attestation cycle matters. An out-of-date CAQH profile is the single most common reason a credentialing application stalls at the payer review stage.

3

OIG Exclusion Is Existential, Not Administrative

Billing for an excluded provider — even unknowingly — triggers federal False Claims Act liability. Screen at hire. Screen monthly. Automate the screening. There is no acceptable miss rate here.

4

Every Payer Is a Different Relationship

What works with one payor won't work with another. Build payer-specific follow-up cadences, know your payer reps by name, and track their quirks in your system. Relationships still move applications.

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Your Next 30 Days

You don't need to overhaul everything at once. These are the highest-leverage moves — the ones that pay off fastest and build the foundation for everything else.

Days 1–7: Audit Your CAQH

Pull every provider's CAQH ProView profile. Check attestation dates, missing documents, and outdated practice locations. This single step uncovers 80% of submission delays before they happen.

Days 8–14: Map Your Payer Timelines

Build a simple tracker: payer name, submission date, expected approval window, follow-up date. If you don't have this, you're flying blind on revenue timing.

Days 15–21: Identify Your Biggest Manual Time Sink

Pick the one credentialing task your team does manually every week that takes the most time. Document the steps. That's your first automation candidate.

Days 22–30: Establish a Re-Credentialing Calendar

Pull every provider's last credentialing date. Flag anyone within 6 months of their 36-month NCQA window. Set calendar reminders now — not when the notice arrives.

Small, consistent improvements compound. You don't need a perfect system — you need a system that moves.

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Thank You — Questions & Discussion

"The best credentialing system is the one your staff will actually follow."

Tools Referenced Today

UIPath

RPA platform powering all three automation demos

Modio OneView

Credentialing lifecycle management and compliance tracking

CAQH · PECOS · OIG

Universal credentialing, Medicare enrollment, exclusion screening

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