Utilization Management-Credentialing-Provider Network (UM-CR-PN)
2023 Marked-Up Standards

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UM 1: Program Structure

The organization's UM program has clearly defined structures and processes, and assigns responsibility to appropriate individuals.

Intent

The organization has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.

Element A: Written Program Description

The organization's UM program description includes the following:

1. **A written description of the program structure.**
2. **The behavioral healthcare aspects of the program.**
3. **Involvement of a designated senior-level physician in UM program implementation.**
4. **Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program.**
5. **The program scope and process used to determine benefit coverage and medical necessity.**
6. **Information sources used to determine benefit coverage and medical necessity.**

Summary of Changes

Policy Change

- Revised the scoring requirements for the 80% and 50% scoring options.

Scoring

100%	80%	50%	20%	0%
The organization meets all 6 factors	The organization meets 4-5 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

NCQA reviews the organization's UM program description.

For factors 3 and 4:

- NCQA also reviews UM Committee minutes or other reports that document active involvement of a senior-level physician and a designated behavioral healthcare practitioner in the UM program throughout the look-back period.
- The organization may present policies and procedures separate from the UM program description for the portion of the look-back period prior to June 1, 2020, in order to allow time for organizations to incorporate these changes into their program description. As of June 1, 2020, the information in factors 3 and 4 must be in the UM program description.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

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Explanation

THIS IS A CORE ELEMENT. The organization must meet this requirement even if it does not have any clients or serve as a delegate. This element is a **structural requirement.** The organization must present its own documentation.

The UM program description is organized and written so that staff members and others can understand the program's structure, scope, processes and information sources used to make UM determinations.

Medical necessity review

Medical necessity review is a process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the member's circumstances, relative to appropriate clinical criteria and the organization's policies.

NCQA's UM standards specify the steps in the medical necessity review. Medical necessity review requires that denial decisions be made only by an appropriate clinical professional as specified in NCQA standards.

Decisions about the following require medical necessity review:

- Covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits.
- Preexisting conditions, when the member has creditable coverage and the organization has a policy to deny preexisting care or services.
- Care or services whose coverage depends on specific circumstances.
- Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits.
- Out-of-network services that are only covered in clinically appropriate situations.
- Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
- "Experimental" or "investigational" requests covered by the organization.

Decisions about the following do not require medical necessity review:

- Services in the member's benefits plan that are limited by number, duration or frequency.
- Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
- Care or services whose coverage does not depend on any circumstances.
- Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other activities of daily living.
- "Experimental" or "investigational" requests that are always excluded and never deemed medically necessary under any circumstance. In these instances, the organization either:
  - Identifies the specific service or procedure excluded from the benefits plan, ***or***
  - If benefits plan materials include broad statements about exclusions but do not specify excluded services or procedures, the materials state that members have the opportunity to request information on excluded services or procedures and that the organization maintains internal policies or criteria for these services or procedures.

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If the services above, which do not require medical necessity review, are covered benefits and are denied and subsequently appealed, they are within the scope of *UM 8: Polices for Appeals* and *UM 9: Appropriate Handling of Appeals*.

NCQA does not have any additional classifications of denials, such as administrative.

Medical necessity review of requests for out-of-network coverage

Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met in-network (e.g., a service or procedure not provided in-network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards).

If the certificate of coverage or summary of benefits specifies that the organization never covers an out-of-network service for any reason or if the request does not indicate the member has a specific clinical need for which out-of-network coverage may be warranted, the request does not require medical necessity review.

File review universe

Although medical necessity review may result in approvals or denials, NCQA reviews only denials resulting from medical necessity review, as defined above, in UM 4–UM 7, with the exception of UM 5, Element D, which applies to both approvals and denials. NCQA reviews denials, whether or not the member is at financial risk, excluding postservice payment disputes initiated by a practitioner or provider where the member is not at financial risk.

Members are considered to be at financial risk when:

- They have financial liability (i.e., co-insurance, deductibles, charges in excess of allowed amounts, differentials in cost between in-network care and out-of-network care, costs that vary for the formulary) for services beyond a flat copay that is always the same fixed dollar amount. Copays may vary across a range of services, but must not be different within the same service category (e.g., $15 for primary care office visits and $25 for specialist office visits is acceptable), ***or***
- They may be balance-billed by a practitioner, provider or other party.

Classification of overturned denials. Although federal regulations may define an overturned denial based on the discussion as an appeal, such an approval does not fall under the scope of NCQA's appeal standards; however, the case is considered a denial if a denial notice was issued.

Organization employees and their dependents: The organization may exclude employees and their dependents from the denial and appeal file universe.

Factor 1: **Program structure**

The written UM description includes all he following information about the UM program structure:

- UM staff's assigned activities.
- UM staff who have the authority to deny coverage.
- Involvement of a designated physician and a designated behavioral healthcare practitioner.
- The process for evaluating, approving and revising the UM program, and the staff responsible for each step.

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- The UM program's role in the QI program, including how the organization collects UM information and uses it for QI activities.
- The organization's process for handling appeals and making appeal determinations.

Staff size. NCQA does not prescribe staff size or a method or criteria for determining staff size.

Factor 2: **Behavioral healthcare aspects of the program**

The program description specifies how the organization addresses sites of behavioral healthcare services (e.g., psychology groups) and the levels of behavioral healthcare services (e.g., inpatient psychiatric care, outpatient psychiatrist visits.) If the organization has a process for triage and referral to behavioral health services, the program description specifies the process.

Factor 3: **Senior-level physician involvement**

The program description specifies how a senior-level physician (a medical director, associate medical director or equivalent), is involved in UM activities, including implementation, supervision, oversight and evaluation of the UM program.

For specialty organizations: If the organization only provides UM for services not provided by physicians (e.g., dental care), a senior-level practitioner who represents the organization's specialty (e.g., a DDS) may substitute.

Factor 4: **Designated behavioral healthcare practitioner involvement**

The program description specifies how a designated behavioral healthcare physician or a doctoral-level behavioral healthcare practitioner is involved in implementing and evaluating the behavioral health aspects of the UM program.

The behavioral healthcare practitioner must be a physician or have a clinical PhD or PsyD, and may be a medical director, clinical director, participating practitioner from the organization or behavioral healthcare delegate (if applicable).

Factors 5, 6: **Processes and information sources used to make determinations**

The program description specifies:

- The UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity, including:
  - How the organization develops and selects criteria.
  - How the organization reviews, updates and modifies criteria.
- How medical necessity and benefits coverage for inpatient and outpatient services are determined.
- The description of the data and information the organization uses to make determinations (e.g., patient records, conversations with appropriate physicians) and guide the UM decision-making process.
  - The description should not be burdensome for the member, the practitioner or the health delivery organization's staff.
- The triage and referral process for behavioral healthcare services (if applicable).
- How sites of service and levels of care are evaluated for behavioral healthcare services (if applicable).

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The program description lists the information (e.g., patient records, conversations with appropriate physicians) the organization uses to make UM determinations.

Factors 2, 4 and behavioral healthcare aspects of factor 5 are NA if all purchasers of the organization's services carve out or exclude behavioral healthcare.

Benefit plan exceptions. If the organization authorizes a service, grants an extension of benefits or makes an exception to a limitation in the benefits plan (e.g., the organization is required to approve 20 visits but allows 21 visits), a subsequent denial of the same service or a request for an extension or exception is not considered a medical necessity determination.

Examples

***Factor 3:* Senior-level physician involvement**

The senior-level physician's responsibilities may include, but are not limited to:

- Setting UM policies.
- Supervising program operations.
- Reviewing UM cases.
- Participating on the UM Committee.
- Evaluating the overall effectiveness of the UM program.

***Factor 4:* Behavioral healthcare practitioner involvement**

The designated behavioral healthcare practitioner's responsibilities may include, but are not limited to:

- Setting UM behavioral healthcare policies.
- Reviewing UM behavioral healthcare cases.
- Participating on the UM Committee.

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UM 5: Timeliness of UM Decisions

The organization makes UM decisions in a timely manner to accommodate the clinical urgency of the situation.

Intent

The organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care.

~~Element D: UM Timeliness Report~~

The organization monitors and submits a report for timeliness of:

1. **Nonbehavioral UM decision making.**
2. **Notification of nonbehavioral UM decisions.**
3. **Behavioral UM decision making.**
4. **Notification of behavioral UM decisions.**
5. **Pharmacy UM decision making.**
6. **Notification of pharmacy UM decisions.**

~~Summary of Changes~~

~~**Clarifications**~~

- ~~Clarified the scope of review that the organization provides aggregated timeliness reports.~~

~~Scoring~~

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets all 6 factors~~	~~The organization meets 4–5 factors~~	~~The organization meets 3 factors~~	~~The organization meets 1–2 factors~~	~~The organization meets 0 factors~~

~~Data source~~ ~~Reports~~

~~Scope of review~~ ~~NCQA reviews the organization's aggregated timeliness reports.~~

~~Look-back period~~ ~~*For Initial Surveys:* 6 months.~~

~~*For Renewal Surveys:* 12 months.~~

~~Explanation~~ ~~This element applies to all UM determinations resulting from medical necessity review, whether they are approvals or denials.~~

~~***Factors 1–6***~~

~~The organization monitors the timeliness of decision making and notification for all requests and, using at least six months of data, calculates the percentage of decisions that adhere to time frames specified in Elements A–C. The six months of data can extend beyond the look-back period; however, the report must be completed within the look-back period.~~

At a minimum, the timeliness report calculates rates of adherence to time frames for each category of request (urgent concurrent, urgent preservice, nonurgent preservice, post-service) for each factor.

Approval decisions must adhere to the timeliness requirements in UM 5 and must be included in factors 1, 3 and 5.

The organization excludes:

- Decisions and notifications for nonemergency transportation approvals and
- Approval notifications for factors 2, 4 and 6.
- Approval decisions made at the pharmacy for factor 6.

Factors 1-2, 3-4 and 5-6 may be NA if all purchasers of the organization's UM services carve out or exclude the related aspect of care.

Examples

Timeliness reports

Factor 1: Timeliness of nonbehavioral UM decision-making

-	Urgent concurrent	Urgent preservice	Nonurgent preservice	Postservice
Numerator[1]	350	560	875	689
Denominator[2]	400	575	880	689
Rate	*87.5%*	*97.4%*	*99.4%*	*100%*

Factor 2: Timeliness of notification of nonbehavioral UM decisions

-	Urgent concurrent	Urgent preservice	Nonurgent preservice	Postservice
Numerator[1]	350	560	875	689
Denominator[2]	400	575	880	689
Rate	*87.5%*	*97.4%*	*99.4%*	*100%*

[1]*Numerator: The number of cases meeting the decision time frame.*

[2]*Denominator: The total number of requests.*

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CRA 2: Agreement and Collaboration With Clients

If the organization acts as a delegate for clients, there is evidence that the organization collaborates with each client and complies with requirements of the delegation agreement.

Intent

The organization has appropriate structures and mechanisms to perform activities agreed upon in the delegation agreement, and provides each client with the documentation necessary for oversight.

Element F: Communication to Practitioners

The organization disseminates communications from clients directly to individual practitioners (e.g., clinical criteria, patient education program information and feedback on performance).

Summary of Changes

Clarifications

- Clarified that the organization receives credit on this element if no clients request that the organization distribute materials.
- Removed the exception for an organization that has not been given materials to distribute to clients' practitioners.

Scoring

100%	80%	50%	20%	0%
There is evidence that the organization disseminates appropriate client communications to practitioners	No scoring option	There is weak evidence that the organization disseminates appropriate client communications to practitioners	No scoring option	There is no evidence that the organization disseminates appropriate client communications to practitioners

Data source Reports, Materials

Scope of review NCQA reviews evidence of distribution from a sample of up to four randomly selected clients, or from all clients if the organization has fewer than four.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation The organization disseminates client communications directly to practitioners in its network, if it has one, and to the client's network, if the client requires it in the delegation agreement. ~~If during the look-back period no clients request that the organization distribute materials, the organization may present its delegation agreement that specifies it will do so when requested.~~ If no clients request that the organization distribute materials during the look-back period, the organization must present its delegation agreement specifying it will distribute client's materials when requested. In such a case, the organization receives credit on this element.

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This element is NA if:

- The organization does not have any clients.
- The organization is not seeking NCQA Accreditation in CR or Provider Network.
- ~~The organization has not been given materials to distribute to clients' practitioners.~~

Examples

- Direct mailing.
- Newsletter article.
- Committee meeting minutes.
- Records of communication with clients and practitioners.

CR 1: Credentialing Policies

The organization has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.

Intent

The organization has a rigorous process to select and evaluate practitioners.

Element A: Practitioner Credentialing Guidelines

The organization's policies and procedures specify:

1. **The types of practitioners to credential and recredential.**
2. **The verification sources it uses.**
3. **The criteria for credentialing and recredentialing.**
4. **The process for making credentialing and recredentialing decisions.**
5. **The process for managing credentialing files that meet the organization's established criteria.**
6. **The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.**
7. **The process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization.**
8. **The process for notifying that practitioners of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee's decision.**
9. **The medical director or other designated physician's direct responsibility and participation in the credentialing program.**
10. **The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.**
11. **The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty.**

Summary of Changes

Policy Change

- Revised the scoring requirement for the 80% and 50% scoring options.

Scoring

100%	80%	50%	20%	0%
The organization meets all 11 factors	The organization meets ~~8~~9-10 factors	The organization meets 5-~~8~~7 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data source Documented process

Scope of review

NCQA reviews the organization's policies and procedures in effect throughout the look-back period.

Look-back period

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

THIS IS A CORE ELEMENT. The organization must meet this requirement even if it does not have any clients or serve as a delegate. This element is a **structural requirement**. The organization must present its own documentation.

Practitioners within the scope of credentialing

Practitioners are within the scope of credentialing if all criteria listed below are met:

- Practitioners are licensed, certified or registered by the state to practice independently (without direction or supervision).
- Practitioners have an independent relationship with the organization.
- An independent relationship exists when the organization directs its members to see a specific practitioner or group of practitioners.
- Practitioners provide care to members under the organization's medical or nonmedical benefits.

The listed criteria apply to practitioners in the following settings:

- Individual or group practices.
- Facilities.
- Rental networks:
  - That are part of the organization’s primary network and the organization has members who reside in the rental network area.
  - Specifically for out-of-area care and members may see only those practitioners or are given an incentive to see rental network practitioners.
- Telemedicine.

Factor 1: **Types of practitioners**

Credentialing policies and procedures include the following types of practitioners.

- *Medical practitioners:*
  - Medical doctors.
  - Oral surgeons.
  - Chiropractors.
  - Osteopaths.
  - Podiatrists.
  - Nurse practitioners.
  - Other medical practitioners who may be within the scope of credentialing.
    - NCQA does not include these practitioners in the credentialing file review.
- *Behavioral healthcare practitioners:*
  - Psychiatrists and other physicians.
  - Addiction medicine specialists.
  - Doctoral or master's-level psychologists.
  - Master's-level clinical social workers.
  - Master's-level clinical nurse specialists or psychiatric nurse practitioners.
  - Other behavioral healthcare specialists who may be within the scope of credentialing.

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If the organization does not have the types of practitioners listed above or is a specialty organization, NCQA reviews all types of practitioners the organization credentials.

Factor 2: Verification sources

Credentialing policies and procedures describe the sources the organization uses to verify credentialing information. The organization uses any of the following sources to verify credentials:

- The primary source (or its website).
- A contracted agent of the primary source (or its website).
  - The organization obtains documentation indicating a contractual relationship between the primary source and the agent that entitles the agent to verify credentials on behalf of the primary source.
- An NCQA-accepted source listed for the credential (or its website).

Factors 3, 4: Decision-making criteria and process

The organization:

- Credentials practitioners before they provide care to members.
- Has a process for making credentialing decisions, and defines the criteria it requires to reach a credentialing decision.
  - Criteria are designed to assess a practitioner's ability to deliver care.
- Determines which practitioners may participate in its network.

Factor 5: Managing files that meet the criteria

Credentialing policies and procedures describe the process used to determine and approve files that meet criteria (i.e., clean files). The organization may present all practitioner files to the Credentialing Committee or may designate approval authority of clean files to the medical director or to an equally qualified practitioner.

Factor 6: Nondiscriminatory credentialing and recredentialing

Credentialing policies and procedures:

- State that the organization does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes.
- Specify the process for preventing discriminatory practices.
  - Preventing involves taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes.
- Specify how the organization monitors the credentialing and recredentialing processes for discriminatory practices, at least annually.
  - Monitoring involves tracking and identifying discrimination in credentialing and recredentialing processes.

Factor 7: Discrepancies in credentialing information

Credentialing policies and procedures describe the organization's process for notifying practitioners when credentialing information obtained from other sources varies substantially from that provided by the practitioner.

***Factor 8:* Notification of decisions**

Credentialing policies and procedures specify that the organization's time frame for notifying applicants of initial credentialing decisions and recredentialing denials does not exceed 60 calendar days from the Credentialing Committee's decision. The organization is not required to notify practitioners regarding recredentialing approvals.

***Factor 9:* Participation of a medical director or designated physician**

Credentialing policies and procedures describe the medical director or other designated physician's overall responsibility and participation in the credentialing process. For specialty organizations (e.g., chiropractic, physical therapy), the medical director or other designated physician may be representative of the organization's practitioners (e.g., DC, DPT).

***Factor 10:* Ensuring confidentiality**

Credentialing policies and procedures describe the organization's process for ensuring confidentiality of the information collected during the credentialing process and the procedures it uses to keep this information confidential.

***Factor 11:* Practitioner directories and member materials**

Credentialing policies and procedures describe the organization's process for ensuring that information provided in member materials and practitioner directories is consistent with the information obtained during the credentialing process.

Exceptions

This element is NA for organizations not seeking NCQA Accreditation in CR.

Factor 11 is NA:

- For organizations that serve as delegates but are not responsible for publishing member materials.
- For UM-CR-PN organizations.

Related information

Appropriate documentation. Credentialing policies and procedures define the organization's process for documenting information and activities in credentialing files. The organization documents verification in the credentialing files using any of the following methods, or a combination:

- Credentialing documents signed (or initialed) and dated by the verifier.
- A checklist that includes for each verification:
  - The source used.
  - The date of verification.
  - The signature or initials of the person who verified the information.
    - Typed initials are only acceptable if there is a unique electronic signature or identifier on the checklist.
  - The report date, if applicable.
- A checklist with a single signature and a date for all verifications that has a statement confirming the signatory verified all of the credentials on that date and that includes for each verification:
  - The source used.
  - The report date, if applicable.

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Automated credentialing system. The organization may use an electronic signature or unique electronic identifier of staff to document verification if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The organization provides its security and login policies and procedures to confirm the unique identifier and the signature can only be entered by the signatory. The system must identify the individual verifying the information, the date of verification, the source and the report date, if applicable.

- Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable.
- If the checklist does not include checklist requirements listed above, appropriate credentialing information must be included.

If the verification is from a report, NCQA uses the date generated by the source when the information is retrieved. If the source report does not generate a date, NCQA uses the date noted in the credentialing file by the organization staff who verified the credentials. The individual who verified the credentials must also sign or initial the verification.

Use of web crawlers. The organization may use web crawlers to verify credentialing information from approved sources. The organization provides documentation that the web crawler collects information only from approved sources, and documents that staff reviewed the credentialing information.

Provisional credentialing. If the organization decides to provisionally credential practitioners, it:

- Has a process for one-time provisional credentialing of practitioners applying to its network for the first time.
- Verifies the following within the required time limits:
  - A current, valid license to practice (*CR 3: Credentialing Verification,* Element A, factor 1).
  - The past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query (CR 3, Element A, factor 6).
  - A current and signed application with attestation (CR 3, Element C, factors 1-6).
- Follows the same process for presenting provisional credentialing files to the Credentialing Committee or medical director as it does for its regular credentialing process.
- Does not perform provisional credentialing for practitioners who were credentialed by a delegate on behalf of the organization.
- Does not hold practitioners in provisional status for longer than 60 calendar days.
- Does not list provisionally credentialed practitioners in the directory.
- Does not allow practitioners to deliver care prior to completion of provisional credentialing.

Practitioners who do not need to be credentialed.

- Practitioners who practice exclusively in an inpatient setting and provide care for organization members only because members are directed to the hospital or another inpatient setting.
- Practitioners who practice exclusively in free-standing facilities and provide care for organization members only because members are directed to the facility.

- Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates utilization management (UM) functions.
- Covering practitioners (e.g., locum tenens).
  - Locum tenens who do not have an independent relationship with the organization are outside NCQA's scope of credentialing.
- Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants).
- Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

Practitioner termination and reinstatement. The organization:

- Initially credentials a practitioner again if the break in network participation is more than 30 calendar days.
- Re-verifies credentials that are no longer within verification time limits.
- Re-verifies credentials that will not be in effect when the Credentialing Committee or medical director makes the credentialing decision.

Examples

***Factor 6:* Nondiscriminatory credentialing and recredentialing**

The organization monitors credentialing decisions to prevent discrimination. Monitoring includes, but is not limited to:

- Maintaining a heterogeneous credentialing committee membership and the requirement for those responsible for credentialing decisions to sign a statement affirming that they do not discriminate.
- Periodic audits of credentialing files (in-process, denied and approved files) that suggest potential discriminatory practice in selecting practitioners.
- Annual audits of practitioner complaints for evidence of alleged discrimination.

Automated credentialing systems

- Adobe Sign.
- DocuSign.