Proposed Standards Updates to 2025 Accreditation Programs:

Credentialing Accreditation

Credentialing Verification Organizations

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CR 1: Internal Quality Improvement

The organization clearly defines its quality improvement (QI) structures and processes.

Intent

The organization has the QI infrastructure needed to improve its credentialing process.

Element A: Quality Improvement Program Structure

The organization has a written QI plan or written comprehensive policies and procedures that include:

1. A defined scope of activities.

2. Defined goals and objectives.

3. A defined process for assessing performance.

	Met	Partially Met	Not Met
Scoring	2-3 factors	No scoring option	0-1 factors

	100%	80%	50%	20%	0%
Scoring	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

Data source   Documented process

Scope of review   NCQA reviews the organization's QI program description that was in place 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 may not be delegated.

Factors 1–3

The QI program description is a comprehensive document or a set of documents that includes, in plain language:

- The scope of activities covered by the QI program.
- Defined SMART goals and objectives for the program and for each quality indicator. SMART goals are specific, measurable, attainable, relevant and time-bound (have a target completion date).
- Indicators and analysis used to measure performance.
- A defined process for resolving client complaints and issues, including procedures for timely response to client concerns.

Examples   **QI indicators**

- Completion time of credentialing files.
- Accuracy of completed credentialing files.

Element B: Analysis of Quality Activities

<u>At least annually, the</u> **organization's analysis of data from its quality improvement indicators includes:**

1. **Evaluation of aggregate data and trends.**

2. **Assessment of opportunities for improvement.**

3. **Assessment of barriers to improvement.**

Scoring

Met	Partially Met	Not Met
3-4 factors	1-2 factors	0 factors

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 1-2 factors~~	~~No scoring option~~	~~The organization meets 0 factors~~

Data source   Reports

Scope of review   NCQA reviews the organization's most recent and previous evaluation reports.

Look-back period   *For Renewal Surveys:* 24 months.

Explanation   This element may not be delegated.

The organization collects and analyzes data from its QI indicators, including client (i.e., health plan, purchaser, employer or payer with which the organization contracts) complaint data, to identify opportunities for improvement in CR operations. Analysis of quality information must go beyond data display to receive credit for this element.

Factor 1: **Evaluation of aggregate data**

The organization conducts a quantitative analysis of data that incorporates aggregate results and trends over time and compares results against a standard or goal. Tests of statistical significance are not required but may be useful when analyzing trends.

Refer to Appendix 6: Glossary for the full definition of and requirements for quantitative analysis.

Factor 2: **Opportunities for improvement**

The organization assesses and chooses opportunities for improvement and describes its reasons for taking action (or not taking action).

Factor 3: **Barriers to improvement**

The organization conducts a root cause analysis or barrier analysis to identify the reasons for the results. The analysis includes organization staff who bring understanding about the processes that may present barriers to improvement.

Factor 4: **Performance**

The organization assess its performance against the goals and objectives defined in Element A.

Exception

This element is NA for Initial Surveys.

Examples   None.

Element C: Action and Follow-Up on Opportunities

For identified opportunities for improvement, the organization implements interventions and conducts follow-up evaluation on actions taken.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

Data source   Reports

Scope of review   NCQA reviews the organization's most recent and previous implementation of interventions and follow-up of its actions on identified opportunities.

Look-back period   *For Renewal Surveys:* 24 months.

Explanation   This element may not be delegated.

Interventions are of sufficient strength and specificity that there is the likelihood they contribute to a measurable improvement and are linked to identified barriers. The organization also assesses the effectiveness of interventions to determine whether the interventions improved performance.

Exceptions

This element is NA:

- For Initial Surveys.
- If the organization does not have any opportunities for improvement.
    – NCQA evaluates whether this conclusion is reasonable, given evaluation results.

Examples   None.

Element D: Confidentiality Policies and Procedures

The organization has written policies and procedures regarding confidentiality that include the following factors:

 1. Specific statements about confidentiality.

 2. Release of credentials information to third parties.

 3. Provisions for paper and electronic information.

 4. Employee orientation.

 5. Employee confidentiality agreements.

 6. Disposal of confidential credential information.

Scoring

Met	Partially Met	Not Met
5-6 factors	No scoring option	0-4 factors

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 6 factors~~	~~The organization meets 5 factors~~	~~No scoring option~~	~~The organization meets 4 factors~~	~~The organization meets 0-3 factors~~

Data source   Documented process

Scope of review   NCQA reviews the organization's confidentiality policies and procedures that are in place 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.

Factor 1: **Statements about confidentiality**

No explanation required.

Factor 2: **Release of information to third parties**

The organization requires practitioner authorization before credentials information is released, unless otherwise permitted or required by law.

Factor 3: **Protecting paper and electronic information**

The organization's policies and procedures:

- Describe how the organization maintains the security and accuracy of the paper and electronic information it gathers and provides to its clients.
- Address all aspects of the organization's operations, including, but not limited to:
  − Personnel.
  − File storage.
  − Electronic data management.

Factors 4, 5: **Employee confidentiality**

The organization's confidentiality policies and procedures:

- Describe its process for orienting new employees to its confidentiality policies and procedures.
- Require employees to sign confidentiality agreements affirming that they will protect, during and after employment with the organization, any confidential information they handle.

Factor 6: **Disposal of confidential information**

The organization's confidentiality policies describe:

- The process for maintaining confidentiality of information when it is being discarded.
- How it secures shredding bins to limit access.

Examples   None.

Element E: Personnel Management

The organization's personnel management procedures stipulate that new employees:

1. **Are given details about credential security roles during orientation.**

2. **Sign confidentiality agreements.***

*Critical factors: Score cannot exceed 0% if one critical factor is scored "no."

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets only factor 2	0-1 factors

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets only factor 2~~	~~No scoring option~~	~~The organization meets factor 1 or meets 0 factors~~

Data source   Documented process

Scope of review   NCQA reviews the organization's personnel management procedures that are in place 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.

Factor 2 is a critical factor; if it is scored "No," the organization's score cannot exceed 0% for the element.

Factor 1: **Security roles during orientation**

The organization orients new staff to their roles in securing credentialing information and explains the rationale for security and confidentiality of credentialing information, security policies, password protection and authorization levels.

Factor 2: **Confidentiality agreements**

The organization requires all staff to sign an agreement stating that they do not share credentialing information and that they follow confidentiality and security procedures.

Exception

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

Examples   None.

Element F: Data Recovery and Back-Up

The organization has security mechanisms in place for the protection and recovery of data by requiring that:

1. Controls are in place to ensure successful completion of back-ups.

2. Back-ups occur at predetermined intervals.

3. Archived data are held in a secured location.

Scoring

Met	Partially Met	Not Met
3 factors	2 factors	0-1 factors

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3 factors~~	~~No scoring option~~	~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

Data source   Documented process, Reports, Materials

Scope of review   NCQA reviews the organization's policies and procedures that are in place throughout the look-back period and the mechanisms the organization uses to protect and recover credentials data.

If the organization outsources data recovery and backup, NCQA reviews an executed contract describing the contracted entity's security mechanisms for data protection and recovery.

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.

Factor 1: **Controls to ensure successful back-ups**

The organization has mechanisms for feedback that appropriate data have been successfully backed up or archived.

Factor 2: **Back-ups at predetermined intervals**

The organization has policies and procedures for periodic back-up of data to ascertain that data are not lost if:

- Computer systems are disabled or destroyed.
- Files are corrupted.
- Files are accidentally deleted.

Back-up reports show that data are backed up at specific intervals.

Factor 3: **Archived data at a secured location**

The organization has the ability to archive data that have been selected for long-term or permanent storage. Documentation specifies the organization's process for archiving data, for securing data and for appropriate access controls.

CR 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 A: Delegation Agreement

The written delegation agreement:

1. **Is mutually agreed upon.**

2. **Describes the responsibilities of the organization and the client.**

3. **Describes the delegated activities.**

4. **Describes the frequency of reporting to the client.**

5. **Describes the process by which the client evaluates the organization's performance.**

6. **Describes the remedies available to the client if the organization does not fulfill its obligations, including revocation of the delegation agree**

Scoring	Met	Partially Met	Not Met
	4-6 factors	3 factors	0-2 factors

Scoring	~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
	~~The organization meets 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 Materials

Scope of review NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected clients, or from all clients if the organization has fewer than four.

The score for the element is the average of the scores for all clients.

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

For Renewal Surveys: 24 months.

Explanation This element applies to agreements that are in effect within the look-back period. The delegation agreement describes all delegated CR activities. A generic policy statement about the content of the delegation agreement does not meet this element.

Factor 1: **Delegation agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the client.

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (the date of the last signature) as the mutually agreed upon effective date.

NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities.

NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.

Factors 2, 3: **Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the client specifies the CR activities:

- Performed by the organization.
- Performed by the client.
  - The client delegation agreement may include a general statement addressing retained functions (e.g., the client retains all other CR functions not specified in this agreement as the organization's responsibility).

Factor 4: **Reporting**

The client determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the organization about delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the client organization).

The client must receive regular reports from all delegates, even NCQA-Accredited or NCQA-Certified delegates.

Factor 5: **Performance monitoring**

The delegation agreement states the client's process for monitoring and evaluating the delegate's performance.

Factor 6: **Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exceptions

This element is NA if:

- The organization does not perform any NCQA-required functions or activities for any clients.

Examples   None.

Element B: Submission of Documents for Oversight

There is evidence that the organization provides each client with the documents necessary to conduct oversight.

Scoring

Met	Partially Met	Not Met
The organization submitted all agreed-upon documents to each client	There was partial or untimely submission of agreed-upon documents to 1 or more clients	The organization did not submit agreed-upon documents

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization submitted all agreed-upon documents to each client~~	~~No scoring option~~	~~There was partial or untimely submission of agreed-upon documents to 1 or more clients~~	~~No scoring option~~	~~The organization did not submit agreed-upon documents~~

Data source   Reports

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

The score for the element is the average of the scores for all clients.

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

For Renewal Surveys: 24 months.

Explanation   The organization complies with the specific requirements of each of its delegation agreements, including providing clients with agreed-upon documents.

NCQA scores this element "Yes" if all clients are NCQA-Accredited. If all clients are not NCQA-Accredited, NCQA scores the randomly selected NCQA-Accredited clients "Yes."

Exceptions

This element is NA if:

- The organization does not perform any NCQA-required functions or activities for any clients.

Examples   **Documents submitted to affiliated clients**

- CR policies and procedures.

Element C: Routine Reporting

The organization provides each client with reports at agreed-upon frequency.

	Met	Partially Met	Not Met
Scoring	The organization reported to all clients according to an agreed-upon schedule	There was partial reporting or reporting was not according to an agreed-upon schedule	The organization provided no reports

	100%	80%	50%	20%	0%
Scoring	~~The organization reported to all clients according to an agreed-upon schedule~~	~~No scoring option~~	~~There was partial reporting or reporting was not according to an agreed-upon schedule~~	~~No scoring option~~	~~The organization provided no reports~~

Data source Reports

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

The score for the element is the average of the scores for all clients.

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

For Renewal Surveys: 24 months.

Explanation **Reporting prior to NCQA Accreditation**

Before an organization achieves NCQA Accreditation, reporting may include raw data, analysis of data, committee meeting minutes or reports designed exclusively for the relationship between the organization and the client. Conference call minutes may also be part of the reporting requirements.

Frequency of reporting may be monthly or quarterly, but no less than semiannually.

Reporting after NCQA Accreditation

Once an organization achieves NCQA Accreditation for a specific category of standards, expectations for routine reporting can be reduced. For example, an organization and a client might agree to limit reporting to semiannual updates on specific activities. Updates could occur at a meeting subject to limited documentation requirements.

Exceptions

This element is NA if:

- The organization does not perform any NCQA-required functions or activities for any clients.

Examples **Reporting for each category of standards**

- Regular reports on credentialed and recredentialed practitioners.

Element D: Cooperating With Client QI Efforts

The organization cooperates with the client's efforts to implement QI and other activities.

Scoring

Met	Partially Met	Not Met
There is evidence of cooperation with all client activities	There is weak evidence of cooperation with client activities	There is no evidence of cooperation with client activities

Scoring

100%	80%	50%	20%	0%
There is evidence of cooperation with all client activities	No scoring option	There is weak evidence of cooperation with client activities	No scoring option	There is no evidence of cooperation with client activities

Data source   Reports, Materials

Scope of review   NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected clients, or from all clients if the organization has fewer than four, and reviews other evidence that the organization cooperates with the client's efforts to implement QI and other activities. NCQA reviews evidence that the organization cooperated with its clients' QI activities. If no clients ask for cooperation during the look-back period, the organization may present its delegation agreement that specifies it will cooperate with clients' efforts.

The score for the element is the average of the scores for all clients.

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

For Renewal Surveys: 24 months.

Explanation   The organization participates in affiliated clients' QI activities and other appropriate activities related to credentialing.

Exceptions

This element is NA if:

- The organization does not perform any NCQA-required functions or activities for any clients.

Examples   **Evidence of cooperation with client initiatives in accordance with the delegation agreement**

- Committee meeting minutes.
- Records of communication with clients.

Types of CR quality improvement activities

- Supporting telehealth or other specialty network expansion initiatives.
- Supporting provider directory accuracy initiatives.

Element E: Medical Record Access

The organization gives the client access to its medical records.

Scoring	100%	80%	50%	20%	0%
	There is evidence that the organization allows access to medical records	No scoring option	There is weak evidence that the organization allows access to medical records	No scoring option	There is no evidence that the organization allows access to medical records

Data source   Materials

Scope of review   NCQA reviews executed contracts or delegation agreements in effect during the look-back period for language allowing access to medical records, from up to four randomly selected clients, or from all clients if the organization has fewer than four.

The score for the element is the average of the scores for all clients.

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

For Renewal Surveys: 24 months.

Explanation   The organization allows client representatives to review the medical records of its members, consistent with applicable state laws.

Exceptions

This element is NA if:

- The organization does not perform any NCQA-required functions or activities for any clients.
- The organization is not seeking NCQA Accreditation in CR or Provider Network.
- The organization does not have access to medical records.

Examples   None.

~~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).**~~

	~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~**Scoring**~~	~~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.~~

~~**Exceptions**~~

~~This element is NA if:~~

- ~~The organization does not perform any NCQA-required functions or activities for any clients.~~
- ~~The organization has not been given materials to distribute to clients' practitioners.~~

~~**Examples**~~ ~~**Distribution**~~

- ~~Direct mailing.~~
- ~~Newsletter article.~~

~~**Evidence of distribution**~~

- ~~Committee meeting minutes.~~
- ~~Records of communication with clients and practitioners.~~

CR 3: Credentialing Information Integrity (Formerly System Controls)

The organization has credentialing information integrity policies and procedures, audits credentialing information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues.

Intent

The organization demonstrates its commitment to protecting the integrity of credentialing information used in the credentialing process.

Element A: Protecting the Integrity of Credentialing Information

The organization has credentialing information integrity policies and procedures that specify:

1. **Scope of credentialing information.**

2. **Staff responsible for performing credentialing activities.**

3. **The process for documenting updates to credentialing information.**

4. **Inappropriate documentation and updates.**

5. **The process for documenting and reporting identified information integrity issues.**

Scoring	Met	Partially Met	Not Met
	The organization meets 5 factors	No scoring option	The organization meets 0-4 factors

Data source   Documented process

Scope of review   **Documentation**

NCQA reviews the organization's policies and procedures for protecting the integrity of credentialing information.

Look-back period   *For All Surveys:* Prior to the survey date.

Explanation   This element may not be delegated.

This element applies to credentialing information (both paper and electronic) used in the credentialing process.

Credentialing information integrity refers to maintaining and safeguarding the information used in the initial credentialing and recredentialing process against inappropriate documentation and updates.

The organization's credentialing information integrity policies and procedures may be separate, or may be incorporated in other organization policies and procedures.

Factor 1: **Scope of credentialing information**

The organization's policies and procedures specify that the organization protects the integrity of the following credentialing information:

- The practitioner application and attestation.

- Credentialing documents received from the source or agent.

- Documentation of credentialing activities:

- Verification dates.
- Report dates.
- Credentialing decisions.
- Credentialing decision dates.
- Signature or initials of the verifier or reviewer.
- Credentialing Committee minutes.
- Documentation of clean file approval, if applicable.
- Credentialing checklist, if used.

Factor 2: **Staff responsible for performing credentialing activities**

The organization's policies and procedures:

- Specify titles of staff who are:
  - Responsible for documenting credentialing activities.
  - Authorized to modify (edit, update, delete) credentialing information.
    - Policies and procedures state if no staff are authorized to modify credentialing information under any circumstances.
  - Responsible for oversight of credentialing information integrity functions, including the audit.

Factor 3: **Process for documenting updates to credentialing information**

The organization's policies and procedures:

- Specify when updating credentialing information is appropriate (e.g., to update expiring credentials).
- Describe the organization's process for documenting the following when updates are made to credentialing information:
  - When (date and time) the information was updated.
  - What information was updated.
  - Why the information was updated.
  - Staff who updated the information.

Factor 4: **Inappropriate documentation and updates**

The organization's policies and procedures:

- Specify that the following documentation and updates to credentialing information are inappropriate:
  - Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates).
  - Creating documents without performing the required activities (e.g., photocopying a prior credential and updating information as new credential).
  - Fraudulently altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).
  - Attributing verification or review to an individual who did not perform the activity.
  - Updates to information by unauthorized individuals.

Factor 5: **Auditing, documenting and reporting information integrity issues**

The organization's policies and procedures:

- Specify that the organization audits credentialing staff documentation and updates.
  - The organization does not have to include the audit methodology, but must indicate that an annual audit is performed.
- Describe the process for documenting and reporting inappropriate documentation and updates to:
  - The organization's designated individual(s) when identified, and
  - NCQA, when it identifies fraud and misconduct.
    - Refer to Section 5 *(Reporting Hotline for Fraud and Misconduct; Notifying NCQA of Reportable Events)* in the Policies and Procedures for additional details.
- Specify consequences for inappropriate documentation and updates.

Examples   None.

Element B: Information Integrity Training

The organization trains credentialing staff on the following, upon hire and annually thereafter:

1. **Inappropriate documentation and updates (Element A, factor 4).**

2. **Organization audits of staff, documenting and reporting information integrity issues (Element A, factor 5).**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source   Reports, Materials

Scope of review Documentation

For All Surveys, NCQA reviews training materials and reports demonstrating that the organization conducted the required trainings for credentialing staff upon hire and annually.

Look-back period   *For All Surveys:* At least once during the prior year.

Explanation   This element may not be delegated.

Factor 1: **Inappropriate documentation and updates**

The organization trains credentialing staff on inappropriate documentation and updates to credentialing information, as defined in Element A, factor 4.

Factor 2: **Auditing, documenting and reporting information integrity issues**

The organization's training informs credentialing staff of:

- Organization audits of staff documentation and updates in credentialing files.
- The process for documenting and reporting inappropriate documentation and updates to:
  - The organization's designated individual(s) when identified.
  - NCQA, when the organization identifies fraud and misconduct.
- The consequences for inappropriate documentation and updates.

Exceptions

None.

Examples   None.

Element C: Audit and Analysis

The organization annually:

1.   Audits for inappropriate documentation and updates to credentialing information.

2.   Conducts qualitative analysis of inappropriate documentation and updates.

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source   Reports

Scope of review

Documentation

For Initial and Renewal Surveys: NCQA reviews the organization's audit and analysis reports completed during the look-back period.

Look-back period

For Initial and Renewal Surveys: At least once during the prior year.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

This element may not be delegated.

Factor 1: **Audit**

The organization annually audits credentialing verifications, decisions and ongoing monitoring (CR 2–CR 5) for the following inappropriate documentation and updates:

- Falsifying credentialing dates (e.g., licensure dates, credentialing decision dates, staff verifier dates, ongoing monitoring dates).
- Creating documents without performing the required activities.
- Altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).

- Attributing verification or review to an individual who did not perform the activity.
- Updates to information by unauthorized individuals.

The audit universe includes practitioner files for all initial credentialing decisions and all recredentialing decisions made or due during the look-back period. The organization randomly audits a sample of practitioner files from the audit universe using 5% or 50 files, whichever is less.

The random sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed within the look-back period, the organization audits all files. The organization may choose to audit more practitioner files than NCQA requires.

The organization provides an auditing and analysis report that includes:

- The date of the report.
- The title of staff who conducted the audit.
- The audit method:
  – Audit period.
  – Audit universe size.
  – Audit sample size.
  – File identifier (individual practitioner).
  – Type of credentialing information audited (e.g., licensure).
- Findings for each file.
  – A rationale for inappropriate documentation and updates (Element A, factor 4).
- The number or percentage and total inappropriate documentation and updates by type of credentialing information.

The organization must provide a completed audit report even if no inappropriate documentation and updates were found.

Factor 2: **Qualitative analysis**

The organization annually conducts qualitative analysis of each instance of inappropriate documentation and update identified in the audit (factor 1) to determine the cause.

The organization's auditing and analysis report includes:

  – Titles of credentialing staff involved in the analysis.
  – The cause of each finding.

Refer to *Appendix 5: Glossary* for the full definition of qualitative analysis.

Exceptions

This element is NA for *Interim Surveys.*

Factor 2 is NA if the organization did not identify any inappropriate documentation and updates (factor 1). NCQA assesses whether this conclusion is reasonable, based on results of the organization's analysis.

Examples   **Excerpt from audit and analysis report**

Factor 1: **Audit sampling**

Each January, the organization's credentialing director audits for inappropriate documentation and updates to credentialing information for the previous calendar year. The audit includes the following information:

- Credentialing verifications.
- Credentialing decisions.
- Ongoing monitoring.

The organization randomly samples and audits 5% or 50 files (whichever is less) of all credentialing decisions made or due in the previous year.

- *Audit period:* January–December of the previous year.

Identify the universe. The organization initial credentialed 2,000 practitioners, and recredentialed 8,000 practitioners who were due for recredentialing in the previous year.

- *Audit date:* January [date].
- *Sample universe:* 10,000 practitioner files.

Calculate the sample size. Multiply the total number of files in the universe by 5% (10,000 files x 0.05 = 500 files).

Randomly select files for the sample, for a total of 50 files:

- 20 initial credentialing files.
- 30 recredentialing files.

Audit the selected file sample. The organization audits the files for inappropriate documentation and updates, and documents findings.

Factor 1: **Audit log**

Audit date: January [date, year].

Audit period: January–December of the previous year.

Audit staff: Names, titles.

Practitioner ID	File Type (Initial/Recred)	Inappropriate Documentation/ Updates?	Credential Affected	Finding
Practitioner 1	Recredential	No		NA
Practitioner 2	Initial	No		NA
Practitioner 3	Recredential	Yes	Attestation	Attestation date updated by staff (name) instead of practitioner because attestation was expiring. 3/3/XX @ 2:59 PM
Practitioner 4	Recredential	Yes	Licensure Sanction Information	Verification of licensure and sanction information updated by staff (name) without going to the source (3/3/XX @ 11:00 AM) because the committee meeting was scheduled for the next day.

Factors 1, 2: **Audit report and analysis**

Methodology

- Frequency: Annual (January).
- Audit sample: Sample practitioner files using NCQA "5% or 50 files" method.
- Universe: All practitioner initial credentialing and recredentialing files.

*Sample **calculation***

- File universe = 10,000 files.
- 5% or 50 files calculation = 10,000 x .05 = 500 files.
- Minimum sample size = 50 files.

Audit findings and analysis. The organization audited a random sample of 50 files that included 20 initial credentialing files and 30 recredentialing files.

Credentialing Information Reviewed	Noncompliant Initial Credentialing Files	Noncompliant Recredentialing Files	Percentage of Noncompliant Modifications
Application and Attestation	4	4	16%
License	2	2	8%
DEA/CDS	0	0	0%
Education and Training	0	NA	0%
Board Certification Status	0	0	0%
Work History	4	NA	8%
Malpractice History	0	0	0%
Sanction Information	2	2	8%
Credentialing Committee Minutes	0	4	8%
Clean-File Approvals	0	0	0%
Ongoing Monitoring Reports	0	0	0%
Total	12	6	36%

Qualitative analysis. The credentialing analyst provided the credentialing director with the audit log documenting when, how, why and by whom files were updated.

The credentialing director met with credentialing staff (credentialing assistant director, credentialing manager, credentialing analyst) to determine the cause of noncompliance with credentialing integrity policies and procedures.

Credentialing Information	Description of Noncompliant Update	Reason
Application and Attestation	Attestation date updated by staff instead of practitioner.	Staff spoke with the practitioner, who stated that all information remained accurate. Staff did not know that only the practitioner can update the information.
License	Verification was updated without going to the source.	Staff responsible for verification of licensure and sanction information was on emergency leave and did not complete verification.
Sanction Information	Verification was updated without going to the source.	Because temporary staff did not have time to complete verification of all practitioners, they copied existing credentials, changed dates and uploaded the information into the CR system before the Credentialing Committee meeting.
Credentialing Committee Minutes	Four practitioners were added to Credentialing Committee minutes without actually being presented to the Committee.	The organization initially terminated the practitioners for not updating their application and attestation. After 30 days, practitioners returned the required document. Organization leadership instructed staff to update minutes to reflect that the practitioners approved in the prior Credentialing Committee meeting.

Element D: Improvement Actions

The organization:

1. **Implements corrective actions to address all inappropriate documentation and updates found in Element C.**

2. **Conducts an audit of the effectiveness of corrective actions (factor 1) on findings 3–6 months after completion of the annual audit in Element C.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source   Documented process, Reports, Materials

Scope of review Documentation

For Initial and Renewal Surveys:

- *For factor 1:* NCQA reviews the organization's documentation of corrective actions planned or taken to address inappropriate documentation and updates.
- *For factor 2:* NCQA reviews the organization's audit of the effectiveness of corrective actions.

Look-back period   *For Initial and Renewal Surveys:* At least once during the prior year.

Explanation   This element may not be delegated.

The organization addresses credentialing information integrity issues identified in Element C.
Factor 1: **Implement corrective actions**

The organization documents corrective actions taken or planned, including dates of actions, to address all inappropriate documentation and updates (findings) identified in Element C. One action may address more than one finding, if appropriate. The organization may not use trainings (Element B) as the only action.

The organization identifies staff (by title) who are responsible for implementing corrective actions.

Factor 2: **Measure of effectiveness follow-up audit**

The organization audits the effectiveness of corrective actions (factor 1) on findings within 3–6 months of the annual audit completed for Element C. and draws conclusions about the actions' overall effectiveness. The audit universe includes practitioner files for all credentialing decisions made or due to be made 3–6 months after the annual audit.

The organization conducts a qualitative analysis if it identifies noncompliance with integrity policies and procedures during the follow-up audit.

Exceptions

This element is NA for *Interim Surveys.*

This element is NA if the organization did not identify any inappropriate documentation and updates, according to the audit and analysis report reviewed for Element C. NCQA assesses whether this conclusion is reasonable, based on results in the organization's audit and analysis report.

Factor 2 is NA if the annual audit is less than 3 months before the organization's NCQA Survey.

Examples   **Excerpt from report on corrective actions and measures of effectiveness**

Factor 1: **Corrective actions**

The organization implemented immediate corrective actions to address noncompliant updates after sharing audit and analysis results with credentialing staff and organization leadership. Leadership required completion of corrective actions, outlined in the table below, on or before March [date, year].

Credentialing Information/ Noncompliant Update	Reason	Actions
Application and Attestation: Attestation date updated by staff instead of by practitioner.	Staff spoke with the practitioner, who stated that all information remained accurate. Staff did not know that only the practitioner can update the information.	Educate staff on the organization's policies and procedures. [Date] Train staff on NCQA's documentation requirements. [Date] Establish automated resending of attestation to practitioner 60 days before expiration. [Date]

Credentialing Information/ Noncompliant Update	Reason	Actions
License: Verification was not updated from the source.	Staff responsible for verification of licensure and sanction information was on emergency leave and did not complete verification.	Require credentialing staff to undergo ethics training, with emphasis on following organization processes even if under pressure to take shortcuts. [Date]
Sanction Information: Verification was not updated from the source.	Because temporary staff did not have time to complete verification of all practitioners, they copied existing credentials, changed dates and uploaded the information into the CR system before the Credentialing Committee meeting.	Incorporate system flag that does not allow updating information without going to the source and require to confirm that the information was received from the source. [Date] Purchase software application to automatically retrieve verification from accepted sources (web crawler). [Date]

Factor 2: **Effectiveness of corrective actions audit**

The organization audits the effectiveness of actions taken in 6 months, using the method described in the report of inappropriate findings from the previous annual audit.

Methodology

- Audit staff: Names, titles.
- Frequency: Six months (June).
- Audit sample: Sample practitioner files using NCQA "5% or 50 files" method.
- Universe: All practitioner initial credentialing and recredentialing files.

Sample calculation

- File universe = 10,000 files.
- 5% or 50 files calculation = 10,000 x .05 = 500 files.
- Minimum sample size = 50 files.

Audit log: Not shown.

Audit findings and analysis. The organization reviewed a random sample of 20 initial credentialing files and 30 recredentialing files.

Credentialing Information Reviewed	Noncompliant Initial Credentialing Files	Noncompliant Recredentialing Files	Percentage of Noncompliant Modifications
Application and Attestation	0	0	0%
License	0	0	0%
Sanction Information	0	0	0%
Total	0	0	0%

Conclusions about the actions' overall effectiveness

Credentialing Information/ Noncompliant Update	Actions	Conclusions
Application and Attestation: Attestation date updated by staff instead of by practitioner.	Educate staff on organization policies and procedures. [Date] Train staff on NCQA documentation requirements. [Feb] Establish automated resending of attestation to practitioner 60 days before expiration. [Mar]	Staff completed the required training and new automated system upgraded to resend attestation to practitioner 60 days before expiration. These actions have eliminated updating of attestation by staff. The were no incidences identified in audit.
License: Verification was not updated from the source. **Sanction Information:** Verification was not updated from the source.	Require credentialing staff to undergo ethics training, with emphasis on following organization processes even if under pressure to take shortcuts. [Feb] Incorporate system flag that does not allow updating information without going to the source and require to confirm that the information was received from the source. [Mar] Purchase software application to automatically retrieve verification from accepted sources (web crawler). [Apr]	Staff and leadership completed the required ethics training. Incorporated system flag that does not allow updating information without going to the source and confirmation functionality. Purchased software application to automatically retrieve verification from accepted sources (web crawler). The were no incidences identified in audit.

The correction implemented has been effective overall; the audit did not identify incidents of inappropriate documentation and update.

CR 4: Delegation of CR

If the organization delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for credentialing and recredentialing its practitioners and for protecting credentialing/recredentialing information integrity, even if it delegates all or part of credentialing activities.

Element A: Delegation Agreement

The written delegation agreement:

1. **Is mutually agreed upon.**

2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**

3. **Requires at least semiannual reporting by the delegated entity to the organization.**

4. **Describes the process by which the organization evaluates the delegated entity's performance.**

5. **Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.**

6. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Scoring

Met	Partially Met	Not Met
The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data source   Documented process

Scope of review

Documentation

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For factor 4:

- New delegation agreements implemented on or after July 1, 2025, must address the delegate's credentialing information integrity.

- Delegation agreements in place prior to July 1, 2025, that address the system controls under the 2022–2024 standards do not need to be updated to address credentialing information integrity requirements. NCQA does not evaluate the agreement against system controls requirements in prior years.

- Delegation agreements in place prior to July 1, 2025, that do not address the system controls intent under the 2022–2024 standards must be updated to address credentialing information integrity requirements.

The score for the element is the average of the scores for all delegates.

Look-back period   *For Interim Surveys and Initial Surveys:* 6 months for factors 1–6.

For Renewal Surveys: 24 months for factors 1–6.

Explanation   This element may not be delegated.

This element applies to agreements that are in effect within the look-back period.

The delegation agreement describes all delegated credentialing activities. A generic policy statement about the content of delegated arrangements does not meet this element.

Factor 1: **Mutual agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (the date of the last signature) as the mutually agreed upon effective date.

NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities.

NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.

Factor 2: **Assigning responsibilities**

The delegation agreement, an addendum thereto or other binding communication between the organization and the delegate specifies credentialing activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
  - The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other credentialing functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify which organization is responsible for oversight of the subdelegate.

Factor 3: **Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited delegates. NCQA scores this factor "yes" if the organization delegates credentialing activities to an NCQA-Certified delegate (e.g., CVO) that is certified to perform the delegated activity.

Factor 4: **Performance monitoring**

The delegation agreement states the organization's process for monitoring and evaluating the delegate's performance, as required in Element C, including credentialing information integrity.

Credentialing information integrity refers to maintaining and safeguarding the information used in the initial credentialing and recredentialing process against inappropriate documentation and updates, as outlined in CR 3, Element A, factor 4.

If the organization delegates any credentialing functions or activities covered in in the scope of these standards, the delegate protects the integrity of the credentialing information used in the credentialing process. The delegation agreement specifies that the following documentation and updates to credentialing information are inappropriate:

- Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates).
- Creating documents without performing the required activities (e.g., photocopying a prior credential and updating information as new credential).
- Fraudulently altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).
- Attributing verification or review to an individual who did not perform the activity.
- Updates to information by unauthorized individuals.

Factor 5: **Right to approve, suspend and terminate**

No additional explanation required.

Factor 6: **Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that result in revocation of the agreement.

Exception

This element is NA if the organization does not delegate credentialing activities.

Related information

Outsourcing credentialing data storage to a cloud-based entity. It is not considered delegation if the organization only outsources credentialing data storage to a cloud-based entity that does not provide services that create, modify or use the credentialing data.

Examples   *Factor 3:* **Reporting for delegation of credentialing**

- Lists of credentialed and recredentialed practitioners.
- Committee meeting minutes.
- List of providers assessed.

Element B: Predelegation Evaluation

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

	Met	Partially Met	Not Met
Scoring	The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data source   Reports

Scope of review   *This element applies if delegation was implemented in the look-back period.*

Documentation

NCQA reviews the organization's predelegation evaluation from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

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

For Renewal Surveys: 12 months.

Explanation   This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Accredited in CR or NCQA-Certified entities (e.g., CVOs), unless the element is NA. NCQA-Certified CVOs must be certified to perform the activity delegated by the organization.

Note: For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. The evaluation may include a review of the organization's structure, processes and staffing in order to determine its capability to perform the delegated function.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.
If the time between the predelegation evaluation and implementation of delegation exceeds 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional credentialing activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate credentialing activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaborative. An organization may collaborate in a statewide predelegation evaluation with other organizations that have overlapping practitioner and provider networks. The organizations in the collaborative use the same audit tool and share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples   **Predelegation evaluation**

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of Delegate's Credentialing Activities

For delegation arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's credentialing policies and procedures.**

2. **Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.**

3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**

4. **Semiannually evaluates regular reports, as specified in Element A.**

5. **Annually audits each delegate's credentialing files for inappropriate documentation and inappropriate updates to credentialing information.**

6. **Implements a corrective actions for each delegate that addresses all inappropriate documentation and inappropriate updates found in factor 5.**

7. **Conducts an audit of the effectiveness of corrective actions (factor 6) on the findings for each delegate 3–6 months after completion of the annual audit for factor 5.**

Scoring

Met	Partially Met	Not Met
The organization meets 6-7 factors	The organization meets 4-5 factors	The organization meets 0-3 factors

Data source   Reports

Scope of review	**Documentation**

NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or from all delegates if the organization has fewer than four.

For All Surveys: NCQA reviews the organization's evaluation of the delegate's credentialing policies and procedures (factor 1).

For Initial Surveys: NCQA also reviews the organization's most recent semiannual evaluation, annual review, audits, performance evaluation, corrective actions and measure of effectiveness (factors 2–7).

For Renewal Surveys:

- *Factors 2–4:* NCQA also reviews the organization's most recent and the previous year's annual reviews, audits, performance evaluations and four semiannual evaluations.
- *Factors 5–7:* NCQA also reviews the organization's most recent annual audit, performance evaluation, corrective actions and measure of effectiveness.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and Initial Surveys: At least once during the prior year.

For Renewal Surveys: 24 months for factors 1–4; at least once during the prior year for factors 5–7.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for factors 2 and 3 if all delegates are NCQA Accredited health plans or MBHOs, NCQA Accredited in CR or NCQA-Certified in CR or CVO, unless delegated credentialing requirements were not in scope or were scored NA during the delegates' NCQA survey.

Organizations who are NCQA-Certified in CR or CVO must be certified to perform the activity delegated by the organization.

Automatic credit for factor 4 is available for NCQA-Certified in CR or CVO that are certified to perform the delegated activity.

Automatic credit is available for factors 5–7 if all the organization's all delegates are NCQA Accredited under the 2025 standards or later.

Note: For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Factor 1: **Review of credentialing policies and procedures**

The appropriate organization staff or committee reviews the delegate's credentialing policies and procedures. At a minimum, the organization reviews the sections of the policies and procedures that apply to the delegated functions.

Factor 2: **Annual file audit**

If the organization delegates credentialing, it audits the delegate's credentialing and recredentialing files against NCQA standards. The organization uses one of the following methods to audit the files:

- 5% or 50 files, whichever is less, to ensure that information is verified appropriately.
  - The sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits all files.
- The NCQA "8/30 methodology" available at https://www.ncqa.org/ programs/health-plans/policy-accreditation-and-certification/

The organization bases its annual audit on the responsibilities of the delegate described in the delegation agreement and the appropriate NCQA standards.

Factor 3: **Annual evaluation**

No additional explanation required.

Factor 4: **Evaluation of reports**

For delegates that are NCQA Accredited in CR, the only NCQA-required reporting is the names or files of practitioners or providers processed by the delegate.

Factor 5: **Annual audit of credentialing information integrity**

If the organization delegates the any credentialing activities covered in the scope of these standards, the organization or the delegate annually audits (as applicable) the delegate's credentialing files for inappropriate documentation and updates to:

- The application and attestation.
- Credentialing documents received from the source or agent.
- Documentation of completion of credentialing activities:
  - Verification dates.
  - Report dates.
  - Credentialing decision dates.
  - Signature or initials of the verifier or reviewer.
- Credentialing checklist, if used.

Inappropriate documentation and inappropriate updates. The following are inappropriate documentation and updates:

- Falsifying credentialing dates (e.g., licensure dates, credentialing decision dates, staff verifier dates, ongoing monitoring dates).
- Creating documents without performing the required activities.
- Altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).
- Attributing verification or review to an individual who did not perform the activity.
- Updates to information by unauthorized individuals.

For each delegate, the audit universe includes practitioner files processed by the delegate for all initial credentialing decisions made and recredentialing decisions made or due to be made within the look-back period.

Because the organization may have several credentialing delegates, the audit uses one of the following methods:

- 5% or 50 files, whichever is less, to ensure that information is verified appropriately.

– The sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files.

- The NCQA "8/30 methodology" available at https://www.ncqa.org/programs/health-plans/policy-accreditation-and-certification/

Either methodology is allowed, for consistency with other delegation oversight requirements for annual file audits.

The organization or delegate may choose to audit more practitioner files than NCQA specifies.

The organization provides an auditing and analysis report for each delegate that includes:

- The date of the report.
- Title of staff who conducted the audit.
- The audit method:
  – Audit period.
  – Audit universe size.
  – Audit sample size.
- File identifier (individual practitioner).
- Type of credentialing information audited (e.g., licensure).
- Findings for each file.
  – Draw a conclusion if inappropriate documentation and updates occur (Element A, factor 2).
- The number or percentage and total inappropriate documentation and updates by type of credentialing information.

The delegate or organization must provide a completed audit report even if no inappropriate finding were found.

If the organization uses the delegate's audit results, it must provide evidence (e.g., report, meeting minutes) that it reviewed and evaluated the delegate's findings.

Factor 6: **Implement corrective actions**

For each delegate with inappropriate documentation and updates (findings) identified in factor 5, the organization documents corrective actions taken or planned, including the time frame for actions, to address all findings identified in factor 5. One action may be used to address more than one finding, if appropriate.

The organization's corrective action plan identifies staff (by title) who are responsible for implementing corrective actions.

Factor 7: **Measure effectiveness of actions audit**

The organization or delegate audits the effectiveness of corrective actions (factor 6) on findings for each delegate within 3–6 months of the annual audit completed for factor 5.

For each delegate, the audit universe includes practitioner files processed by the delegate for all initial credentialing decisions made and for recredentialing decisions made or due to be made 3–6 months after the annual audit.

The organization or delegate conducts an qualitative analysis if it identifies integrity during the follow-up audit.

If the organization uses the delegate's audit results, the organization must provide evidence (e.g., a report, meeting minutes, other evidence) that it reviewed and evaluated the delegate findings.

The organization draws conclusions on the overall effectiveness of corrections implemented.

Exceptions

The element is NA if:

- The organization does not delegate credentialing activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is NA if no practitioners were initial credentialed or were due for recredentialing.

Factors 2–7 are NA for Interim Surveys.

Factors 5–7 are NA if the delegate only provides cloud-based credentialing data storage functions and does not provide services that create, modify or use credentialing data.

Factors 6–7 are NA if the organization's annual audit of all delegates' credentialing files did not identify any inappropriate documentation and updates to credentialing information used in the credentialing process. This must be evident in reports reviewed for factor 5.

Factor 7 is NA if the timing of the organization's annual audit is less than 3 months before the organization's NCQA Survey.

Related information

Use of collaborative. The organization may collaborate in a statewide, annual file audit and evaluation with other organizations that have overlapping practitioner and provider networks. The organizations in the collaborative use the same audit tool and share data.

Auditing CVOs. The organization is not required to audit CVOs against timeliness requirements during the delegation audit, because NCQA does not recognize CVOs for decision making. If the organization delegates decision making, NCQA assesses the organization for timeliness of the credentialing decision.

Oversight of national delegates. NCQA allows a national corporate office to perform credentialing oversight of a nationally contracted delegate on behalf of its affiliated organizations (accreditable entities). Oversight results must be available for each accreditable entity survey. The organization reviews 75 randomly selected files across all Accreditable entities.

If the delegate's credentialing system is not centralized, separate oversight audits must be conducted for each accreditable entity.

Examples   *Factor 2:* **Annual evaluation**

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Factor 5: **Excerpt from audit and analysis report**

Audit sampling

Each January, the delegate's credentialing director audits for inappropriate documentation and updates to credentialing information for the previous calendar year. The audit includes the following information:

- Credentialing verifications.
- Credentialing decisions.
- Ongoing monitoring process.

The delegate randomly samples and audits 5% or 50 files (whichever is less) of all credentialing decisions made or due in the previous year.

- *Audit period:* January–December of the previous year.

Identify the universe. The delegate initial credentialed 2,000 practitioners, and recredentialed 8,000 practitioners who were due for recredentialing in the previous year.

- *Audit date:* January [date].
- *Sample universe:* 10,000 practitioner files.

Calculate the sample size. Multiply the total number of files in the universe by 5% (10,000 files x 0.05 = 500 files).

Randomly select files for the sample, for a total of 50 files:

- 20 initial credentialing files.
- 30 recredentialing files.

Audit the selected file sample. Audit the files for inappropriate documentation and updates, and document findings.

Audit log

Audit date: January [date, year].

Audit period: January–December of the previous year.

Audit staff: Names, titles.

Practitioner ID	File Type (Initial/ Recred)	Inappropriate Documentation/ Updates?	Credential Affected	Finding
Practitioner ABC	Recredential	No		NA
Practitioner DEF	Initial	No		NA
Practitioner GHI	Recredential	Yes	Attestation	Attestation date updated by staff (name) instead of practitioner because attestation was expiring. 3/3/XX @ 2:59 PM
Practitioner XYZ	Recredential	Yes	Licensure Sanction Information	Verification of licensure and sanction information updated by staff (name) without going to the source (3/3/XX @ 11:00 AM) because the committee meeting was scheduled for the next day.

Audit report and analysis

Methodology

- Frequency: Annual (January).
- Audit sample: Sample practitioner files using NCQA "5% or 50 files" method.
- Universe: All practitioner initial credentialing and recredentialing files.

Sample calculation

- File universe = 10,000 files.
- 5% or 50 files calculation = 10,000 x .05 = 500 files.
- Minimum sample size = 50 files.

Audit findings and analysis. The delegate reviewed a random sample of 20 initial credentialing files and 30 recredentialing files with modifications.

Credentialing Information Reviewed	Noncompliant Initial Credentialing Files	Noncompliant Recredentialing Files	Percentage of Noncompliant Modifications
Application and Attestation	4	4	16%
License	2	2	8%
DEA/CDS	0	0	0%
Education and Training	0	NA	0%
Board Certification Status	0	0	0%
Work History	4	NA	8%
Malpractice History	0	0	0%
Sanction Information	2	2	8%

Credentialing Information Reviewed	Noncompliant Initial Credentialing Files	Noncompliant Recredentialing Files	Percentage of Noncompliant Modifications
Credentialing Committee Minutes	0	4	8%
Clean-File Approvals	0	0	0%
Ongoing Monitoring Reports	0	0	0%
Total	12	6	36%

Qualitative analysis. The credentialing analyst provided the credentialing director with the audit log documenting when, how, why and by whom files were updated.

The delegate's credentialing director met with credentialing staff (credentialing assistant director, credentialing manager, credentialing analyst) to determine the cause of noncompliance with credentialing integrity policies and procedures.

Credentialing Information	Description of Noncompliant Update	Reason
Application and Attestation	Attestation date updated by staff instead of practitioner.	Staff spoke with the practitioner, who stated that all information remained accurate. Staff did not know that only the practitioner can update the information.
License	Verification was not updated from the source.	Staff responsible for verification of licensure and sanction information was on emergency leave and did not complete verification.
Sanction Information	Verification was not updated from the source.	Because temporary staff did not have time to complete verification of all practitioners, they copied existing credentials, changed dates and uploaded the information into the CR system before the Credentialing Committee meeting.
Credentialing Committee Minutes	Four practitioners were added to Credentialing Committee minutes who did not attend the meeting.	The organization initially terminated the practitioners for not updating their application and attestation. After 30 days, practitioners returned the required document. Organization leadership instructed staff to update minutes to reflect that the practitioners attended the Credentialing Committee meeting.

Excerpt from reports of corrective actions and measures of effectiveness

Factor 6: **Corrective actions**

The organization required the delegate to implement immediate corrective actions to address information integrity issues after sharing audit and analysis results with credentialing staff and organization leadership.

Leadership required completion of corrective actions, outlined in the table below, on or before March [date, year].

Credentialing Information/ Noncompliant Update	Reason	Actions
Application and Attestation: Attestation date updated by staff instead of by practitioner.	Staff spoke with the practitioner, who stated that all information remained accurate. Staff did not know that only the practitioner can update the information.	Educate delegate's staff on organization policies and procedures [Date] Train delegate's staff on NCQA's documentation requirements. [Date] Delegate to establish automated resending of attestation to practitioner 60 days before expiration. [Date]
License: Verification was not updated from the source. **Sanction Information:** Verification was not updated from the source.	Staff responsible for verification of licensure and sanction information was on emergency leave and did not complete verification. Because temporary staff did not have time to complete verification of all practitioners, they copied existing credentials, changed dates and uploaded the information into the CR system before the Credentialing Committee meeting.	Require delegate's credentialing staff to undergo ethics training, with emphasis on following organization processes even if under pressure to take shortcuts. [Date] Require delegate to incorporate system flag that does not allow updating information without going to the source and require to confirm that the information was received from the source. [Date] Require delegate to purchase software application to automatically retrieve verification from accepted sources (web crawler). [Date]
Credentialing Committee Minutes: Four practitioners were added to Credentialing Committee minutes who did not attend the meeting.	The organization initially terminated the practitioners for not updating their application and attestation. After 30 days, practitioners returned the required document. Delegate's leadership instructed its staff to update minutes to reflect that the practitioners attended the Credentialing Committee meeting.	Require delegate's leadership and credentialing staff to undergo ethics training, with emphasis on following credentialing information integrity policies and procedures. [Date] Require delegate to establish read only records for minutes and other credentialing information. [Date]

*Factor 7: M*easure of effectiveness audit

The delegate audits the effectiveness of actions taken in 6 months, using the method described in the report of inappropriate findings, from the previous annual audit.

Methodology

Audit staff: Names, titles.

Frequency: 6 months (June).

Audit sample: Sample practitioner files using NCQA "5% or 50 files" method.

Universe: All practitioner initial credentialing and recredentialing files.

Sample calculation

File universe = 10,000 files.

5% or 50 files calculation = 10,000 x .05 = 500 files.

Minimum sample size = 50 files.

Audit log: Not shown.

Audit findings and analysis. The delegate audited a random sample of 20 initial credentialing files and 30 recredentialing files and shared the audit finding and analysis on [date].

Credentialing Information Reviewed	Noncompliant Initial Credentialing Files	Noncompliant Recredentialing Files	Percentage of Noncompliant Modifications
Application and Attestation	0	0	0%
License	0	0	0%
Sanction Information	0	0	0%
Credentialing meeting minutes	0	0	0%
Total	0	0	0%

Conclusions on the actions' overall effectiveness

Credentialing Information/ Noncompliant Update	Actions	Conclusions
Application and Attestation: Attestation date updated by staff instead of by practitioner.	Delegate to educate staff on organization policies and procedures. [Date] Delegate to train staff on NCQA documentation requirements. [Feb] Delegate to establish automated resending of attestation to practitioner 60 days before expiration. [Mar]	Delegate's staff completed the required training [Date] and new automated system upgraded [Date] to resend attestation to practitioner 60 days before expiration. These actions have eliminated updating of attestation by staff. The were no incidences identified in audit.

Credentialing Information/ Noncompliant Update	Actions	Conclusions
License: Verification was not updated from the source.

Sanction Information: Verification was not updated from the source. | Delegate's credentialing staff to undergo ethics training, with emphasis on following organization processes even if under pressure to take shortcuts. [Feb]

Delegate to incorporate system flag that does not allow updating information without going to the source and require to confirm that the information was received from the source. [Mar]

Delegate to purchase software application to automatically retrieve verification from accepted sources (web crawler) [Apr] | Delegate's staff and leadership completed the required ethics training. [Date]

Incorporated system [Date] flags that does not allow updating information without going to the source and confirmation functionality.

Purchased software application [Date] to automatically retrieve verification from accepted sources (web crawler).

The were no incidences identified in audit. |
| **Credentialing Committee Minutes:** Four practitioners were added to Credentialing Committee minutes who did not attend the meeting. | Delegate's leadership and credentialing staff to undergo ethics training, with emphasis on following credentialing information integrity policies and procedures. [Date]

Delegate to establish read only records for minutes and other credentialing information. [Date] | Delegate's leadership and credentialing staff completed ethics training [Date] and credentialing information integrity policies and procedures training. [Date]

Delegate updated [system name] to read only records for minutes and all other credentialing information. [Date] |

The organization reviewed and evaluated the delegate's audit results and analysis report on [date]. The corrective actions implemented have been effective overall; the audit did not find incidents inappropriate documentation and update.

Element D: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Scoring

Met	Partially Met	Not Met
The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

Data source   Documented process, Reports, Materials

Scope of review

Documentation

NCQA reviews reports of opportunities for improvement, from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For Initial Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

For Initial Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

This element does not apply to credentialing information integrity requirements, which are addressed in CR 4, Element C, factors 5–7.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, NCQA Accredited in CR or NCQA-Certified CVOs, unless the element is NA. NCQA-Certified CVOs must be certified to perform the delegated activity.

Note: For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports or annual evaluation to identify areas of improvement.

Exceptions

Factors 2–6 are NA for Interim Surveys.

This element is NA if:

- The organization does not delegate credentialing activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
  - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples

None.

CR ACCREDITATION STANDARDS (CRA)
Applicable to organizations pursuing Credentialing Accreditation

CRA 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: 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 <u>and do not meet</u> the organization's established criteria.**

6. **<u>The criteria for practitioner sanctions, complaints and other adverse events found during ongoing monitoring that need to be reviewed by the credentialing committee.</u>**

7.~~6~~ **The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.**

8.~~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.**

9~~8~~. **The process for notifying that practitioners of the credentialing and recredentialing decision within ~~60~~ <u>30</u> calendar days of the credentialing committee's decision.**

10~~9~~. **The medical director or other designated physician's direct responsibility and participation in the credentialing program.**

11~~0~~. **The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.**

12~~1~~. **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.**

13. **<u>The process for documenting information and activities in credentialing files.</u>**

Scoring

Met	Partially Met	Not Met
~~9~~13 factors	~~5-8~~ 8-12 factors	~~0-4~~ 0-7 factors

Scoring

100%	80%	50%	20%	0%
~~The organization meets 11 factors~~	~~The organization meets 9-10 factors~~	~~The organization meets 5-8 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 Interim Surveys:* Prior to the survey date.

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.
  - Please note, organizations that utilize locum tenens are required to include those practitioners in the scope of credentialing.
- 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.
- PPO network.
  - NCQA considers this to be an independent relationship if:
    - Information about the network is included in member materials or on an ID card that directs members to the network (e.g., network name, phone number, logo).
    - There are incentives for members to see the PPO's practitioners.

In this type of contractual arrangement, the organization must credential the practitioners or delegate credentialing to the PPO network.

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 (e.g., certified nurse midwife).
    - 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 (e.g., licensed professional counselor).

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.
  - Criteria are reviewed and approved by the medical director or the Credentialing Committee.
- Makes a final determination regarding Determines which practitioners may participate in its network based on specified criteria.

Factor 5: **Managing files that meet and do not meet the criteria**

Credentialing policies and procedures describe the process used to determine and approve files that meet criteria (i.e., clean files) and files that do not meet the criteria. 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: **Criteria for ongoing monitoring notifications to the credentialing committee.**

Credentialing policies and procedures outline the criteria the organization uses to determine the types of practitioner sanctions, complaints and other adverse events found during ongoing monitoring that need to be reviewed by the credentialing committee.

Factor 76: **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.
  – Considers the demographic makeup of the credentialing committee to the demographic makeup of the patient population.
- 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 87: **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 in their credentialing application.

Factor 98: **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 30 calendar days from the Credentialing Committee's decision. The organization is not required to notify practitioners regarding recredentialing approvals.

Factor 109: **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 1~~1~~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 12~~1~~: **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.

Factor 13: **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.

Exceptions

Factor 12~~1~~ is NA for organizations that serve as delegates but are not responsible
for publishing ~~member materials~~ provider directory information.

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.~~

Verification 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.~~ Staff who verified the credentials must also sign or initial the verification.

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.

Use of web crawlers. The organization may use web crawlers to verify credentialing information from approved sources. A "web crawler" is software that retrieves information directly from a primary or approved source website (e.g., the state licensing or certification agency). 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 (*CRA 43: Credentialing Verification,* Element A~~, factor 1~~).
- The past 5 years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query (CRA 43, Element FA~~, factor 6~~).
- A current and signed application with attestation (CRA 3, Element AC~~, 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 (e.g., board-certified consultants who may provide a professional opinion to the treating practitioner).
- 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.
- The organization re-verifies credentials that are no longer within verification time limits.

The organization re-verifies credentials that will not be in effect when the Credentialing Committee or medical director makes the credentialing decision.

Examples   *Factor 76:* **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.

Electronic signature software applications

- Adobe Sign.
- DocuSign.

CRA 2: Credentialing Committee

The organization designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions.

Element A: Credentialing Committee

The organization's Credentialing Committee:

1. Uses participating practitioners to provide advice and expertise for credentialing decisions.

2. Reviews credentials for practitioners who do not meet established thresholds.

3. Ensures that files that meet established criteria are reviewed and approved by a medical director, designated physician or the Credentialing Committee.

<u>4.</u> <u>Reviews sanctions, complaints and other adverse events found during ongoing monitoring based on the organization's criteria in CRA1, Element A and makes recommendations about actions.</u>

Scoring

Met	Partially Met	Not Met
<u>3-4 factors</u>	<u>No scoring option</u>	<u>0-1 factors</u>

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

Data source Documented process, Reports

Scope of review <u>For Interim Surveys: NCQA reviews Credentialing Committee minutes from three different meetings, or reviews the Credentialing Committee charter, and reviews a timeline for operationalizing the committee, if the committee has not met. If the required meeting minutes are not available for review, NCQA reviews the meeting minutes that are available within the look-back period.</u>

<u>For Initial and Renewal Surveys:</u> NCQA reviews Credentialing Committee meeting minutes from three different meetings within the look-back period.

If the required meeting minutes are not available for review, NCQA reviews the meeting minutes that are available within the look-back period.

<u>NCQA also reviews the organization's list of practitioners who had sanctions, complaints, and other adverse events during ongoing monitoring (CRA 5, Element A, factors 1 and 2), and Credentialing Committee meeting minutes for recommendations on the listed practitioners at the next Committee meeting after the identified occurrence.</u>

Look-back period *For Interim Surveys:* Prior to the survey date.

For Initial Surveys: 6 months<u>, prior to survey for factor 4</u>

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.

Factor 1: **Participating practitioners**

The Credentialing Committee is a peer-review body with members from the types of practitioners participating in the organization's network. For specialty organizations, non-physicians (e.g., nurse practitioners) may be included in the Credentialing Committee, but the Credentialing Committee must represent the type of practitioners in the network.

The organization may have separate review bodies for each practitioner type (e.g., physician, oral surgeon, psychologist), specialty or multidisciplinary committee, with representation from various specialties. Nurse practitioners may peer-review the Credentialing Committee to make decisions on nurse practitioners. In states that require a collaboration agreement with a physician, there must be a physician on the committee.

Chief nursing officers who are nurse practitioners may sign off on clean nurse practitioner files. Credentials must be verified by staff and all credentialing criteria must be met. If any criteria are not met, the chief nursing office is not permitted to sign off and the file must go to the Credentialing Committee.

If the organization is part of a regional or national organization, a regional or national Credentialing Committee that meets the criterion may serve as the peer review committee for the local organization.

Note: Participating practitioners are external to the organization and are part of the organization's network.

Factor 2: **Committee review**

The Credentialing Committee:

- <u>Reviews the credentials of practitioners who do not meet the organization's criteria for participation in the network.</u>
- Gives thoughtful consideration to credentialing information.
- Documents discussions about credentialing in meeting minutes.

Meetings and decisions may take place in real-time, virtual meetings (i.e., through video conference or web conference with audio), but may not be conducted only through email.

Factor 3: **Review of files that meet established thresholds**

For files that meet the organization's credentialing criteria, the organization:

- Submits all practitioner files to the Credentialing Committee for review, *or*
- Has a process for medical director or qualified physician review and approve clean files.
    – Evidence of review and approval is a handwritten signature, handwritten initials or unique electronic identifier if the organization has appropriate controls for ensuring that only the designated medical director or qualified physician can enter the electronic signature.
    – An individual signature is not required in each practitioner file if there is one report with a signature that lists all required credentials for all practitioners with clean files.
    – Clean files that meet the organization's established criteria may be reviewed by email.

The organization may have a process for review and approval of clean nurse practitioner files by chief nursing officers.

NCQA scores this factor "Yes" if the organization presents all files (including clean files) to the Credentialing Committee.

Factor 4: **Review of sanctions, complaints, or other adverse events**

During ongoing monitoring, the committee meets and reviews practitioners sanctions, complaints or other adverse events to determine action following the information found. The committee documents its findings and subsequent actions in between recredentialing cycles.

Exceptions

None.

CRA 3: Credentialing Application and Practitioner Rights

The organization includes applicable information in its credentialing application that may affect patient care.

Element A: Credentialing Application

Applications for credentialing include the following:

1. Reasons for inability to perform the essential functions of the position.

2. Lack of present illegal drug use.

3. History of loss of license and felony convictions.

4. History of loss or limitation of privileges or disciplinary actions.

5. Current malpractice insurance coverage.

6. Practitioner race, ethnicity and language.

7. Current and signed attestation confirming the correctness and completeness of the application.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

100%	80%	50%	20%	0%
~~High (90-100%) on file review for 6 factors~~	~~High (90-100%) on file review for 4 or 5 factors and medium (60-89%) on file review for the remaining 1-2 factors~~	~~At least medium (60-89%) on file review for 6 factors~~	~~Low (0-59%) on file review for 1-3 factors~~	~~Low (0-59%) on file review for 4 or more factors~~

Data source Records or files

Scope of review NCQA reviews application and attestation within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

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

For Renewal Surveys: 36 months.

Explanation **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CRA 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

NCQA counts back from the decision date to the verification date to assess timeliness of credentialing and recredentialing decisions.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Appropriate documentation

Attestation verification time limit: ~~365~~90 calendar days.

Each file contains the application and attestation, and evidence of review by the organization's staff. Refer to CRA 1, Element A, *Related information,* "Appropriate documentation."

Factor 1: **Inability to perform essential functions**

The inquiry regarding inability to perform essential functions may vary or may exceed NCQA standards, depending on the organization's interpretation of applicable legal requirements such as the Americans with Disabilities Act (ADA).

Factor 2: **Illegal drug use**

Practitioners may use language other than "drug" to attest they do not use illegal substances. The organization may use more general or extensive language to query practitioners about impairment; language is not required to refer exclusively to the present or only to illegal substances.

Factor 3: **History of loss of license**

At initial credentialing, practitioners attest to any loss of license since their initial licensure. At recredentialing, practitioners attest to any loss of licensure since the last credentialing cycle.

Factor 3: **History of felony convictions**

At initial credentialing, practitioners attest to any felony convictions since their initial licensure. At recredentialing, practitioners attest to any felony convictions since the last credentialing cycle.

Factor 4: **Limitation of privileges or disciplinary actions**

At initial credentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since their initial licensure. At recredentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since the last credentialing cycle.

Factor 5: **Current malpractice coverage**

The application states the amount of a practitioner's current malpractice insurance coverage (even if the amount is $0) and the date when coverage expires.

If the practitioner's malpractice insurance coverage is current and is provided in the application, it must be current as of the date when the practitioner signed the attestation and include the amount of coverage the practitioner has on the date when the attestation was signed. If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates.

Documentation of malpractice insurance coverage may also be a face sheet, a federal tort letter or employer professional liability policy as an addendum to the application. In this case, the practitioner is not required to attest to malpractice coverage on the application. The face sheet, federal tort letter or employer professional liability policy must include the insurance effective and expiration dates (the future effective date is acceptable).

Evidence of private malpractice insurance coverage must also include a roster of all individuals in the practice who are covered under the policy. For evidence of federal tort coverage, the federal tort letter may apply to all employed practitioners; the name of every practitioner is not required.

Factor 6: **Race, ethnicity and language**

<u>The organization includes a field on the application for race, ethnicity and language</u>.

Factor 7: **Correctness and completeness of the application**

If the application and attestation must be updated, only the practitioner may attest to the update; organization staff may not. If a copy of an application from an entity external to the organization is used, it must include an attestation to the correctness and completeness of the application. NCQA does not count the associated attestation elements as present if the practitioner did not sign the application within the required time frame.

Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired and the disability is documented in the practitioner's file.

CAQH. CAQH has a system that allows the practitioner to update application information electronically. NCQA accepts the last attestation date generated by this system as the date when the practitioner signed and dated the application to attest to its completeness and correctness.

Exceptions

None.

Related information

Meeting time limits. NCQA does not require receipt of the attestation before the organization conducts credentialing verification and queries required for other elements. If the signature attestation exceeds the time limit before the credentialing decision, the practitioner must attest that the information on the application remains correct and complete but is not required to complete another application. NCQA recommends that the organization send a copy of the completed application with the new attestation form when it requests the practitioner to update the attestation.

Use of other applications. The organization may use a state application or an application from another entity if it meets the factors in this element.

If state regulations require the organization to use a credentialing application that does not contain an attestation, or all information in factors 1–<u>7</u>6, the organization attaches the attestation or additional information as an addendum to the application. If state regulations prohibit addenda to the application, the organization attaches a copy of the relevant regulations when it submits the survey tool.

Examples   None.

Element B: Practitioner Rights

The organization notifies practitioners about their right to:

1. Review information submitted to support their credentialing application.

2. Correct erroneous information.

3. Receive the status of their credentialing or recredentialing application, upon request.

Scoring

Met	Partially Met	Not Met
2-3 factors	No scoring option	0-1 factors

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

Data source   Documented process, Materials

Scope of review   NCQA reviews the organization's policies and procedures for all three factors.

NCQA also reviews three materials sent to affected practitioners throughout the look-back period, or reviews all materials if the organization has fewer than three.

Look-back period   *For Interim Surveys:* Prior to the survey date.

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.

Factor 1: **Review information**

The organization notifies practitioners of their right to review information obtained from outside sources (e.g., malpractice insurance carriers, state licensing boards) to support their credentialing application. The organization is not required to make available:

- References.
- Recommendations.
- Peer-review protected information.

Factor 2: **Correct erroneous information from other sources**

The organization notifies practitioners of their right to correct erroneous information and of:

- The time frame for making corrections.
- The format for submitting corrections.
- Where to submit corrections.

The organization is not required to reveal the source of information that was not obtained to meet verification requirements or if federal or state law prohibits disclosure.

The organization documents receipt of corrected information in the practitioner's credentialing file.

Factor 3: **Application status**

The organization notifies practitioners of:

- Their right to be informed of the status of their application, upon request.
- The information it is allowed to share with practitioners.
- Its process for responding to requests for application status.

Exceptions

None.

Examples   **Avenues for notification**

- Application.
- Contract.
- Provider manual.
- Other information distributed to practitioners.
- Website.
- Letter to practitioners.

Factor 2: **Areas where variation from information provided may occur**

- Actions on a license.
- Malpractice claims history.
- Board certification.

CRA 4: Credentialing Verification

The organization verifies credentialing information through primary sources, unless otherwise indicated.

Intent

The organization conducts timely verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care.

Element A: Verification of Licensure

The organization verifies that practitioners have a current and valid license to practice within <u>90 calendar days at the time of the credentialing decision.</u>

	Met	Partially Met	Not Met
Scoring	<u>To be determined</u>	<u>To be determined</u>	<u>To be determined</u>

	~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
Scoring	~~High (90-100%) on file review for 6 factors~~	~~High (90%-100%) on file review for 4-5 factors and medium (60-89%) on file review for the remaining 1-2 factors~~	~~At least medium (60-89%) on file review for 6 factors~~	~~Low (0-59%) on file review for 1-3 factors~~	~~Low (0-59%) on file review for 4 or more factors~~

Data source   Records or files

Scope of review   NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

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

For Renewal Surveys: 36 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CR<u>A</u> 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

For factors with verification time limits, NCQA counts back from the decision date to the verification date to assess timeliness of verification.

All credentials must be current at the time of the Credentialing Committee decision.

Appropriate documentation

Each file contains evidence of verification from a listed source and review by organization staff. Refer to CR<u>A</u> 1, Element A, *Related Information,* "Appropriate documentation."

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Verification time limit: ~~180~~ 90 calendar days.

The organization verifies that the practitioner has a valid and current license to practice at the time of the credentialing decision. The organization verifies license in all states where the practitioner provides care to members. The organization must verify license directly from state licensing or certification agency or its website.

Element B: Verification of DEA or CDS

The organization verifies that practitioners have a valid DEA or CDS, if applicable:

	Met	Partially Met	Not Met
Scoring	To be determined	To be determined	To be determined

	~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
Scoring	~~High (90-100%) on file review for 6 factors~~	~~High (90%-100%) on file review for 4-5 factors and medium (60-89%) on file review for the remaining 1-2 factors~~	~~At least medium (60-89%) on file review for 6 factors~~	~~Low (0-59%) on file review for 1-3 factors~~	~~Low (0-59%) on file review for 4 or more factors~~

Data source Records or files

Scope of review NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

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

For Renewal Surveys: 36 months.

For All Surveys: For credentialing files where verification of DEA or CDS is before June 1, 2020, and a practitioner who is DEA- or CDS-eligible does not have a DEA or CDS certificate, NCQA accepts either the verification process required in the 2022 standards or the applicable prior year's standards, which state, "If a qualified practitioner does not have a valid DEA or CDS certificate, the organization notes this in the credentialing file and arranges for another practitioner to fill prescriptions."

Explanation   **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CR<u>A</u> 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

For factors with verification time limits, NCQA counts back from the decision date to the verification date to assess timeliness of verification.

All credentials must be current at the time of the Credentialing Committee decision.

Appropriate documentation

Each file contains evidence of verification from a listed source and review by organization staff. Refer to CR 1, Element A, *Related information,* "Appropriate documentation."

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Verification time limit: Prior to the credentialing decision.

This factor applies to practitioners who are qualified to write prescriptions. The organization verifies that the practitioner's Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members. Acceptable verification sources:

- DEA or CDS agency.
- DEA or CDS certificate, or a photocopy of the certificate.
- Documented visual inspection of the original DEA or CDS certificate.
- Confirmation from the American Medical Association (AMA) Physician Masterfile (DEA only).
- American Osteopathic Association Official Osteopathic Physician Profile Report or Physician Master File (DEA only).
- Confirmation from the state pharmaceutical licensing agency, where applicable.

Pending DEA certificates. The organization may credential a practitioner whose DEA certificate is pending if it has a documented process for allowing a practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner whose DEA is pending until the practitioner has a valid DEA certificate.

DEA- and CDS-eligible practitioners who do not have certificates. The organization verifies that all DEA- and CDS-eligible practitioners who do not have a valid DEA/CDS certificate, and for whom prescribing controlled substance is in the scope of their practice, have in place a designated practitioner to write prescriptions on their behalf. The organization documents the practitioner's lack of DEA/CDS certificate in the credentialing file and obtains the name of a designated alternate prescriber from the practitioner. If the alternate prescriber is a practice rather than an individual, the file may include the practice name. The organization is not required to arrange an alternate prescriber.

If the practitioner states in writing that they do not prescribe controlled substances and that in their care do not require controlled substances, they are therefore not required to have a DEA/CDS certificate but must describe their process for handling instances when a patient requires a controlled substance. The organization includes the practitioner's statement and process description in the credentialing file.

Element C: Verification of Education and Training

The organization verifies the practitioner's education, training.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

100%	80%	50%	20%	0%
High (90-100%) on file review for 6 factors	High (90%-100%) on file review for 4-5 factors and medium (60-89%) on file review for the remaining 1-2 factors	At least medium (60-89%) on file review for 6 factors	Low (0-59%) on file review for 1-3 factors	Low (0-59%) on file review for 4 or more factors

Data source   Records or files

Scope of review   NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

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

For Renewal Surveys: 36 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CRA 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

For factors with verification time limits, NCQA counts back from the decision date to the verification date to assess timeliness of verification.

All credentials must be current at the time of the Credentialing Committee decision.

Appropriate documentation

Each file contains evidence of verification from a listed source and review by organization staff. Refer to CRA 1, Element A, *Related Information,* "Appropriate documentation."

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Education and training

Verification time limit: Prior to the credentialing decision.

The organization verifies the highest of the following three levels of education, ~~and~~ training obtained by the practitioner as appropriate:

1. Board certification.
2. Residency.
3. Graduation from medical or professional school.

Additionally, the organization verifies fellowship, if applicable.

The organization uses any of the following to verify education and training:

- The primary source.
- The state licensing agency, specialty board or registry, if it performs primary source verification.
  - The organization:
    - Obtains written confirmation at least annually from the state licensing agency, specialty licensing agency, specialty board or registry that primary source verifies education and training information, *or*
    - Provides a printed, dated screenshot of the state licensing agency, specialty board or registry website displaying the statement that it performs primary source verification of practitioner education and training information, *or*
    - Provides evidence of a state statute requiring the licensing agency, specialty board or registry to obtain verification of education and training directly from the institution.
- Sealed transcripts, if the organization provides evidence that it inspected the contents of the envelope and confirmed that the practitioner completed (graduated from) the appropriate training program.

~~Verification of fellowship does not meet the intent of this factor.~~

Future dates of program completion do not meet the intent of this factor.

Other acceptable verification sources for physicians (MD, DO)

Board certification

- For physicians (MD, DO):
  - ABMS or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided.
    ***Note:** The ABMS "Is Your Doctor Board Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.*
  - AMA Physician Masterfile.
  - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.

      – Boards in the United States that are not members of the ABMS or AOA (e.g., NBPAS), if the organization documents within its policies and procedures which specialty boards it accepts and obtains annual written confirmation from the board that the board performs primary source verification of completion of education and training.

- For other health care professionals:
  – Registry that performs primary source verification of board status if the organization obtains annual written confirmation that the registry performs primary source verification of board certification status.

Expired board certification meets requirements because primary-source verified education and training information would not change with expiration of board certification.

Graduation from medical school

- AMA Physician Masterfile.
- American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.
- Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

Completion of residency training

- AMA Physician Masterfile.
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
- FCVS for closed residency programs.

NCQA only recognizes residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Accreditation Council for Graduate Medical Education—International, the American Osteopathic Association (in the United States), the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada.

Element D: Verification of Board Certification Status

The organization verifies practitioners board certification status <u>within 90 calendar days at the time of the credentialing decision</u>, if applicable.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 6 factors~~	~~High (90%-100%) on file review for 4-5 factors and medium (60-89%) on file review for the remaining 1-2 factors~~	~~At least medium (60-89%) on file review for 6 factors~~	~~Low (0-59%) on file review for 1-3 factors~~	~~Low (0-59%) on file review for 4 or more factors~~

Data source	Records or files
Scope of review	NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.
Look-back period	*For Initial Surveys:* 6 months. *For Renewal Surveys:* 36 months.
Explanation	**THIS IS A MUST-PASS ELEMENT**. This element applies to:

- Practitioners in the scope of credentialing as defined in CR<u>A</u> 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

For factors with verification time limits, NCQA counts back from the decision date to the verification date to assess timeliness of verification.

All credentials must be current at the time of the Credentialing Committee decision.

Appropriate documentation

Each file contains evidence of verification from a listed source and review by organization staff. Refer to CR<u>A</u> 1, Element A, *Related Information,* "Appropriate documentation."

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Verification time limit: ~~180~~ <u>90</u> calendar days.

NCQA does not require board certification; however, the organization verifies current certification status of practitioners who state that they are board certified.

The organization documents the expiration date of the board certification in the credentialing file. If a practitioner has a certification that does not expire (e.g., a lifetime certification status), the organization verifies that board certification is current and documents the date of verification. <u>If the expiration date is not provided, the organization may leave the expiration date blank in the practitioner file.</u>

Verification sources. The organization uses any of the following to verify board certification:

- For all practitioner types:
    – The primary source (appropriate specialty board).
    – The state licensing agency if it primary source verifies board certification.
- For physicians (MD, DO), the sources listed under Factor 3: Education and Training.

Note: *Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification to members.*

Element E: Verification of Work History

The organization verifies practitioner work history <u>within 90 calendar days at the time of the credentialing decision.</u>

Scoring

Met	Partially Met	Not Met
<u>To be determined</u>	<u>To be determined</u>	<u>To be determined</u>

Scoring

100%	80%	50%	20%	0%
~~High (90-100%) on file review for 6 factors~~	~~High (90%-100%) on file review for 4-5 factors and medium (60-89%) on file review for the remaining 1-2 factors~~	~~At least medium (60-89%) on file review for 6 factors~~	~~Low (0-59%) on file review for 1-3 factors~~	~~Low (0-59%) on file review for 4 or more factors~~

Data source Records or files

Scope of review NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

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

For Renewal Surveys: 36 months.

Explanation **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CR<u>A</u> 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

For factors with verification time limits, NCQA counts back from the decision date to the verification date to assess timeliness of verification.

All credentials must be current at the time of the Credentialing Committee decision.

Appropriate documentation

Each file contains evidence of verification from a listed source and review by organization staff. Refer to CR<u>A</u> 1, Element A, *Related Information,* "Appropriate documentation."

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Verification time limit: ~~365~~ <u>90</u> calendar days.

Employment dates. The organization obtains a minimum of the most recent 5 years of work history as a health professional through the practitioner's application or CV. If the practitioner has fewer than 5 years of work history, the time frame starts at the initial licensure date.

The application or CV includes the beginning and ending month and year for each position of employment experience, unless the practitioner has had continuous employment for 5 years or more with no gap. In such a case, providing the year meets the intent of this factor.

Gaps in work history. The organization documents its review of the practitioner's work history and any gaps on the application, CV, checklist or other identified documentation methods (i.e., signature or initials of staff who reviewed the history and the date of review).

- *If a gap in employment exceeds 6 months,* the practitioner clarifies the gap verbally or in writing. The organization documents a verbal clarification or includes the written notice in the practitioner's credentialing file.

- *If the gap in employment exceeds 1 year,* the practitioner clarifies the gap in writing and the organization documents its review.

Element F: Verification of Malpractice History

The organization verifies a history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner <u>within 90 calendar days </u>at the time of the credentialing decision.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 6 factors~~	~~High (90%-100%) on file review for 4-5 factors and medium (60-89%) on file review for the remaining 1-2 factors~~	~~At least medium (60-89%) on file review for 6 factors~~	~~Low (0-59%) on file review for 1-3 factors~~	~~Low (0-59%) on file review for 4 or more factors~~

Data source Records or files

Scope of review NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

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

For Renewal Surveys: 36 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to:

- Practitioners in the scope of credentialing as defined in CR<u>A</u> 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

For factors with verification time limits, NCQA counts back from the decision date to the verification date to assess timeliness of verification.

All credentials must be current at the time of the Credentialing Committee decision.

Appropriate documentation

Each file contains evidence of verification from a listed source and review by organization staff. Refer to CR<u>A</u> 1, Element A, *Related Information,* "Appropriate documentation."

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Verification time limit: ~~180~~ <u>90</u> calendar days.

The organization obtains confirmation of the past 5 years of malpractice settlements from the malpractice carrier or queries the National Practitioner Databank (NPDB). The 5-year period may include residency or fellowship years. The organization is not required to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship.

Element G: Verification of State Licensing Sanctions

The organization verifies state sanctions, restrictions on licensure and limitations on scope of practice <u>within 90 calendar days at the time of the credentialing decision.</u>

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 2 factors~~	~~High (90-100%) on file review for 1 factor and medium (60-89%) on file review for 1 factor~~	~~Medium (60-89%) on file review for 2 factors~~	~~Low (0-59%) on file review for 1 factor~~	~~Low (0-59%) on file review for 2 factors~~

Data source Records or files

Scope of review	NCQA reviews verification of sanctions information within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.
Look-back period	*For Initial Surveys:* 6 months.
	For Renewal Surveys: 36 months.
Explanation	**THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CRA 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

NCQA counts back from the decision date to the verification date to assess timeliness of verification.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Appropriate documentation

Verification time limit: ~~180~~ 90 calendar days.

Each file contains evidence of verification of sanction information from a listed source and review by organization staff. Refer to CRA 1, Element A, *Related information,* "Appropriate documentation."

The organization verifies state sanctions, restrictions on licensure and limitations on scope of practice in all states where the practitioner provides or has provided care to members for the most recent 5-year period available. If practitioners were licensed in more than one state in the most recent 5-year period, the query must include all states in which they provided care. The organization may obtain verification from the NPDB for all practitioner types listed below.

The following sources may be used for verification:

- *Physicians:*
  - Appropriate state agencies.
  - Federation of State Medical Boards (FSMB).
- *Chiropractors*:
  - State Board of Chiropractic Examiners.
  - Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD).
- *Oral surgeons*:
  - State Board of Dental Examiners or State Medical Board.
- *Podiatrist*s:
  - State Board of Podiatric Examiners.
  - Federation of Podiatric Medical Boards.
- *Other nonphysician health care professionals*:
  - State licensure or certification board.
  - Appropriate state agency.

Element H: Verification of Medicare and Medicaid Sanctions <u>and Exclusions</u>

The organization verifies practitioner's Medicare and Medicaid sanctions <u>and exclusions within 90 calendar days.</u>

Scoring

Met	Partially Met	Not Met
<u>To be determined</u>	<u>To be determined</u>	<u>To be determined</u>

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for 2 factors~~	~~High (90-100%) on file review for 1 factor and medium (60-89%) on file review for 1 factor~~	~~Medium (60-89%) on file review for 2 factors~~	~~Low (0-59%) on file review for 1 factor~~	~~Low (0-59%) on file review for 2 factors~~

Data source   Records or files

Scope of review   NCQA reviews verification of sanctions information within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

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

For Renewal Surveys: 36 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CR<u>A</u> 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

NCQA counts back from the decision date to the verification date to assess timeliness of verification.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Appropriate documentation

Verification time limit: ~~180~~ <u>90</u> calendar days.

Each file contains evidence of verification of sanction <u>and exclusion</u> information from a listed source and review by organization staff. Refer to CR<u>A</u> 1, Element A, *Related information,* "Appropriate documentation."

The organization ~~may~~ obtains verification **~~from any~~** ~~of~~ <u>from</u> the following sources, <u>as applicable:</u>

- State Medicaid agency <u>for all organizations that have a Medicaid line a business.</u> ~~or intermediary~~.

- All line of business obtain verification from any of the following sources:
- ~~Medicare intermediary.~~
    – List of Excluded Individuals and Entities maintained by OIG ~~and available over the internet~~) or FSMB.
- ~~Medicare Exclusion Database.~~
- ~~Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General.~~
    – AMA Physician Master File.
- ~~FSMB.~~
    – SAM.gov

Exceptions

None.

Related information

Use of verifications in CRA 45: Ongoing Monitoring. The organization may use sanctions information in CRA 45, Element A, factors 1 and 2 to meet CRA 3, Element B if the information is no more than 90~~180~~ calendar-days old and the organization provides documentation that the practitioner was enrolled in alert services at the time of the cited report.

- *Query results.* The organization is not required to share query results with NCQA. NCQA accepts documentation of the query and of the organization's receipt of the information.

CRA 5: Ongoing Monitoring

The organization develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.

Intent

The organization identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.

Element A: Ongoing Monitoring ~~and Interventions~~

The organization implements ongoing monitoring ~~and makes appropriate interventions~~ by:

1. **Collecting and reviewing Medicare and Medicaid sanctions <u>and exclusions</u>.**

2. **Collecting and reviewing sanctions, ~~and~~ limitations <u>and expiration</u> on licensure.**

3. **Collecting and reviewing complaints.**

4. **Collecting and reviewing information from identified adverse events.**

5. ~~**Implementing appropriate interventions when it identifies instances of poor quality related to factors 1–4.**~~

Scoring

Met	Partially Met	Not Met
<u>3-4 factors</u>	<u>2 factors</u>	<u>0-1 factors</u>

Scoring

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

Data source   Documented process, Reports, Materials, Records or files

Scope of review   NCQA reviews the organization's policies and procedures.

<u>NCQA also reviews evidence of the organization's enrollment, contract, subscription to an approved source or reports obtained from the approved sources.</u> ~~of interventions 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 a delegate. This element applies to practitioners in the scope of credentialing as defined in CRA 1, Element A.

The organization conducts ongoing monitoring between recredentialing cycles.

Factor 1: **Sources for Medicare/Medicaid sanctions <u>and exclusions</u>**

- State Medicaid agency <u>for all organizations that have a Medicaid line of business.</u> ~~or intermediary~~.
- ~~Medicare intermediary.~~
- <u>All line of business obtain verification from any of the following sources</u>:
  - List of Excluded Individuals and Entities maintained by OIG ~~and available over the internet~~)
  - FSMB.
- ~~Medicare Exclusion Database.~~
- ~~Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General.~~
  - AMA Physician Master File.
  - <u>SAM.gov</u>
  - NPDB.

Factor 2: **Sources for sanctions and limitations <u>and expiration</u> on licensure**

The organization collects and reviews information from any of the following sources~~:~~

- *Physicians:*
  - Appropriate state agencies.
  - FSMB.
  - NPDB.
- *Chiropractors:*
  - State Board of Chiropractic Examiners.
  - Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD).
  - NPDB.
- *Oral surgeons:*
  - State Board of Dental Examiners or State Medical Board, depending on the state.
  - NPDB.
- *Podiatrists:*
  - State Board of Podiatric Examiners.
  - Federation of Podiatric Medical Boards.
  - NPDB.
- *Nonphysician healthcare practitioners:*
  - Appropriate state agency.
  - State licensure or certification board.
  - NPDB.

Factors 1, 2: **Time frame for reviewing sanction information**

~~The organization reviews information within 30 calendar days of its release by the reporting entity.~~

~~If the reporting entity does not publish sanction information on a set schedule, the organization:~~

- ~~Documents that the reporting entity does not release information on a set schedule.~~

> > - ~~Queries for this information at least every 6 months.~~
>
> ~~If the reporting entity does not release sanction information reports, the organization conducts individual queries of credentialed practitioners every 12–18 months.~~
>
> ~~If the organization subscribes to a sanctions alert service, it~~ <u>The organization</u> reviews ~~the~~ information <u>from approved sources</u>
>
> > - <u>At least monthly.</u>
> > - Within <u>10</u> ~~30~~ calendar days of a new alert <u>if subscribed to a continuous monitoring service (e.g., NPDB).</u>
> > - Shares information with the credentialing committee <u>based on criteria defined in CRA 1, Element A: Credentialing Policies</u>.

Factor 3: <u>Collecting and reviewing</u> ~~Investigating~~ complaints

The organization:

- Investigates practitioner-specific member complaints upon their receipt and evaluates the practitioner's history of complaints, if applicable.
- Evaluates the history of complaints for all practitioners at least every 6 months.

Factor 4: **Adverse events**

The organization monitors for adverse events at least <u>monthly.</u> ~~every 6 months.~~

~~The organization may limit monitoring of adverse events to primary care practitioners and high-volume behavioral healthcare practitioners.~~

~~*Factor 5:*~~ ~~**Implementing interventions**~~

~~The organization implements interventions based on its policies and procedures if there is evidence of poor quality that could affect the health and safety of its members.~~

~~Exception~~
~~Factor 5 is NA if there are no sanctions, complaints or adverse events that require the organization to implement an intervention.~~

Examples   None.

Element B: Appropriate Interventions

<u>The organization reports the findings from Element A to the Credentialing Committee and implements interventions as needed.</u>

Scoring

Met	Partially Met	Not Met
<u>The organization meets the requirement.</u>	<u>No scoring option.</u>	<u>The organization does not meet the requirement</u>

Data source   <u>Documented process, Reports</u>

Scope of review	NCQA reviews the organization's policies and procedures for implementing appropriate interventions based on the information found in Element A. NCQA reviews credentialing committee meeting minutes and reviews reports demonstrating how the organization takes action to address ongoing monitoring findings.
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 a delegate. This element applies to practitioners in the scope of credentialing as defined in CRA 1, Element A. The organization follows its policies and procedures outlined in CRA 1, Element A for implementing interventions based on the information found in CRA 4, Element A. The organization reports the findings to its credentialing committee and documents the results of the actions proposed.

Element C: Actions Against Practitioners

The organization has policies and procedures for:

1. The range of actions available to the organization.

2. Making the appeal process known to practitioners.

Scoring

Met	Partially Met	Not Met
2 factors	1 factor	0 factors

Scoring

100%	80%	50%	20%	0%
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

Data source	Documented process
Scope of review	NCQA reviews the organization's policies and procedures.
Look-back period	*For Interim Surveys:* Prior to the survey date. *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. This element applies to practitioners in the scope of credentialing as defined in CRA 1, Element A. *Factor 1:* **Range of actions available** Policies and procedures:

- Specify that the organization reviews participation of practitioners whose conduct could adversely affect members' health or welfare.
- Specify the range of actions that may be taken to improve practitioner performance before termination.
- Specify that the organization reports its actions to the appropriate authorities.

Factor 2: **Making the appeal process known**

No additional explanation required.

Exceptions

None.

Examples   None.

CRA 6: Recredentialing Cycle Length

The organization formally recredentials its practitioners at least every 36 months.

Intent

The organization conducts timely recredentialing.

Element A: Recredentialing Cycle Length

The length of the recredentialing cycle is within the required 36-month time frame.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

100%	80%	50%	20%	0%
High (90-100%) on file review	No scoring option	Medium (60-89%) on file review	No scoring option	Low (0-59%) on file review

Data source   Records or files

Scope of review   *This element applies to Renewal Surveys.*

NCQA reviews the timeliness of recredentialing within a random sample of up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

Look-back period   *For Renewal Surveys:* 36 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CRA 1, Element A.
- Recredentialing files, unless an exception noted below applies.

Each file contains the Credentialing Committee decision date. The 36-month recredentialing cycle begins on the date of the previous credentialing decision. NCQA counts the 36-month cycle to the month, not to the day.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Exception

This element is NA for Initial Surveys.

Related information

Extending the recredentialing cycle length. The organization may extend a practitioner's recredentialing cycle time frame (beyond 36 months) if the practitioner is:

- On active military assignment.
- On medical leave (e.g., maternity leave).
- On sabbatical.

The organization documents this and recredentials the practitioner within 60 calendar days of the practitioner's return to practice.

Termination and reinstatement. If the organization terminates a practitioner for administrative reasons (e.g., the practitioner failed to provide complete credentialing information) and not for quality reasons, it may reinstate the practitioner within 30 calendar days of termination and is not required to perform initial credentialing. The organization performs initial credentialing if reinstatement is more than 30 calendar days after termination.

If the organization does not have the necessary information for recredentialing, it informs the practitioner that this information is needed at least 30 calendar days before the recredentialing deadline and that without this information, the practitioner will be administratively terminated. The organization includes this notification in the practitioner's credentialing file. If the practitioner is subsequently terminated for lack of information, the termination notice should be in the practitioner's file.

Failure to recredential within 36 months. The organization will be scored down if it missed the 36-month time frame for recredentialing a practitioner but did not terminate the practitioner. The organization may recredential the practitioner within 30 calendar days of missing the deadline, but if recredentialing is not completed within 30 calendar days, the organization must initial credential the practitioner.

Termination of delegate. NCQA requires an unbroken string of recredentialing at least every 3 years. If an organization can obtain files from the delegate, it is not required to start over with initial credentialing; it may continue the process begun by the delegate and recredential practitioners when they are due.

If the organization cannot obtain files from the delegate, it must perform initial credentialing within 6 months of the delegate's termination date. The organization is responsible for ensuring that credentialing occurs according to NCQA standards.

Examples   None.

CRA 7: Assessment of Organizational Providers

The organization has written policies and procedures for the initial and ongoing assessment of providers with which it contracts.

Intent

The organization evaluates the quality of providers with which it contracts.

Element A: Review and Approval of Provider

The organization's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it:

1. Confirms that the provider is in good standing with state and federal regulatory bodies.

2. Confirms that the provider has been reviewed and approved by an accrediting body.

3. Conducts an onsite quality assessment if the provider is not accredited.

Scoring

Met	Partially Met	Not Met
2-3 factors	1 factor	0 factors

Scoring

100%	80%	50%	20%	0%
~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

Data source   Documented process

Scope of review   NCQA reviews the organization's policies and procedures in place throughout the look-back period.

Look-back period   *For Interim Surveys:* Prior to the survey date.

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation   Organizational providers refer to facilities providing services to members and where members are directed for services rather than being directed to a specific practitioner. This element applies to all organizational providers with which the organization contracts (e.g., telemedicine providers, urgent care centers).

Factor 1: **Confirmation with state and federal regulatory bodies**

The organization's policies and procedures specify sources used to confirm that providers are in good standing with state and federal requirements, including:

- Applicable state or federal agency.
- Agent of the applicable state or federal agency.
- Copies of credentials (e.g., state licensure) from the provider.

NCQA does not accept an attestation from a provider to the organization regarding the provider's regulatory status.

Factor 2: **Confirmation of review and approval by an accrediting body.**

The organization's policies and procedures specify sources used to confirm the provider's accreditation status, including:

- Applicable accrediting body for each type of organizational provider
- Agent of the applicable accrediting body.
- Copies of credentials (e.g., accreditation report, certificate or decision letter) from the provider.

NCQA does not accept an attestation from a provider to the organization regarding the provider's accreditation status.

Factor 3: **Site visits for unaccredited facilities**

The organization's policies and procedures include:

- Onsite quality assessment criteria for each type of provider.
- A process ensuring that the providers credential their practitioners.

The organization receives credit for this factor if its policies and procedures specify that it contracts only with accredited providers.

If a provider has satellite facilities that follow the same policies and procedures as the provider, the organization may limit site visits to a main facility.

State or federal review in lieu of a site visit. The organization may have a policy to substitute a CMS or state quality review in lieu of a site visit under the following circumstances:

- The CMS or state review is no more than 3 years old.
  - If the CMS or state review is older than 3 years, the organization conducts its own onsite quality review.
- The organization obtains a survey report or letter from CMS or the state, from either the provider or the agency, stating that the facility was reviewed and passed inspection.
  - The report meets the organization's quality assessment criteria or standards.

The organization is not required to conduct a site visit if the provider is in a rural area, as defined by the U.S. Census Bureau (https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html), and the state or CMS has not conducted a site review.

Exceptions

This element is NA for organizations that do not contract with organizational providers.

Related information

Time frame. NCQA does not prescribe a time frame for gathering data to use for assessing organizational providers (e.g., the 180-calendar-day rule, applied against the verification of credentials of individual practitioners, is NA).

Telemedicine organizations. If telemedicine practitioners are credentialed under CRA 1–CRA 6, organizations are not required to also assess the telemedicine organization under CRA 7, but if telemedicine practitioners are not credentialed under CRA 1–CRA 6, the telemedicine organization must be assessed under CRA 7.

Examples   None.

Element B: Medical Providers

The organization includes at least the following medical providers in its assessment:

1. Hospitals.*

2. Home health agencies.

3. Skilled nursing facilities.

4. Free-standing surgical centers.

Critical factors: Score cannot exceed 20% if one critical factor is scored "no."

Scoring

Met	Partially Met	Not Met
3-4 factors	2 factors	0-1 factors

Scoring

100%	80%	50%	20%	0%
~~The organization meets 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets 0 factors~~

Data source   Documented process

Scope of review   NCQA reviews the organization's policies and procedures in place throughout the look-back period.

Look-back period   *For Interim Surveys:* Prior to the survey date.

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation   Factor 1 is a critical factor; if this critical factor is scored "no," the organization's score cannot exceed 20% for the element.

Factors 2–4

No additional explanation required.

Exceptions

This element is NA for organizations that do not contract with organizational providers.

Related information

Non-skilled home health agencies. Home health agencies that only provide home aides (e.g., for help with cooking, dressing, medical appointments) are not within the scope of CRA 7.

Examples   None.

Element C: Behavioral Healthcare Providers

The organization includes behavioral health care facilities providing mental health or substance abuse services in the following settings:

1. Inpatient.

2. Residential.

3. Ambulatory.

	Met	Partially Met	Not Met
Scoring	3 factors	1-2 factors	0 factors

	100%	80%	50%	20%	0%
Scoring	~~The organization meets 3 factors~~	~~No scoring option~~	~~The organization meets 1-2 factors~~	~~No scoring option~~	~~The organization meets 0 factors~~

Data source   Documented process

Scope of review   NCQA reviews the organization's policies and procedures in place throughout the look-back period.

Look-back period   *For Interim Surveys:* Prior to the survey date.

For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation   Assessment policies and procedures address all applicable types of providers, regardless of how many members are treated at the facilities.

The organization is not required to credential organizational providers that operate only as 12-step programs.

Exceptions

This element is NA:

- For organizations that do not contract with organizational providers.
- If all purchasers of the organization's services carve out or exclude behavioral healthcare.

Factor 2 is NA if residential treatment facilities are not part of the organization's benefits package or are unavailable in the service area.

Examples   **Behavioral healthcare providers**
- Psychiatric hospitals and clinics.
- Addiction disorder facilities.
- Residential treatment centers for psychiatric and addiction disorders.

Element D: Assessing Medical Providers

The organization assesses contracted medical health care providers against the requirements and within the time frame in Element A.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

100%	80%	50%	20%	0%
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

Data source   Reports, Records or files

Scope of review   NCQA reviews evidence that the organization assessed the providers in Element B. The organization provides documentation of a tracking mechanism (checklist or spreadsheet); a separate tracking mechanism or report is not required for each provider.

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

For Renewal Surveys: 24 months.

Explanation   The organization is not required to conduct a site visit if the provider is in a rural area, as defined by the U.S. Census Bureau (https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html), and the state or CMS has not conducted a site review.

Exception

This element is NA for organizations that do not contract with organizational providers.

Examples   *Table 1: Assessment of organizational providers tracking log*

Org. Name	Org. Type	Confirmation Dates and Statuses		
		Licensing & Regulatory	**Accrediting Body**	**Site Visit**
Mega	Hospital	4/1/2019; Active	4/10/2019; Name; Active	Rural provider, visit not conducted by the state or CMS.
		4/5/2022; Active	4/15/2022; Name; Active	Rural provider, visit not conducted by the state or CMS.
Downtown Surgery Center	Free-Standing Surgical Center	3/2/2019; Active	None	2/10/2019; CMS Compliant

Org. Name	Org. Type	Confirmation Dates and Statuses		
		Licensing & Regulatory	Accrediting Body	Site Visit
		3/15/2022; Active	None	2/2/2022; CMS Compliant
District Physicians	Home Health	3/2/2019; Active	3/20/2019; Name; Active	Rural provider, visit not conducted by state or CMS.
		3/17/2022; Active	3/20/2022; Name; Active	Rural provider, visit not conducted by state or CMS.

Element E: Assessing Behavioral Healthcare Providers

The organization assesses contracted behavioral healthcare providers against the requirements and within the time frame in Element A.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

100%	80%	50%	20%	0%
~~The organization meets the requirement~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet the requirement~~

Data source   Reports, Records or files

Scope of review   NCQA reviews evidence that the organization assessed the providers in Element C. The organization provides documentation of a tracking mechanism (checklist or spreadsheet); a separate tracking mechanism or report is not required for each provider.

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

For Renewal Surveys: 24 months.

Explanation   The organization is not required to conduct a site visit if the provider is in a rural area, as defined by the U.S. Census Bureau (https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html), and the state or CMS has not conducted a site review.

The organization is also not required to conduct a site visit of ambulatory facilities that are not part of the benefits package or are not available in the service area.

Exceptions

This element is NA:

- For organizations that do not contract with organizational providers.
- If all purchasers of the organization's services carve out or exclude behavioral healthcare.

The organization provides evidence to support the score of "NA."

Examples

Table 2: Assessment of behavioral healthcare organizational providers tracking log

| | | Confirmation Dates and Statuses | | |
Org. Name	Org. Type	Licensing & Regulatory	Accrediting Body	Site Visit
Mega X	Ambulatory	4/1/2019; Active	4/10/2019; Name; Active	NA
		4/5/2022; Active	4/15/2022; Name; Active	NA
Getting Better	Residential	3/2/2019; Active	None	2/2/2019; CMS Compliant
		3/15/2022; Active	None	2/10/2022; CMS Compliant

CR Certification Standards (CRC)
Applicable to Certifications (each standard applies only to its accompanying Certification)

CRC 1: Written Policies and Procedures

The organization has written policies and procedures for verification, frequency of reporting and management of credentials data.

Intent

The organization clearly documents the methods, sources and processes it uses to gather, verify and report credentials data.

Element A: Policies and Procedures

The organization's credentialing policies and procedures address:

1. The scope of verification activities, including practitioner type and credentials.

2. The process for ensuring that time-sensitive information is no more than <u>60</u> calendar-days old, where specified, when reported to clients or the parent organization.

3. The responsibilities of staff in completing verification activities.

4. The methods used to access and verify credentials information.

5. The sources used to obtain and verify credentials information.

6. The process for compiling and reporting information to clients or the parent organization.

7. The provisions for periodic review, update and approval.

8. <u>The process for documenting information and activities in credentialing files.</u>

	Met	Partially Met	Not Met
Scoring	8 factors	5-7 factors	0-4 factors

	100%	80%	50%	20%	0%
Scoring	~~The organization meets 7 factors~~	~~The organization meets 5-6 factors~~	~~No scoring option~~	~~The organization meets 4 factors~~	~~The organization meets 0-3 factors~~

Data source   Documented process, Reports, Materials

Scope of review   NCQA reviews the organization's policies and procedures that are in place throughout the look-back period.

For factor 6, NCQA also reviews evidence that the organization maintains and reports the most recent data from the source, when applicable.

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

For Renewal Surveys: 24 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

This element may not be delegated. <u>All organizations must have policies and procedures for this element regardless of the certification(s) selected.</u>

Factors 1–7: **Credentialing verification process**

The credentialing policies and procedures:

- Define the types of practitioners within the scope of credentialing (e.g., practitioners who are licensed, certified or registered through the state to practice independently), for which the organization is contracted to provide credentialing verification services or its own practitioners.
- State that the organization verifies the following credentials of each practitioner in the scope of credentialing, within the required time period, as applicable, for the certification option selected:

Credential	Verification Time Limit
License to practice	~~120~~ 60 calendar days
Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certification	Prior to reporting
Education and training	Prior to reporting
Work history	~~305~~ 60 calendar days
Professional liability claims settlement history	~~120~~ 60 calendar days
State sanctions	~~120~~ 60 calendar days
Medicare and Medicaid sanctions	~~120~~ 60 calendar days
Application with attestation	~~305~~ 60 calendar days

The organization documents verification in the practitioner credentialing file.

The credential verification may not be older than the specified verification time limit (~~120 or 305~~ 60 calendar days) when reported to the client. The organization only needs to verify static credentials (e.g., evidence of medical school graduation or completion of residency) once and may provide this information to numerous clients.

~~NCQA does not require the organization to verify credentials every 120 or 305 calendar days.~~

Reverification of information that exceeds the time limit is not necessary, unless the information is being reported to the client.

The policies and procedures also:

- Describe how staff conduct credentialing verification activities, including appropriate handling of time-sensitive credentialing information and documentation of verification activities. Refer to *Related information.*
- Specify how the organization:
  - Obtains and maintains credentials information.
  - Reports credential information to its clients.

- List the verification sources used for each credential by practitioner type. Acceptable verification sources are:
  - The primary source (or its website).
  - ~~A contracted agent of the primary source, if the organization obtains documentation indicating that the agent has been contracted by the primary source to verify credentials on its behalf.~~
  - An NCQA-accepted source listed for the credential (or its website).
- Describe the process for compiling aggregate reports and data files from the primary and NCQA-approved sources. At a minimum, the organization reviews reports and data files from primary and NCQA-approved sources as often as a fully updated data source is available, unless:
  - The source updates its data files on ongoing basis (e.g., daily). In such cases, the organization updates its database at least quarterly.
  - The source releases reports or updated data files less than semiannually. In such cases, the organization queries the source for individual practitioners.
- Describe the process for populating the database and for providing its clients or parent organization with the most recent data available from the source. When applicable, NCQA reviews:
  - The contract with the data source.
  - The data-tape library, to confirm that data used are the most recent available.
  - Invoices for source data.
- Canceled checks showing full payment for source data.
- Define the process for periodic review of the policies and procedures and for updates, as necessary.
- Describe the process for providing accurate information to clients, correcting discrepancies, and notifying practitioners or clients when credentialing information obtained through the verification process varies substantially from that provided by the practitioner, including, but not limited to:
  - Updated information.
  - Erroneous information.

The policies and procedures include the dates of implementation and evidence of approval by the governing body or designee.

Factors 1–7: **Credentialing verification process**

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.

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.~~

Verification 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. Staff who verified the credentials must sign or initial the verification.

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.

Use of web crawlers. The organization may use web crawlers to verify credentialing information from approved sources. A "web crawler" is software that retrieves information directly from a primary or approved source website (e.g., the state licensing or certification agency). The organization provides documentation that the web crawler collects information only from approved sources, and documents that staff reviewed the credentialing information.

Examples   ***Automated credentialing systems***

- Adobe Sign.
- DocuSign.

Element B: Review and Approval by a Governing Body

The organization's credentialing policies and procedures have been:

1. Reviewed by a governing body or designee.

2. Approved by a governing body or designee.

Scoring

Met	Partially Met	Not Met
2 factors	1 factor	0 factors

Scoring

100%	80%	50%	20%	0%
~~The organization meets 2 factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets 0 factors~~

Data source Documented process, Reports

Scope of review NCQA reviews the organization's minutes or signed credentialing policies and procedures (that were in place throughout the look-back period) demonstrating review and approval.

If an individual reviews and approves the credentialing policies and procedures, rather than a governing body, NCQA also reviews the organization's policies and procedures for evidence that the organization validates the role of the designated individual.

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

For Renewal Surveys: 24 months.

Explanation This element may not be delegated.

Factors 1, 2: **Review and approval by a governing body or designee**

The organization's credentialing policies and procedures have been reviewed and approved by a governing body or designee. The organization's policies and procedures describe the role of the individual who has been designated to review and approve the credentialing policies and procedures.

Examples None.

CRC 2: Verifying and Reporting Licensure

The organization collects and reports licensure from the state licensing agency.

Intent

The organization verifies licensure so managed care clients can evaluate and select practitioners based on current licensure information.

Element A: Verifying Licensure

The organization verifies licensure through the state licensing agency.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

100%	80%	50%	20%	0%
High (90-100%) on file review	No scoring option	No scoring option	No scoring option	Low (less than 90%) on file review

Data source Records or files

Scope of review NCQA reviews verification of licensure in a random sample of 75 credentialing files processed by the organization during the look-back period.

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

For Renewal Surveys: 24 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Credentials verification, documentation and timeliness

The organization documents verification from the primary source or NCQA-approved sources and verifies and reports all credentials to the client within NCQA specified time limits. The practitioner's credentials file contains sufficient documentation to demonstrate that the information was present when it was reported to the client.

Licensure

Verification time limit: ~~120~~ 60 calendar days. The verification may not be older than ~~120~~ 60 calendar days when it is reported to the client.

The organization verifies that the practitioner has a valid and current license to practice at the time the credentialing information is reported to the client. If the practitioner's license is not valid or current, the organization reports this to the client.

The organization must verify licenses directly from the state licensing or certification agencies (or their website) in all states where the practitioner provides care to members.

Exceptions

None.

Related information

180 calendar days vs. 120 calendar days

Managed care clients participating in NCQA Accreditation programs must ensure that most credentials information is no more than 180 calendar-days old at the time of the Credentialing Committee's decision, unless otherwise noted in the standards.

For an organization participating in the NCQA CVO Certification program, the information should be no more than 120 calendar-days old when it is reported to the organization's client and designated as ready for committee review.

NCQA determines performance against the 120-calendar-day rule by counting back from the date reported to the client to the verification date.

CRC 3: Verifying and Reporting DEA or CDS Certification

The organization collects and reports DEA or CDS certification from the primary source or NCQA-approved sources.

Intent

The organization verifies DEA and CDS certification so managed care clients can evaluate and select practitioners based on current information.

Element A: Verifying DEA or CDS Certification

The organization verifies DEA or CDS certification from the primary source or NCQA-approved sources.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

100%	80%	50%	20%	0%
~~High (90-100%) on file review~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~Low (less than 90%) on file review~~

Data source   Records or files

Scope of review   NCQA reviews verification of DEA or CDS certification in a random sample of 75 credentialing files processed by the organization during the look-back period.

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

For Renewal Surveys: 24 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Credentialing verification, documentation and timeliness

The organization documents verification from the primary source or NCQA-approved sources, and verifies and reports all credentials to the client within NCQA specified time limits. The practitioner's credentials file contains sufficient documentation to demonstrate that the information was present when it was reported to the client.

Verification of DEA or CDS certification
Verification time limit: Prior to reporting to client. The organization verifies that the practitioner has a current DEA or CDS certification at the time the credentialing information is reported to the client. If the practitioner's DEA or CDS certificate is not current, the organization reports this to the client.

This element applies to practitioners who are qualified to write prescriptions. The organization verifies that the practitioner's Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members. Acceptable verification sources:

- DEA or CDS agency.
- DEA or CDS certificate, or a photocopy of the DEA or CDS certificate.
- Documented visual inspection of the original DEA or CDS certificate.
- Confirmation from the American Medical Association (AMA) Physician Masterfile (DEA only).
- American Osteopathic Association Official Osteopathic Physician Profile Report or Physician Masterfile (DEA only).
- Confirmation from the state pharmaceutical licensing agency, where applicable.

Pending DEA certificates

The organization may credential a practitioner whose DEA certificate is pending if it has a documented process for allowing a practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner whose DEA is pending until the practitioner has a valid DEA certificate.

DEA- and CDS-eligible practitioners who do not have a certificate

The organization verifies that all DEA- and CDS-eligible practitioners who do not have a valid DEA/CDS certificate and for whom prescribing controlled substance is in the scope of their practice, have in place a designated practitioner to write prescriptions on their behalf. The organization documents the practitioner's lack of DEA/CDS certificate in the credentialing file and obtains the name of a designated alternate prescriber from the practitioner. If the alternate prescriber is a practice rather than an individual, the file may include the practice name. The organization is not required to arrange an alternate prescriber.

If the practitioner states in writing that they do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances, they are therefore not required to have a DEA/CDS certificate, but must describe their process for handling instances when a patient requires a controlled substance. The organization includes the practitioner's statement and process description in the credentialing file.

Exceptions

None.

Examples   **DEA- and CDS- eligible practitioner who does not have a certificate**

Practitioner's statement. I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management.

CRC 4: Verifying and Reporting Education and Training

The organization collects and reports education ~~and~~ training _and fellowship_ from the primary source or NCQA-approved sources.

Intent

The organization verifies education and training so managed care clients can evaluate and select practitioners based on current information.

Element A: Verifying Education and Training

The organization verifies education and training from the primary source of NCQA-approved sources.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

100%	80%	50%	20%	0%
~~High (90-100%) on file review~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~Low (less than 90%) on file review~~

Data source   Records or files

Scope of review   NCQA reviews verification of education and training in a random sample of 75 credentialing files processed by the organization during the look-back period.

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

For Renewal Surveys: 24 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Credentials verification, documentation and timeliness

The organization documents verification from the primary source or NCQA-approved sources and verifies and reports all credentials to the client within NCQA specified time limits. The practitioner's credentials file contains sufficient documentation to demonstrate that the information was present when it was reported to the client.

Education and training

Verification time limit: Prior to reporting to the client.

The organization verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate:

1. Board certification (as required in <u>CRC 5</u><s>CVO 7</s>).
2. Residency.
3. Graduation from medical or professional school.

<u>Additionally, the organization verifies fellowship, if applicable.</u>

The organization uses any of the following to verify education and training:

- The primary source
- The state licensing agency, specialty board or registry, if it performs primary source verification.
  - The organization:
    - Obtains written confirmation of primary source verification from the primary source at least annually, ***or***
    - Provides a printed, dated screenshot of the state licensing agency, specialty board or registry website displaying the statement that it performs primary source verification of practitioner education and training information, ***or***
    - Provides evidence of a state statute requiring the licensing agency, specialty board or registry to obtain verification of education and training directly from the institution.
- Sealed transcripts, if the organization provides evidence that it inspected the contents of the envelope and confirmed that the practitioner completed (graduated from) the appropriate training program.

<s>Verification of fellowship does not meet the intent of this element.</s>

Future dates of program completion do not meet the intent of this factor.

Other acceptable verification sources for physicians (MD, DO)

Board certification

- *For physicians (MD, DO):*
  - ABMS or its member boards or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided.
    Note: The ABMS "Is Your Doctor Board Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.
  - AMA Physician Masterfile.
  - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
  - Boards in the United States that are not members of the ABMS or AOA (e.g., NBPAS), if the organization documents within its policies and procedures which specialty boards it accepts and obtains annual written confirmation from the board that the board performs primary source verification of completion of education and training.
- For other health care professionals:
  - Registry that performs primary source verification of board status, if the organization obtains annual written confirmation that the registry performs primary source verification of board certification status.

Graduation from medical school
- AMA Physician Masterfile.
- American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.
- Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

Completion of residency training
- AMA Physician Masterfile.
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
- FCVS for closed residency programs.

NCQA only recognizes residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Accreditation Council for Graduate Medical Education—International, the American Osteopathic Association (in the United States), the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada.

Exception

This element is NA for recredentialing files.

Examples   None.

CRC 5: Verifying and Reporting Board Certification Status

The organization verifies and reports practitioner board certification status from the primary source or NCQA-approved sources.

Intent

The organization verifies board certification status so managed care clients can evaluate and select practitioners based on current information.

Element A: Verifying Board Certification Status

The organization verifies practitioner board certification status from the primary source or NCQA-approved sources.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

100%	80%	50%	20%	0%
High (90-100%) on file review	No scoring option	No scoring option	No scoring option	Low (less than 90%) on file review

Data source   Records or files

Scope of review   NCQA reviews verification of practitioner board certification status in a random sample of 75 credentialing files processed by the organization during the look-back period.

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

For Renewal Surveys: 24 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Credentials verification, documentation and timeliness

The organization documents verification from the primary source or NCQA-approved sources and verifies and reports all credentials to the client within NCQA specified time limits. The practitioner's credentials file contains sufficient documentation to demonstrate that the information was present when it was reported to the client.

Board certification status

Verification time limit: ~~120~~ 60 calendar days. The verification may not be older than ~~120~~ 60 calendar days when it is reported to the client.

The organization verifies current certification status of practitioners who state that they are board certified. If the practitioner is no longer board certified, the organization reports this to the client.

The organization documents the expiration date of board certification in the credentialing file. If a practitioner has a certification that does not expire (e.g., a lifetime certification status) the organization verifies that board certification is current and documents the date of verification. If the expiration date is not provided, the organization may leave the expiration date blank in the practitioner file.

Verification sources

The organization uses any of the following to verify board certification:

- For all practitioner types:
  – The primary source (appropriate specialty board).
  – The state licensing agency if it primary source verifies board certification.
- For physicians (MD, DO), the sources listed under *CRC 4:~~CVO 6~~: Verifying and Reporting Education and Training.*

Exceptions

This element is NA if the practitioner is not board certified.

~~Related information~~

~~180 calendar days vs. 120 calendar days~~

~~Managed care clients participating in NCQA Accreditation programs must ensure that most credentials information is no more than 180 calendar-days old at the time of the Credentialing Committee's decision, unless otherwise noted in the standards.~~

~~For an organization participating in the NCQA CVO Certification program, the information should be no more than 120 calendar-days old when it is reported to the organization's client and designated as ready for committee review.~~

~~NCQA determines performance against the 120-calendar-day rule by counting back from the date of the report to the client to the verification date.~~

Examples   None.

CRC 6: Verifying and Reporting Work History

The organization collects and reports work history through the practitioner's application or curriculum vitae.

Intent

The organization verifies work history so managed care clients can evaluate and select practitioners based on current information.

Element A: Verifying Work History

The organization verifies work history through the practitioner's application or curriculum vitae.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

100%	80%	50%	20%	0%
High (90-100%) on file review	No scoring option	No scoring option	No scoring option	Low (less than 90%) on file review

Data source — Records or files

Scope of review — NCQA reviews verification of work history in a random sample of 75 credentialing files processed by the organization during the look-back period.

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

For Renewal Surveys: 24 months.

Explanation — **THIS IS A MUST-PASS ELEMENT.**

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Credentials verification, documentation and timeliness

The practitioner's credentials file contains sufficient documentation to demonstrate that the information was present when it was reported to the client.

Work history

Verification time limit: ~~305~~ 60 calendar days. The verification may not be older than ~~305~~ 60 calendar days when it is reported to the client.

Employment dates

The organization obtains a minimum of the most recent 5 years of work history as a health professional through the practitioner's application or CV. If the

practitioner has fewer than 5 years of work history, the time frame starts at the initial licensure date.

The application or CV includes the beginning and ending month and year for each position of employment experience, unless the practitioner has had continuous employment for 5 years or more with no gap. In such a case, providing the year meets the intent of this element.

Gaps in work history

The organization documents its review of the practitioner's work history and any gaps on the application, CV, checklist or other identified documentation methods (signature or initials of staff who reviewed the history and the date of review).

- *If a gap in employment exceeds 6 months,* the practitioner clarifies the gap verbally or in writing. The organization documents a verbal clarification or includes the written notice in the practitioner's credentialing file.
- *If the gap in employment exceeds 1 year,* the practitioner clarifies the gap in writing and the organization documents review.

Exception

This element is NA for recredentialing files.

~~**Related information**~~

~~365 calendar days vs. 305 calendar days~~

~~Managed care clients participating in NCQA Accreditation programs must ensure that some of the credentials information is no more than 365 calendar-days old at the time of the Credentialing Committee's decision, unless otherwise noted in the standards.~~

~~For an organization participating in the NCQA CVO Certification program, the information should be no more than 305 calendar-days old when it is reported to the organization's client and designated as ready for committee review.~~

~~NCQA determines performance against the 365-calendar-day rule by counting back from the date of the report to the client to the verification date.~~

Examples   None.

CRC 7: Verifying and Reporting Malpractice History

The organization collects and reports malpractice claims history from the primary source or NCQA-approved sources.

Intent

The organization verifies history of malpractice claims so managed care clients can evaluate and select practitioners based on current information.

Element A: Verifying Malpractice History

The organization verifies the malpractice claims history from the primary source or NCQA-approved sources.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~Low (less than 90%) on file review~~

Data source   Records or files

Scope of review   NCQA reviews verification of history of malpractice claims in a random sample of 75 credentialing files processed by the organization during the look-back period.

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

For Renewal Surveys: 24 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Credentials verification, documentation and timeliness

The organization documents verification from the primary source or NCQA-approved sources and verifies and reports all credentials to the client within NCQA specified time limits. The practitioner's credentials file contains sufficient documentation to demonstrate that the information was present when it was reported to the client.

Malpractice claims history

Verification time limit: ~~120~~ 60 calendar days. The verification may not be older than ~~120~~ 60 calendar days when it is reported to the client.

The organization obtains confirmation of the past five years of malpractice settlements from the malpractice carrier or queries the National Practitioner Databank (NPDB).

The five-year period may include residency or fellowship years. The organization is not required to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship.

Exceptions

None.

Related information

180 calendar days vs. 120 calendar days

Managed care clients participating in NCQA Accreditation programs must ensure that most credentials information is no more than 180 calendar-days old at the time of the Credentialing Committee's decision, unless otherwise noted in the standards.

For an organization participating in the NCQA CVO Certification program, the information should be no more than 120 calendar-days old when it is reported to the organization's client and designated as ready for committee review.

NCQA determines performance against the 120-calendar-day rule by counting back from the date of the report to the client to the verification date.

Examples   None.

CRC 8: Verifying and Reporting State Licensing Board Sanctions

The organization collects and reports state licensing board sanctions from the primary source or NCQA-approved sources.

Intent

The organization verifies state licensing board sanctions so managed care clients can evaluate and select practitioners based on current information.

Element A: Verifying State Licensing Board Sanctions

The organization verifies and reports on state sanctions, restrictions on licensure and limitations on scope of practice from the primary source or NCQA-approved sources.

Scoring

Met	Partially Met	Not Met
To be determined	To be determined	To be determined

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~Low (less than 90%) on file review~~

Data source Records or files

Scope of review NCQA reviews verification of state licensing board sanctions in a random sample of 75 credentialing files processed by the organization during the look-back period.

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

For Renewal Surveys: 24 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Credentials verification, documentation and timeliness

The organization documents verification from the primary source or NCQA-approved sources and verifies and reports all credentials to the client within NCQA specified time limits. The practitioner's credentials file contains sufficient documentation to demonstrate that the information was present when it was reported to the client.

Scope of review for sanctions and limitations on licensure

Verification time limit: ~~120~~ 60 calendar days. The verification may not be older than ~~120~~ 60 calendar days when it is reported to the client.

The organization verifies state sanctions, restrictions on licensure and limitations on scope of practice in all states where the practitioner provides care to members.

The organization may obtain verification from the NPDB for all practitioner types listed below.

The organization verifies the most recent five-year period available through any of the following sources:

- *Physicians:*
  - Appropriate state agencies.
  - Federation of State Medical Boards (FSMB).
- *Chiropractors:*
  - State Board of Chiropractic Examiners.
  - Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD).
- *Oral surgeons:*
  - State Board of Dental Examiners or State Medical Board.
- *Podiatrists:*
  - State Board of Podiatric Examiners.
  - Federation of Podiatric Medical Boards.
- *Other nonphysician health care professionals:*
  - State licensure or certification board.
  - Appropriate state agency.

Exceptions

None.

Related information

180 calendar days vs. 120 calendar days

Managed care clients participating in NCQA Accreditation programs must ensure that most credentials information is no more than 180 calendar-days old at the time of the Credentialing Committee's decision, unless otherwise noted in the standards.

For an organization participating in the NCQA CVO Certification program, the information should be no more than 120 calendar-days old when it is reported to the organization's client and designated as ready for committee review.

NCQA determines performance against the 120-calendar-day rule by counting back from the date of the report to the client to the verification date.

Examples   None.

CRC 9: Verifying and Reporting Medicare/Medicaid Sanctions

The organization collects and reports Medicare/Medicaid sanctions from the primary source or NCQA approved sources.

The organization verifies Medicare/Medicaid sanctions so managed care clients can evaluate and select practitioners based on current information.

Element A: Verifying Medicare/Medicaid Sanctions <u>and Exclusions</u>

The organization verifies and reports on Medicare and Medicaid sanctions <u>and exclusions</u> from the primary source or NCQA-approved sources.

Scoring

Met	Partially Met	Not Met
<u>To be determined</u>	<u>To be determined</u>	<u>To be determined</u>

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~Low (less than 90%) on file review~~

Data source Records or files

Scope of review NCQA reviews verification of Medicare/Medicaid sanctions in a random sample of 75 credentialing files processed by the organization during the look-back period.

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

For Renewal Surveys: 24 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Credentials verification, documentation and timeliness

The organization documents verification from the primary source or NCQA-approved sources and verifies and reports all credentials to the client within NCQA specified time limits. The practitioner's credentials file contains sufficient documentation to demonstrate that the information was present when it was reported to the client.

Medicare/Medicaid sanctions

Verification time limit: ~~120~~ 60 calendar days. The verification may not be older than ~~120~~ 60 calendar days when it is reported to the client.

The organization ~~may~~ obtains verification from ~~any of~~ the following sources:

- State Medicaid agency ~~or intermediary~~ <u>for all organizations that have a Medicaid line of business</u>.
- ~~Medicare intermediary.~~
- All lines of business obtain verification from any of the following sources:
  - List of Excluded Individuals and Entities ~~(maintained by OIG and available over the Internet)~~<u>.</u>
  - <u>FSMB.</u>
  - ~~Medicare Exclusion Database.~~
  - ~~Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General.~~
  - AMA Physician Master File.
  - <u>SAM.gov.</u>
  - NPDB.

Exceptions

None.

~~Related information~~

~~Use of verifications in CVO 14: Ongoing Monitoring of Sanctions.~~ ~~The organization may use sanctions information in CVO 14, Element B, factors 1 and 2 to meet CVO 11 if the information is no more than 120 calendar-days old.~~

~~180 calendar days vs. 120 calendar days.~~

~~Managed care clients participating in NCQA Accreditation programs must ensure that most credentials information is no more than 180 calendar-days old at the time of the Credentialing Committee's decision, unless otherwise noted in the standards.~~

~~For an organization participating in the NCQA CVO Certification program, the information should be no more than 120 calendar-days old when it is reported to the organization's client and designated as ready for committee review.~~

~~NCQA determines performance against the 120-calendar-day rule by counting back from the date of the report to the client to the verification date.~~

Examples   None.

CRC 10: Processing Application and Attestation

The organization processes applications and attestations according to NCQA standards and guidelines.

The organization confirms that practitioners have disclosed information that may adversely affect their ability to provide care, so managed care clients can evaluate and select practitioners based on current information.

Element A: Processing Application/Attestation

The application includes a current and signed attestation and addresses:

1. **Reasons for inability to perform the essential functions of the position.**

2. **Lack of present illegal drug use.**

3. **History of loss of license and felony convictions.**

4. **History of loss or limitation of privileges or disciplinary activity.**

5. **Limitation of privileges or disciplinary actions.**

6. **Current malpractice insurance coverage.**

7. <u>**Practitioner race, ethnicity and language.**</u>

~~8~~7. **Current and signed attestation confirming the correctness and completeness of the application.**

Scoring

Met	Partially Met	Not Met
<u>To be determined</u>	<u>To be determined</u>	<u>To be determined</u>

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~Low (less than 90%) on file review~~

Data source   Records or files

Scope of review   NCQA reviews application and attestation in a random sample of 75 credentialing files processed by the organization during the look-back period.

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

For Renewal Surveys: 24 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Processing of application and attestation

Verification time limit: ~~305~~ 60 calendar days. The practitioner's attestation may not be older than ~~305~~ 60 calendar-days when the application is reported to the client.

For NCQA to count any element as present, the practitioner must sign and date the application and all relevant addenda. The application may refer to all six factors in one question or several questions. Each file contains evidence of review by the organization's staff.

Factor 1: **Inability to perform essential functions**

The inquiry regarding inability to perform essential functions may vary or may exceed NCQA standards, depending on the organization's interpretation of applicable legal requirements, such as the Americans with Disabilities Act (ADA).

Factor 2: **Illegal drug use**

Practitioners may use language other than "drug" to attest they do not use illegal substances. The organization may use more general or extensive language to query practitioners about impairment; language is not required to refer exclusively to the present or only to illegal substances.

Factor 3: **History of loss of license**

At initial credentialing, practitioners attest to any loss of license since their initial licensure. At recredentialing, practitioners attest to any loss of licensure since the last credentialing cycle.

Factor 4: **History of felony convictions**

At initial credentialing, practitioners attest to any felony convictions since their initial licensure. At recredentialing, practitioners attest to any felony convictions since the last credentialing cycle.

Factor 5: **Limitation of privileges or disciplinary actions**

At initial credentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since their initial licensure. At recredentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since the last credentialing cycle.

Factor 6: **Current malpractice coverage**

The application states the amount of a practitioner's current malpractice insurance coverage (even if the amount is $0) and the date when coverage expires.

If the practitioner's malpractice insurance coverage is current and is provided in the application, it must be current as of the date when the practitioner signed the attestation and include the amount of coverage the practitioner has on the date when the attestation was signed. If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates.

Documentation of malpractice insurance coverage may also be a face sheet, a federal tort letter, or employer professional liability policy as an addendum to the application. In this case, the practitioner is not required to attest to malpractice coverage on the application. The face sheet, federal tort letter, or employer professional liability policy must include the insurance effective and expiration dates (the future effective date is acceptable).

Factor 7: Race/ethnicity and language

The organization includes a field on the application for race, ethnicity and language

Factor 8̶7̶: Correctness and completeness of the application

If the application and attestation must be updated, only the practitioner may attest to the update; organization staff may not. If a copy of an application from an entity external to the organization is used, it must include an attestation to the correctness and completeness of the application. NCQA does not count the associated attestation elements as present if the practitioner did not sign the application within the required time frame.

Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired and the disability is documented in the practitioner's file.

CAQH. CAQH has a system that allows the practitioner to update application information electronically. NCQA accepts the last attestation date generated by this system as the date when the practitioner signed and dated the application to attest to its completeness and correctness.

Exceptions

None.

Related information

Use of other applications. The organization may use a state application or an application from another entity if it meets the factors in this element.

If state regulations require the organization to use a credentialing application that does not contain an attestation or all information in factors 1–6̶7̲, the organization attaches the attestation or additional information as an addendum to the application. If state regulations prohibit addenda to the application, the organization attaches a copy of the relevant regulations when it submits the survey tool.

~~*365 calendar days vs. 305 calendar days.* Managed care clients participating in NCQA Accreditation Programs must ensure that some credentials information is no more than 365 calendar-days old at the time of the Credentialing Committee's decision, unless otherwise noted in the standards.~~

~~For an organization participating in the NCQA CVO Certification program, the information should be no more than 305 calendar-days old when it is reported to the organization's client and designated as ready for committee review.~~

~~NCQA determines performance against the 365-calendar-day rule by counting back from the date of the report to the client to the verification date.~~

Examples   **Current malpractice coverage**

Newly licensed practitioners recently hired by Mega Group apply for network participation with the organization. The practitioners applied for but do not currently have malpractice insurance. The practitioners attest on their application that the amount of their malpractice insurance is $0.00. The organization credentials the practitioners.

In this example, the organization met the intent of factor 5. NCQA requires practitioners to attest to the dates and amount of malpractice insurance coverage; it does not require practitioners to have malpractice insurance or maintain a certain amount of malpractice insurance.

CRC 11: Application and Attestation Content

The application includes practitioner health status and history of loss or limitation of license or privileges and other issues that may affect patient care.

Intent

The organization requires practitioners to disclose information that may adversely affect their ability to provide care.

Element A: Contents of the Application

The practitioner application developed by the organization for use by its clients includes:

1. **Reasons for inability to perform the essential functions of the position.**

2. **Lack of present illegal drug use.**

3. **History of loss of license and felony convictions.**

4. **History of loss and limitation of privileges or disciplinary action.**

5. **Limitation of privileges or disciplinary actions.**

6. **Current malpractice insurance coverage.**

7. **Practitioner race, ethnicity and language**

~~6.~~8. **An affirmative attestation to the correctness and completeness of the application.**

Scoring

Met	Partially Met	Not Met
8 factors	No scoring option	0-7 factors

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 6 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-5 factors~~

Data source   Materials

Scope of review   NCQA reviews the organization's practitioner application.

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

For Renewal Surveys: 24 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

This element applies to an organization that uses its own practitioner application for credentials verification or offers it for use by external clients.

Factor 1: **Inability to perform essential functions**

The inquiry regarding inability to perform essential functions may vary or may exceed NCQA standards, depending on the organization's interpretation of applicable legal requirements such as the Americans with Disabilities Act (ADA).

Factor 2: **Illegal drug use**

Practitioners may use language other than "drug" to attest they do not use illegal substances. The organization may use more general or extensive language to query practitioners about impairment; language is not required to refer exclusively to the present or only to illegal substances.

Factor 3: **History of loss of license**

At initial credentialing, practitioners attest to any loss of license since their initial licensure. At recredentialing, practitioners attest to any loss of licensure since the last credentialing cycle.

Factor 4: **History of felony convictions**

At initial credentialing, practitioners attest to any felony convictions since their initial licensure. At recredentialing, practitioners attest to any felony convictions since the last credentialing cycle.

Factor 5: **Limitation of privileges or disciplinary actions**

At initial credentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since their initial licensure. At recredentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since the last credentialing cycle.

Factor 6: **Current malpractice coverage**

The application states the amount of a practitioner's current malpractice insurance coverage (even if the amount is $0) and the date when coverage expires.

If the practitioner's malpractice insurance coverage is current and is provided in the application, it must be current as of the date when the practitioner signed the attestation and include the amount of coverage the practitioner has on the date when the attestation was signed.

If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates.

Documentation of malpractice insurance coverage may also be a face sheet or a federal tort letter as an addendum to the application. In this case, the practitioner is not required to attest to malpractice coverage on the application. The face sheet or federal tort letter must include the insurance effective and expiration dates (the future effective date is acceptable).

Factor 7: <u>**Race/ethnicity and language**</u>

<u>The organization includes a field on the application for race, ethnicity and language</u>

Factor 86: **Correctness and completeness of the application**

If the application and attestation must be updated, only the practitioner may attest to the update; organization staff may not. If a copy of an application from an entity external to the organization is used, it must include an attestation to the correctness and completeness of the application. NCQA does not count the associated attestation elements as present if the practitioner did not sign the application within the required time frame.

Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired and the disability is documented in the practitioner's file.

Exceptions

None.

Examples   None.

CRC 12: Ongoing Monitoring of Sanctions <u>and Exclusions</u>

The organization develops and implements policies and procedures for ongoing monitoring of practitioner sanctions between recredentialing cycles.

Intent

The organization ensures quality and safety of care by monitoring for sanctions against practitioners between recredentialing cycles so client organizations can identify important quality safety issues in a timely manner.

Element A: Policies and Procedures

The organization has policies and procedures that include:

1. Types of disciplinary information reported.

2. A process for discovering and reporting practitioner sanctions <u>and exclusions</u>.

	Met	Partially Met	Not Met
Scoring	2 factors	No scoring option	0-1 factors

	100%	80%	50%	20%	0%
Scoring	~~The organization meets 2 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

Data source   Documented process

Scope of review   NCQA reviews the organization's policies and procedures that are in place throughout the look-back period.

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

For Renewal Surveys: 24 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

The organization's policies and procedures describe:

- The types of disciplinary information it reports.
- The process for reporting disciplinary information.
- The process for discovering and reporting adverse and disciplinary actions against practitioners.

Exceptions

None.

Examples   None.

Element B: Ongoing Monitoring

The organization's policies and procedures for ongoing monitoring address:

1. Medicare and Medicaid sanctions <u>and exclusions</u>.

2. State sanctions, limitations, <u>and expiration</u> on licensure.

Scoring

Met	Partially Met	Not Met
2 factors	No scoring option	0-1 factors

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 2 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-1 factors~~

Data source Documented process

Scope of review NCQA reviews the organization's policies and procedures that are in place throughout the look-back period.

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

For Renewal Surveys: 24 months.

Explanation **THIS IS A MUST-PASS ELEMENT.**

The organization's policies and procedures describe its process for:

- Ongoing monitoring between recredentialing cycles for all practitioners in the scope of credentialing.
- Reporting the information to its clients.
- Reporting evidence of poor quality to clients.

Factor 1: **Sources for Medicare/Medicaid sanctions**

The organization's policies and procedures describe the sources the organization uses to verify Medicare and Medicaid sanctions. <u>The</u> organization uses the following sources.

- State Medicaid agency for all organizations that have a Medicaid line a business. ~~or intermediary~~.
- ~~Medicare intermediary.~~
- All lines of business obtain verification from any of the following sources:
  - AMA Physician Master File entry.
  - *~~FEHB Program Department Record,~~* published by the Office of Personnel Management, Office of the Inspector General.
  - *List of Excluded Individuals and Entities* (maintained by OIG).
  - ~~Medicare Exclusion Database.~~
  - FSMB.
  - NPDB.
  - <u>SAM.gov.</u>

Factor 2: **Sources for sanctions, ~~and~~ limitations <u>and expiration</u> on licensure**

The organization's policies and procedures describe the sources the organization uses to verify sanctions and limitations on licensure.

- *Physicians:*
  - Appropriate state agencies.
  - FSMB.
  - NPDB.
- *Chiropractors:*
  - State Board of Chiropractic Examiners.
  - Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD).
  - NPDB.
- *Oral surgeons:*
  - State Board of Dental Examiners or State Medical Board, depending on the state.
  - NPDB.
- *Podiatrists:*
  - State Board of Podiatric Examiners.
  - Federation of Podiatric Medical Boards.
  - NPDB.
- *Nonphysician healthcare practitioners:*
  - Appropriate state agency.
  - State licensure or certification board.
  - NPDB.

Exceptions

None.

Examples   None.

Element C: Collecting Sanction Information

The organization collects and reports information on the following:

1. Medicare and Medicaid sanctions and exclusions.

2. State sanctions or limitations on licensure.

Scoring

Met	Partially Met	Not Met
2 factors	No scoring option	0-1 factors

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	No scoring option	No scoring option	The organization meets 0-1 factors

Data source   Reports

Scope of review
~~NCQA reviews the organization's monitoring reports and documentation of relevant findings reported to clients.~~

NCQA also reviews evidence of the organization's enrollment, contract, subscription to an approved source or reports obtained from the approved sources.

Look-back period
For Initial Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

Factor 1: **Sources for Medicare/Medicaid sanctions and exclusions**

- State Medicaid agency ~~or intermediary~~ for all organizations that have a Medicaid line of business.
- ~~Medicare intermediary.~~
- All lines of business obtain verification from any of the following sources:
  - AMA Physician Master File entry.
  - ~~*FEHB Program Department Record,* published by the Office of Personnel Management, Office of the Inspector General.~~
  - *List of Excluded Individuals and Entities* (maintained by OIG)~~, available online.~~
  - FSMB.
  - ~~Medicare Exclusion Database.~~
  - NPDB.
  - SAM.gov.

Factor 2: **Sources for sanctions, limitations and expiration on licensure**

~~The organization uses any of the following sources.~~

- *Physicians:*
  - Appropriate state agencies.
  - FSMB.
  - NPDB.
- *Chiropractors:*
  - State Board of Chiropractic Examiners.
  - Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD).
  - NPDB.
- *Oral surgeons:*
  - State Board of Dental Examiners or State Medical Board, depending on the state.
  - NPDB.
- *Podiatrists:*
  - State Board of Podiatric Examiners.
  - Federation of Podiatric Medical Boards.
  - NPDB.
- *Nonphysician healthcare practitioners:*
  - Appropriate state agency.
  - State licensure or certification board.
  - NPDB.

Factors 1, 2: **Time frame for reviewing sanction information**

The organization reviews information ~~within 30 calendar days of its release by the~~ from approved sources:

- At least monthly
- Within 10 ~~30~~ calendar days of a new alert if subscribed to a continuous monitoring service (e.g., NPDB)
- Shares information with the credentialing committee based on criteria defined in CRA 1, Element A: Credentialing Policies .

~~If the reporting entity does not publish sanction information on a set schedule, the organization:~~

- ~~Documents that the reporting entity does not release information on a set schedule.~~
- ~~Queries for this information at least every six months.~~

~~If the reporting entity does not release sanction information reports, the organization conducts individual queries of credentialed practitioners every 12–18 months.~~

~~An organization that subscribes to a sanctions alert service reviews the information within 30 calendar days of a new alert. The organization shows evidence of its subscription to the sanctions alert service during the look-back period and reviews of the information within 30 calendar days of a new alert.~~

Factors 1, 2: **Reporting discovered sanction information**

The organization reviews Medicare/Medicaid and state sanctions information for practitioners whose credentials it has verified and reports the following to the appropriate client:

- Loss or limitation of license.

- State sanctions, restrictions or limitations in scope of practice, as defined by the state licensing agent.
- Medicare or Medicaid sanctions.

If the organization determines there is evidence of poor quality for a practitioner it has credentialed, it reports this evidence to the appropriate client.

Exceptions

None.

Examples   None.