NAMSS
Consolidated Standards
AAAHC, HFAP, NCQA, TJC, URAC
(Includes only standards not listed in the NAMSS Comparison of Accreditation Standards)

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Key AAAHC Core Standards

**Governance:** The governing body addresses and is fully and legally responsible for the operation and performance of the organization. This can be done directly or by appropriate professional delegation.

The governing body must meet at least annually and keep minutes or other records as may be required for the orderly conduct of the organization.

**Credentialing**

Credentials must be verified according to the procedures established in bylaws, rules and regulations. Provisions must be made for expeditious processing of applications for clinical privileges.

There must be a procedure for obtaining primary or secondary source information.

Credentialing is a three-phase process to assess can validate qualifications to provide services.

1. Establish minimum training, experience, and other requirements for physicians and other healthcare professionals
2. Establish a process to review, assess, and validate an individual’s qualifications, including education, training, experience, certification, licensure, and any other competence-enhancing activities against the organization’s established minimum requirements
3. Carries out review, assessment, and validation outlined in the organization’s description of the process

The governing body must:
- establish and is responsible for a credentialing and reappointment process and applying criteria uniformly to all individuals who provide patient care
- approve mechanisms for credentialing, reappointment, and granting of privileges, suspending or terminating clinical privileges, including provisions for appeal of such decisions
- either directly or by delegation, make initial appointment, reappointment, and assignment or curtailment of clinical privileges based on peer evaluation (must be consistent with state law)
- have specific criteria for initial appointment and reappointment of physicians and dentists
- make provisions for expeditious processing of clinical privileges applications
Information that must be monitored on an ongoing basis (at expiration, appointment, and re-appointment, at minimum.):

The organization monitors and document the currency of date sensitive information such as licensure, professional liability insurance (if required), certifications, DEA registrations, and other such items, where applicable, on an ongoing basis.

Privileging

The organization has its own independent process of credentialing and privileging that includes review and approval by the governing body.

Appointment or privileges may not be approved solely on the basis that another organization, such as a hospital, took such action, although this information can be used in consideration of the application.

The governing body provides a process for the initial appointment, reappointment, assignment or curtailment of privileges and practice for allied health care professionals (based on state law and evidence of education, training, experience and competency).

- CVO is okay if you have proper assessment of capability and quality of CVO
- Another health care organization, such as a hospital or group practice, that has carried out primary source or acceptable secondary source verification, provided it supplies directly, without transmission or involvement by the applicant or other third party, original documents or photocopies of the verification reports it has relied upon. A statement that it has performed verification is not sufficient.

Documents, diplomas, certificates or transcripts provided directly by the applicant rather than by the primary or secondary source are not acceptable.
Healthcare Facilities Accreditation Program (HFAP)
Medical Staff Resource Guide

FAIR HEARING AND APPEAL PROCESS (Standard 03.01.20)
The hospital shall have a fair hearing plan for members of the Medical Staff and allied health practitioners. Individuals involved in Peer Review activities shall be impartial peers and shall not have an economic interest in and/or a conflict of interest with the subject of the Peer Review activity. Impartial peer would also exclude individuals with blood relationships, employer/employee relationships, or other potential conflicts that might prevent the individual from giving an impartial assessment, or give the appearance for the potential of bias for or against the subject of the Peer Review. The fair hearing and appeal process may differ for members of the Medical Staff and nonmembers (Allied Health Practitioners). The fair hearing plan outlines the circumstances under which a practitioner may request (or waive) this mechanism:
• Denial.
• Modification or changes in appointment/reappointment category.
• Initial or re-granting of privileges with final review/action by the Governing Body.

UTILIZATION OF OSTEOPATHIC METHODS & CONCEPTS COMMITTEE (OMCC) (Standard 03.05.01)
Only required for hospitals with ten or more Doctors of Osteopathic Medicine who admit and manage patients.

TIME FRAME FOR PROCESSING OF APPLICATIONS (Standard 03.06.08)
A recommendation shall be made to the Medical Executive Committee (MEC) within 60 days of receipt of completed application. The recommendations of the Credentials Committee (function) will be based on individual practitioner’s qualifications and competency at the time the privileges are requested. All recommendations to the Medical Executive Committee (MEC) shall contain a delineation of the privileges to be extended to the applicant.

ONGOING PROFESSIONAL PRACTICE EVALUATION (Standard 03.15.01)
Ongoing professional practice evaluation (OPPE) information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), and/or to revoke an existing privilege prior to or at the time of renewal.

The Medical Staff have a process to monitor the competency of its members. Through an ongoing review of performance measurements, negative trends are tracked and trended in a manner that allows the leadership to identify performance issues and implement strategies that will effect change. Prospective and real-time evaluation is important to ensure the delivery of safe and competent care. The Medical Staff develop
an ongoing professional practice evaluation plan that is applicable to all practitioners with privileges granted by the governing body. The plan for the evaluation of each practitioner’s professional practice is clearly defined. This medical staff approved plan addresses each of the following:

1. Reasons for ongoing professional practice performance evaluations
2. Identification of performance indicators specific to each department of the medical staff
3. Data collection methods
4. Individual(s) responsible for data collection
5. Sources of data, e.g., medical records
6. Frequency of data collection
7. Methods for evaluation and analysis of data
8. Confidentiality and security of data
9. Individuals that may access individual practitioner’s professional practice data
10. Explanation that data will be used as a measure of competency and will be reviewed at time of reappointment to determine eligibility
11. Evaluation of low volume practitioners
12. Triggers for additional, focused monitoring

Processes are established to ensure the confidentiality and security of the ongoing professional practice

FOCUSED PROFESSIONAL PRACTICE EVALUATION (Standard 03.15.02)

The organized medical staff defines the circumstances requiring additional, focused monitoring and evaluation of a practitioner’s professional performance. The focused professional practice evaluation (FPPE) process is designed to be a fair, balanced, and educational approach to ensure the competency of the staff. Focused professional practice evaluation (FPPE) is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.
Selected Joint Commission Standards Related to the Medical Staff

MS.06.01.03 – Credentialing

Information specific to the applicant’s current licensure status, training, and current competence must be gathered by the hospital using a defined credentialing process that is based on medical staff recommendations, approved by the governing body, and documented in the medical staff bylaws. Verification must be in writing and must come from the primary source, if possible, or from a CVO. (Note: Joint Commission also includes some designated equivalent sources that may be used in lieu of primary source.) The identity of the applicant must be verified. This can be accomplished by viewing either a current picture hospital ID card or a valid picture ID issued by a state or federal, agency such as a driver’s license or passport.

MS.06.01.07 – Analysis and Use of Information

The medical staff must actually review and analyze all relevant information received regarding current licensure status, training, experience, current competence, and ability to perform the requested privileges through a clearly defined process. The organization develops and consistently applies criteria that will be considered in the decision to grant, limit, or deny a requested privilege. These criteria are based on recommendations by the medical staff and approved by the governing body. Criteria must be directly related to the quality of health care, treatment, and services or, if criteria are not related to quality of care, there must be evidence that the impact of the resulting decisions on the quality of care, treatment, and services has been evaluated. The governing body or its delegated committee has final authority for granting, renewing, or denying privileges. Privileges cannot exceed two years.

MS.06.01.09 – Privilege Decision Notification

The privileging decision must be communicated to the requesting practitioner within a time frame specified in the medical staff bylaws. In the case of a denial, the applicant must be told the reason for denial. The privileging decision must be distributed and made available to all appropriate internal and/or external persons or entities, as defined by the organization and applicable law. The practitioner must be notified of available due process or, when applicable, the option to implement the fair hearing and appeal process.

MS.06.01.11 – Expediting the credentialing and privileging processes

If it chooses, the governing body can use an expedited process for initial appointments and for reappointments to the medical staff and when granting privileges. The governing body may delegate these decisions to a committee consisting of at least two voting governing body members. Expedited credentialing may not be used if the
applicant’s application is incomplete or the medical staff executive committee makes a final recommendation that is adverse or has limitations. Criteria developed by the medical staff for the expedited process must be followed.

The standard lists the following situations that should be evaluated on a case-by-case and would *usually* lead to ineligibility for expedited credentialing:

- the applicant has current or previously successful challenge to licensure or registration;
- the applicant has had an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges; or
- the applicant has had an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment.

Note that this standard does not say that these issues definitely make the practitioner ineligible. Joint Commission allows the organization to consider each specific case.

**MS.10.01.01 – Fair Hearing and Appeals Process for Adverse Privileging Decisions**

The medical staff must have a fair hearing and appeal process for addressing adverse decisions regarding reappointment, denial, reduction, suspension, or revocation of privileges that relate to quality of care, treatment, and service issues. A fair hearing and appeals process allows the practitioner the opportunity to defend him or herself against the adverse action before an unbiased hearing panel of the medical staff. In addition, the practitioner has the opportunity to appeal the decision of the hearing panel to the governing body. The hearing and appeals procedure must be fair and must include a mechanism to schedule a hearing, procedures for the hearing to follow, the composition of the hearing committee as a committee of impartial peers, and a governing body mechanism to appeal adverse decisions. The process may differ for medical staff members and those nonmembers who are granted privileges.

**MS.07.01.01 – Recommendations for Staff Membership/Appointment**

The medical staff makes recommendations to the governing body for medical staff appointment as part of its oversight of the quality of care, treatment, and services provided by privileged practitioners. The medical staff must develop and utilize criteria for medical staff membership. These criteria should be designed to assure the medical staff and governing body that patients will receive quality care, treatment, and services. Appointments and subsequent reappointments cannot not exceed a period of two years.
MS.12.01.01– Continuing Education

Hospital-sponsored educational activities must be prioritized by the medical staff. These activities should relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital and on the findings of performance improvement activities.
Summary of Selected NCQA Health Plan Credentialing Standards

CR 1: Credentialing Policies

A well-defined credentialing and recredentialing process is utilized to evaluate and select licensed independent practitioners (LIPs) to provide care to members.

Credentialing policies and procedures specify:
- Types of practitioners to credential and recredential
- Verification sources used
- Credentialing and recredentialing criteria
- Process for making credentialing and recredentialing decisions
- Process for managing credentialing files that meet the organization’s criteria
- Process for delegating credentialing or recredentialing
- Process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner
- Process for notifying practitioners if information obtained during the organization’s credentialing process varies substantially from information they provided to the organization
- Process for ensuring that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision
- Medical director or other designated physician's direct responsibility and participation in the credentialing program
- Process used for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law
- Process for ensuring that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification and specialty.

Credentialing standards apply to all LIPs or groups of practitioners who provide care to members and practitioners who are licensed, certified or registered by the state to practice independently. They also apply to practitioners with an independent relationship with organization, meaning the organization employs, contracts with, or otherwise directs its members to the practitioner for care.

The organization’s policies must describe the sources used to verify credentialing information. Information must come from the primary source, a contracted agent of the primary source, or other NCQA-accepted sources listed for the credential.

The organization determines which practitioners can participate within its network. It must credentials practitioners before the practitioners provide care to members. There must be a process for making credentialing decisions. The criteria required to reach credentialing decisions must be defined and must be designed to assess a practitioner’s ability to deliver care.
Credentialing policies and procedures must:

- describe the process used to determine and approve files that meet criteria (all practitioner files can be presented to the Credentialing Committee or the organization may designate approval authority of clean files to the medical director or to an equally qualified practitioner)
- describe any credentialing activities that may be delegated, how the decision is made to delegate, and if the organization does or does not delegate credentialing activities
- specify that the organization does not base credentialing decisions on an race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes
- have a process for preventing and monitoring discriminatory practices including taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes including at least annual monitoring for discrimination in credentialing and recredentialing practices
- describe the process for notifying practitioners when credentialing information obtained from other sources varies substantially from that provided by the practitioner
- specify that the time frame for notifying applicants of initial credentialing decisions and recredentialing denials does not exceed 60 calendar days from the Credentialing Committee’s decision (not required to notify practitioners regarding recredentialing approvals)
- describe the medical director’s or other designated physician’s overall responsibility and participation in the credentialing process
- describe the process for ensuring confidentiality of information collected during credentialing
- describe the process for making sure that information provided in member materials and practitioner directories is consistent with the information obtained during the credentialing process

The organization must notify the practitioner about the right to review information submitted to support his/her credentialing application, to correct erroneous information, and to be informed of the status of their credentialing or recredentialing application.

**CR 2: Credentialing Committee**

There must be a Credentialing Committee which utilizes a peer-review process to make recommendations regarding credentialing decisions. The Credentialing Committee’s makeup must have representation from a range of participating practitioners.
The committee must be given the opportunity to review the credentials of all practitioners credentialed or recredentialed who do not meet the organization’s established criteria, and to offer advice. The organization must consider this advice. The committee must give thoughtful consideration to the credentialing elements before making recommendations and document discussions in minutes.

The Credentialing Committee may review all files or it may give the medical director (or approved qualified physician designee) authority to evaluate and approve files. Policies and procedures must describe the process used to determine what applications meet the organization’s criteria and must assign the medical director (or designee) the authority to determine that the file is “clean” allowing the medical director to evaluate and approve to the file. The file must include evidence of this evaluation and approval. The medical director’s approval date is considered the “credentialing decision date.” Even if a review board or governing body reviews a decision after the Credentialing Committee, NCQA considers the decision made by the Credentialing Committee to be final. Credentials must be verified within the specified time limits and must be valid at the time of the Credentialing Committee’s or medical director’s review and approval.

**Provisional Credentialing**

Provisional credentialing can be used when it is in the best interest of members to have the practitioner available before the initial credentialing process is complete. NCQA accepts provisional credentialing under the following conditions:

- There is PSV of a current, valid license to practice
- There is written confirmation of the past five years of malpractice claims or settlements from the malpractice carrier, or NPDB query
- There is a complete application and signed attestation
- The Credentialing Committee bases the decision to provisionally credential a practitioner based on the above information
- Provisional status cannot last for more than 60 calendar days at which time the full credentialing process must be completed
- A practitioner can only be provisionally credentialed once.

**CR 5: Practitioner Office Site Quality**

The organization has a process to ensure that the offices of practitioners meet its office site standards.

The organization sets site performance standards for physical appearance/accessibility, adequacy of waiting and examining room space, and adequacy of medical/treatment record-keeping.

The organization implements appropriate interventions by:

- Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days if a threshold was met
• Instituting actions to improve offices that do not meet thresholds
• Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds
• Documenting follow-up visits for offices that had subsequent deficiencies.

CR 7: Notification to Authorities and Practitioner Appeal Rights

When an organization has taken actions against a practitioner for quality reasons, it offers the practitioner a formal appeal process and reports the action to the appropriate authorities.

The organization has written policies and procedure for:
• the range of actions available to the organization
• procedures for reporting to authorities
• a well-defined appeal process and
• making the appeal process known to practitioners

The organization reports practitioner suspension or termination to the appropriate authorities. The organization informs affected practitioners of its appeal process and includes the following in its written communication:
• notification that a professional review action has been taken, reasons for the action, and a summary of the appeal rights and process
• allowance for provider to request a hearing and the specific time frame in which to submit the request
• allowance of 30 days after the notification for the practitioner to request a hearing
• allowance for the provider to be represented by an attorney, or another person of the practitioner’s choice
• appointment of a hearing office or panel to review the appeal, and
• provision of written notification of the appeal decision and the reasons.

CR 8: Assessment of Organizational Providers

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

The organization’s policy for assessing health care delivery providers specifies that, before it contracts with a provider and at least every three years, it does the following:
• confirms that the provider is in good standing with state and federal regulatory bodies
• confirms that the provider has been reviewed and approved by an accrediting body
• conducts an on-site quality assessment, if the provider is not accredited
The organization assesses at least hospitals, home health agencies, skilled nursing facilities, and free-standing surgical centers, inpatient/residential/ambulatory behavioral health facilities, and contracted medical and behavioral health care providers.

**CR 9: Delegation of CR**

If the organization chooses to delegate credentialing and recredentialing activities, there is evidence of oversight of the activity.

The written delegation document is:
- mutually agreed upon
- describes the responsibilities of the organization and the delegated entity
- describes the delegated activities
- requires at least semi-annual reporting to the organization
- describes the process by which the organization evaluates the delegated entity’s performance
- describes the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations

If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes a listing of the allowed uses of PHI and a description of safeguards in place to protect the information from inappropriate use or further disclosure. The agreement must stipulate that the delegate will:
- ensure that sub delegates have similar safeguards
- provide individuals with access to their PHI
- inform the organization if inappropriate uses of the information occur and
- ensure PHI is returned, destroyed or protected if the delegation agreement ends.

As reflected in the delegation agreement, the organization must retain the right to approve, suspend and terminate individual practitioners, providers and sites in situations where it has delegated decision making.

For new delegation agreements, the organization evaluates the delegate’s capacity to meet NCQA requirements within the 12 months prior to implementing delegation. If the delegation agreement does not include a future implementation date, NCQA considers the date of the agreement to be the implementation date.

For delegation arrangements in effect for 12 months or longer, the organization has audited files against NCQA standards annually for each year that the delegation has been in effect. The scope of the annual evaluation is based on compliance with the appropriate NCQA standards, the delegation agreement, and includes a review of the delegate’s credentialing policies and procedures. The delegate’s report on delegated activities is evaluated by the organization. If the delegate is NCQA Accredited or NCQA
Certified in CR, the only NCQA-required reporting is the names or files of practitioners or providers processed by the delegate.

At least once in each of the past 2 years that delegation has been in effect, the organization has identified and followed up on opportunities for improvement, if applicable.

**RR 4: Provider Directories**

The organization has a web-based physician directory that includes the following information to assist members and prospective members in choosing physicians:

- name
- gender
- specialty
- hospital affiliations
- medical group affiliations, if applicable
- board certification
- acceptance of new patients
- languages spoken by the practitioner or clinical staff (the organization may include office staff but must identify them as such). The organization is not required to include English in the list of spoken languages.
- office locations

There is a search function showing how to find the information regarding each item listed above. Additionally, the organization provides an explanation of the item, its source, the frequency of validation and limitations. The organization updates the physician directory within 30 days of receiving new information from the practitioner.

Board certification needs to include a list of board certifications as reported by the ABMS or AOA boards and either a link directly to ABMS or AOA websites, or instructions on how to check the most current board certification status.

*For hospital providers, there is a web-based hospital directory that includes hospital name, location, accreditation status, and quality data from recognized sources. There is an explanation of the each item, its source, the frequency of validation and limitations regarding the hospital’s name, location, and accreditation status. There are search functions for the hospital name and location.*

*Directory information is updated within 30 calendar days of receiving new information from the hospital.*
Summary of URAC Health Credentialing Standards
Health Plan Accreditation Guide, Version 7.2

P-CR 1 – Practitioner and Facility Credentialing

The organization has a credentialing program that is used to verify professional qualifications of all participating practitioners.

The credentialing program covers all practitioners who are participating providers and are providing health care services. Facilities that provide covered health care services to consumers should also be credentialed, including acute care inpatient facilities, surgery centers, home health agencies and skilled nursing facilities. Additionally, if the organization chooses to list practitioners who provide services at a contracted facility in its provider directory, it must credential those practitioners even if the organization does not contract directly with the practitioner.

Credentialing may be delegated to a contracted network, group or clinic. If this occurs, delegation oversight is required and the delegated entity must be performing credentialing according to the URAC standards.

The following credentials must be collected for health care facilities that are credentialed by the organization:

- State licensure
- Medicare or Medicaid certification status via OIG
- Copy of the facility’s liability insurance policy declaration sheet
- Any other information necessary to determine if the facility meets the network-based health benefits plan participation criteria
- A signed and dated attestation statement and authorization to collect information necessary to verify the information in the credentialing application.
- Accreditation status (TJC, AAAHC, CARF, etc.)

P-CR 2 – Credentialing Program Oversight

The organization’s senior clinical staff person is responsible for oversight of clinical aspects of the credentialing program. This should be an M.D. or D.O. unless it is a specialty network, in which case the senior staff person from the network can provide oversight.
P-CR 3 – Credentialing Committee

There is a credentialing committee that:

- Has as a member at least one participating provider who is a practitioner and with no other role in organization management
- Discusses if providers meet reasonable standards of care
- Utilize clinical peer input when discussing standards of care for a specific type of provider
- Has final authority to:
  - Approve or disapprove applications
  - Delegate the authority to approve clean applications to the senior clinical staff person. This designation must be documented and include reasonable guidelines (“Clean applications” do not need to go to the Credentialing Committee);
- Keeps minutes of all committee meetings including documenting all actions
- Gives the organization with guidance on the overall direction of the credentialing program to organization staff
- Evaluates the effectiveness of the credentialing program and reports such to organization management
- Reviews and approves credentialing policies and procedures
- Meets at least quarterly and as necessary to fulfill its responsibilities.

P-CR 4 – Credentialing Program Plan

The organization has a written description for its credentialing program that:

- Has been approved by the credentialing committee
- Defines the scope and objectives of the credentialing program and the roles and responsibilities of the credentialing committee, the medical director (or clinical director), and the credentialing staff
- Defines criteria for qualification as a participating provider
- Defines the information collected for each type of provider credentialed and how the information is verified
- Includes rules about maintaining and storing credentialing information and files
- Includes a statement that the organization will not discriminate against any provider
- Describes the credentials committee approval process or approval by a senior clinical staff person of clean files, prior to being listed in any provider directory
- Describes how a provider is removed from provider directories if the provider ceases to comply with credentialing criteria or is not recredentialed within the time frame required by the organization's credentialing plan.
- Is reviewed and updated at least annually by the credentialing committee
P-CR 5 – Credentialing Application

Each applicant within the scope of the credentialing program submits an application that includes at least the following:

- Education and professional training, including board certification status
- State licensure information, including current license(s) and history of licensure in all jurisdictions
- Evidence of current DEA certificate or state controlled dangerous substance certificate, if applicable
- Proof of liability insurance and professional liability claims history
- History of sanctions, loss or limitation of privileges or disciplinary activity
- Hospital affiliations or privileges, if applicable
- Physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the practitioner’s ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients;
- Signed and dated attestation statement regarding the completeness and accuracy of the application
- Signed and dated statement authorizing the organization to collect information necessary to verify the information in the application.

P-CR 6 – Credentialing Confidentiality

The organization ensures the confidentiality of credentialing information and limits access to credentialing files to authorized persons only.

P-CR 7 – Review of Credentialing Information

The organization has mechanisms to review credentialing information for completeness, accuracy, and any conflicting information.

P-CR 8 – Credentialing Communication Mechanism

There is a mechanism to communicate with providers about their credentialing status when requested and; prior to review, to accept additional information from providers to correct incomplete, inaccurate, or conflicting credentialing information.

P-CR 9 – Primary Source Verification

The organization performs primary source verification of state licensure and board certification or highest level of education.
P-CR 10 – Consumer Safety Credentialing Investigation

There is a mechanism to conduct additional review and investigation of credentialing applications where the credentialing process reveals factors that may impact on the quality of care or services.

P-CR 11 – Credentialing Application Review

There is a mechanism to provide for review and approval of the credentialing application prior to the applicant’s designation as a participating provider.

The only exception to this standard is when a provider is granted provisional participation status by the senior clinical staff person. This status must be time-limited and granted due to continuity or quality of care issues. The full credentialing process must be completed as quickly as possible.

P-CR 12 – Credentialing Timeframe

No credentialing application is submitted for initial review if it is signed and dated more than 180 days prior to credentialing committee review or if it contains primary or secondary source verification information collected more than six months prior to review.

P-CR 13 – Credentialing Determination Notification

The organization provides written notification to providers within 10 business days of the determination.

P-CR 14 – Participating Providers Credentials Monitoring

There is a process to monitor continuing compliance with criteria for network participation and mechanisms to respond in cases where a participating provider ceases to comply with criteria. The organization is expected to routinely monitor reports of disciplinary actions published by state licensing boards and the U.S. Department of Health and Human Services, Office of Inspector (OIG) or periodically query the National Practitioner Data Bank (NPDB).

P-CR 16 – Recredentialing & Participating Provider Quality Monitoring

The recredentialing process
- requires an application updating any information subject to change
- verifies through primary or secondary sources information that is subject to change
• considers information regarding the participating provider’s performance within the organization, including information collected through the quality management program.

P-CR 17 – Credentialing Delegation

The organization complies with the Core Standards for any credentialing functions it delegates. The organization retains authority to make the final credentialing determinations. At least every three years, the organization must either conduct an on-site survey of each entity that performs credentialing functions on behalf of the organization; or if not doing an on-site review, it requests and reviews random credentialing files that must be made available within a specified amount of hours or days of the request. The organization must provide an annual report on delegated credentialing oversight to the credentialing committee.