## 60.3 - Credentialing, Monitoring, and Recredentialing

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An MA organization must have written policies and procedures for the selection and evaluation of health care professionals that conform with the following credentialing requirements and the provider anti-discrimination policy discussed directly above. Credentialing is the review of qualifications and other relevant information pertaining to a health care professional who seeks appointment (in the case of an MA organization directly employing health care professionals) or who seeks a contract or participation agreement with the MA organization. Note that MA organization oversight of credentialing in contracted, subcontracted, and other related entities is an MA organization contract requirement imposed by 42 CFR 422.502(i)(4)(iv) and is addressed further in Chapter 11, "Contracts With Medicare Advantage Organizations."

Credentialing is required for:

- All physicians who provide services to the MA organization's enrollees, including members of physician groups; and

- All other types of health care professionals who provide services to the MA organization's enrollees, and who are permitted to practice independently under state law.

Credentialing is not required for:

- Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner;

- Hospital-based health care professionals who provide services to enrollees incident to hospital services, unless those health care professionals are separately identified in enrollee literature as available to enrollees; or

- Students, residents, or fellows.

**Initial Credentialing**

Procedures for initial credentialing involve a written application; verification of information from primary and secondary sources; confirmation of eligibility for payment under Medicare; and site visits as appropriate. A limited set of procedures for newly trained health care professionals permits initial credentialing for a period of up to 60 days.

**Written Application**

The credentialing process begins with the completed application and attestation of correctness signed by the health care professional. The application must be signed, dated and include an attestation by the applicant of the correctness and completeness of the application. The information collected must be no more than six months old on the date on which the health care professional is determined (for example, by a credentialing committee) to be eligible for appointment or contract. All items must be verified prior to the appointment of the health care provider, with the exception being in the case of a pending Drug Enforcement Agency (DEA) number.

The application includes a work history covering at least 5 years and a statement by the applicant regarding: (1) Any limitations in ability to perform the functions of the position, with or without accommodation; (2) History of loss of license and/or felony convictions; and (3) History of loss or limitation of privileges or disciplinary activity.

(**NOTE:** Work history refers to relevant work that is applicable to the position being sought. If the applicant is a new health care professional, he/she may not have 5 years of relevant work history.)

**Verification of Information**

Some information may be verified from a primary source and some information may be verified from secondary sources. A "primary source" is an organization or entity with legal responsibility for originating a document and ensuring the accuracy of the information it conveys. Primary source verification may be achieved through the use of industry-recognized verification sources. The nationally recognized accrediting organizations specify which sources they consider to be appropriate primary sources for verifying credentials. In some instances, except for licensure, a secondary source will be considered acceptable provided that the secondary source verifies the information from the originator. If the MA organization uses one of the primary sources identified by one of these nationally recognized accrediting organizations, CMS will consider that source acceptable. If questioned, the MA organization should be able to reference which organization identified that source. In addition, although the National Practitioner Data Bank (NPDB) does not have any legal responsibility for issuing a document, it is generally considered an appropriate source of verification by most private accrediting organizations as well as by CMS.

**Primary Source Verification Required**

An MA organization must verify the following from primary sources and include in the credentialing records:

1. A current valid license to practice: Verification must show that the license was in effect at the time of the credentialing decision.

2. Education and training records, including evidence of graduation from the appropriate professional school and completion of a residency or specialty training, if applicable: Verification is required only for the highest level of education or training attained. For example, health care professionals who have completed residency, then the verification from the residency program is the highest credential to be verified, and for those who only completed medical school, the medical school verification must be obtained. When verifying the highest level of education or training through primary sources, the assumption is that all other education or training requirements prior to the highest level achieved have been met. This assumption is consistent with current credentialing practices.

3. Board certification in each clinical specialty area for which the health care professional is being credentialed if he/she states that he/she is board certified on the application: If board certification is verified, CMS will accept this as also

satisfying the requirement to verify education and training, provided that board uses primary source verification for education and training.

**Primary Source Verification Not Required**

Following are other credentialing requirements that must be verified and included in the credentialing files. Previously, these requirements also stipulated primary source verification. This change from primary source to secondary source aligns these requirements with current industry standards. Secondary sources of information for these requirements are widely accepted and appropriate. The sources of and methods for obtaining the designated credentialing requirements listed below are suggested appropriate sources/methods; however, this is not intended as an all-inclusive listing of sources/methods that an MA organization may employ to acquire the requisite information.

1. Clinical privileges in good standing at the hospital designated by the health care professional as the primary admitting facility if the physician or other health care professional has admitting privileges: Health care professionals who have the ability to have admitting privileges may choose not to have them, as they may not manage care in the inpatient setting. However, if a health care professional does have admitting privileges, he/she is required to list those privileges. Lack of privileges does not exclude a health care professional from participation in a MA organization. Information obtained by an MA organization on applications from physicians and other health care professionals that lists the current status and type of admitting privileges would meet this requirement. (This information may be obtained by contacting the facility, obtaining a copy of the practitioner directory or attestation by the health care professional.)

2. Current, adequate malpractice insurance meeting the MA organization's requirements: (This information may be obtained via the malpractice carrier, a copy of the insurance face sheet or attestation by the health care professional.)

3. A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate in effect at the time of the credentialing decision: However, if a health care professional's DEA certificate is pending, the MA organization may credential the practitioner provided the MA organization has adopted and implemented a process under which other DEA-certified contracted practitioners write all prescriptions that require a DEA number. The process must also include verification of the newly issued DEA certificate. If a health care professional states that he/she does not prescribe, this requirement is not applicable. (This information can be obtained through confirmation with CDS, entry into the National Technical Information Service (NTIS) database, or by obtaining a copy of the certificate.)

4. A history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the health care professional: (This information can be obtained from the malpractice carrier or from the National Practitioner Data Bank.)

5. For physicians, any other information from the National Practitioner Data Bank.

6. Information about sanctions or limitations on licensure from the applicable state licensing agency or board, or from a group such as the Federation of State Medical Boards.

7. Eligibility for participation in Medicare. (See excluded and opt-out provider checks above.)

**Site Visits**

The MA organization must establish a policy for conducting site visits. It is the responsibility of the MA organization to decide the frequency of site visits, as part of its site visit policy. The CMS does not, however, require MA organizations to conduct initial credentialing or recredentialing site visits. Each MA organization's site visit policy will be reviewed pursuant to CMS' monitoring protocol.

An MA organization's site visit policy must include procedures for detecting deficiencies and have mechanisms in place to address those deficiencies. At a minimum, the MA organization should consider requiring initial credentialing site visits of the offices of primary care practitioners, obstetrician-gynecologists, or other high-volume providers, as defined by the MA organization. If the organization chooses to conduct site visits for "high volume" providers, the organization's procedures may specify the criteria for determining that a provider is "high-volume". The organization may also consider developing criteria that target high-volume providers, or those against whom grievances have been filed.

The site visit should include an evaluation of the site's accessibility, appearance, and adequacy of equipment, using standards developed by the MA organization. Each MA organization must send appropriately qualified personnel to conduct site visits. Those personnel may or may not be clinicians, depending on the focus of the evaluation and the evaluation criteria established by the MA organization.

In addition, the visits should include a determination of whether the site conforms to the MA organization's standards for medical record keeping practices and the confidentiality requirements discussed in Chapter 4. Although CMS is not establishing a methodology for conducting medical record reviews, each MA organization is directed to verify that its practitioners' enrollee health records meet its own standards.

**Initial Requirements for a Newly Trained Health Care Professional**

In an effort to promote access to services for beneficiaries and allow a newly trained healthcare professional to begin providing care at an earlier date, CMS has established a temporary, streamlined credentialing guideline for these newly trained individuals. In the case of a newly trained health care professional who has completed all appropriate training and education within the last 12 months, the MA organization may establish a policy that permits initial credentialing for a period of up to 60 days if the MA organization:

1. Verifies that the practitioner has a current, valid license from primary sources;

2. Verifies malpractice settlements from the last 5 years. (This may be done by verifying with the malpractice carrier or the National Practitioner Data Bank; attestation is not accepted.);

3. Has a policy and procedure which ensures that the practitioner meets all standard credentialing requirements after 60 days; and

4. Ensures that the Credentialing Committee has reviewed the case and makes the final determination about granting such an initial 60-day credentialing period.

**Monitoring**

The MA organization must develop and implement policies that address the ongoing monitoring of sanctions and grievances filed against health care professionals. The MA organization must regularly obtain and review reports and other documentation as indicated below. The MA organization must also provide, through documentation, evidence that its policies have been implemented.

The CMS requires ongoing monitoring of lists of practitioners who have been sanctioned and of practitioners who opt-out of accepting Federal reimbursement from Medicare (see above for details), as well as ongoing monitoring and resolution of beneficiary grievances. In addition to these standing requirements, MA organizations are also required to monitor sanctions and limitations on licensure on a regular basis between recredentialing cycles.

In the event that an MA organization finds an incidence of poor quality or any type of sanction activity against a health care professional, it should intervene and correct the situation appropriately.

If the MA organization becomes aware of conditions at a site that suggest compromised safety or other concerns related to the delivery of care, the MA organization will be

expected to perform a site visit as soon as possible to assess the facility and identify corrective actions.

While the MA organization is required to ensure that all credentialing requirements are current at the time of initial credentialing and/or recredentialing, the MA organization is not required to monitor and account for any expiration dates on a continuous basis unless required to do so by the state.

**Recredentialing**

The MA organization must have procedures for recredentialing, at least every 3 years, through a process that updates information obtained in initial credentialing, considers performance indicators such as those collected through the QAPI program, the utilization management system, the grievance system, enrollee satisfaction surveys, and other activities of the MA organization, and that includes an attestation of the correctness and completeness of the new information.

Licensure must be re-verified from primary sources. Board certification must be re-verified only if the provider was due to be recertified or states that he/she has become board certified since the last time he/she was credentialed or recredentialed. The following must also be re-verified in the same manner as performed under the Initial Credentialing Requirements: admitting privileges; malpractice coverage; and DEA/CDS certificate. In addition, the MA organization must perform another search of the National Practitioner Data Bank and obtain updated sanction or restriction information from licensing agencies and Medicare (see above for details). If a provider is confirmed eligible to participate in Medicare, the MA organization should require that a provider, who has been otherwise disciplined, have a corrective action plan in place, and the MA organization should have procedures to ensure that the provider's plan is followed and is effective. The MA organization is not required to conduct site visits as part of its recredentialing policies, but may choose to do so at its own discretion.

(Source: 42 CFR 422.204(b)(2)(i) and (ii) and additional instructions)