TRIANGLE MEDICAL GROUP CREDENTIALING CRITERIA BASED ON SELECTED NCQA HEALTH PLAN 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 f 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 3: Credentialing Verification

The organization must verify credentialing information through primary sources, unless otherwise indicated by the standards.

Licensure Verification

Verification time limit is 180 calendar days

Verification must come directly from the state licensing agency. Licensure must be in effect at the time of the credentialing decision. Licensure must be verified only in the state(s) where the practitioner provides care for the organization's members.

Valid DEA or CDS Certificate, if applicable

Verification time limit: None

The certificate must be effective at the time of the credentialing decision. The organization can credential a practitioner whose DEA certificate is pending if it has a documented process for another practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number until the practitioner has a valid DEA certificate.

Education and Training

Verification time limit: None for graduation from medical or professional school and training

The organization must verify the highest of the three levels of education and training obtained by the practitioner (applies to initial credentialing only).

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

Board Certification

Verification time limit: 180 calendar days.

If a practitioner claims to be board certified, the organization must verify it. This applies to lifetime boards as well.

Work History

Verification time limit: 365 calendar days.

NCQA does not require primary source verification of work history. The health plan must obtain a minimum of five years of relevant work history through the practitioner's application or curriculum vitae including the beginning and ending month and year for each work experience. Any gaps exceeding 6 months should be reviewed and clarified either verbally or in writing. An oral explanation of a gap must be documented in the credentialing file. Gaps that exceed one year must be clarified in writing.

Malpractice History

Verification time limit: 180 calendar days.

Document written confirmation of the past 5 years of history of malpractice that resulted in settlements or judgments paid by or on behalf of the practitioner from the malpractice carrier or must query the NPDB.

Sanction Information

Time limit: 180 days

Information on practitioner sanctions is received before making a credentialing decision. This includes state sanctions, restriction on licensure and/or limitations on scope of practice, and Medicare and Medicaid sanctions.

The organization must verify the most recent 5-year period availalble for sanctions or limitations on licensure in each state where the practitioner provides care for its members.

Application and Attestation

Time limit: 365 days.

The application includes a current, signed attestation addressing the following:

1. Reasons for any inability to perform the essential functions of the position, with or without accommodation
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. Current malpractice insurance coverage
6. Current and signed attestation to the correctness and completeness of the application

CR 4: Recredentialing Cycle Length

The organization formally recredentials its practitioners at least every 36 months. The recredentialing cycle is calculated from month/year to month/year. For example, a provider initially credentialed on 3/13/2012, must be recredentialed no later than 3/31/2015.

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 6: 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.

The organization implements ongoing monitoring and takes appropriate interventions by collecting and reviewing Medicare and Medicaid sanctions, sanctions or limitations on licensure, complaints, information from identified adverse events. It implements appropriate interventions when instances of poor quality are identified based on these reviews.

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 network physicians:

- name
- gender
- specialty
- hospital affiliations
- medical group affiliations
- 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.

The directory may list the physicians' board certification as reported by the ABMS or AOA boards or may provide 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.