# Medical Credentialing in the U.S.: Process and Requirements

**Credentialing** is the formal process of verifying that a healthcare provider (physicians, NPs, PAs, etc.) has the required education, training, licensure, and competency to deliver carencbi.nlm.nih.govncbi.nlm.nih.gov. Historically a hospital-based process, credentialing is now required by nearly all healthcare settings (hospitals, clinics, insurers, telemedicine) to ensure patient safety and compliance with standardsncbi.nlm.nih.govncbi.nlm.nih.gov. All licensed independent practitioners who deliver care (MDs, DOs, NPs, PAs, etc.) must be credentialed before practicencbi.nlm.nih.govncbi.nlm.nih.gov. Below is an overview of the **initial credentialing** and **re-credentialing** steps, key verification sources, timelines, accreditation requirements, and how processes differ for hospitals, payers, and telehealth.

## 1. Initial Credentialing – Step-by-Step Process

- **Provider Application:** The provider submits a credentialing application (often using a standardized form) with personal data, education, training, work history, licensure, DEA/CDS registration, malpractice history, and references. The application includes a signed attestation of accuracy and a release of information. Government photo ID (e.g. driver's license or passport) is collected to verify identityjointcommission.org. The Joint Commission explicitly requires identity proof (photo ID) at application or onboardingjointcommission.org.
- **Primary Source Verification (PSV):** The credentialing office contacts original sources to verify each claim on the application. This typically includes:
    - **Education & Training:** Verify medical/NP/PA school diplomas and completion of residency/fellowship with the issuing institution or accrediting body (e.g. ECFMG for foreign medical graduates).
    - **Licensure:** Check each state medical/nursing board's database to confirm current license(s) and statusncbi.nlm.nih.govverifiable.com. (State sites often list expiry dates, discipline, and restrictions.)
    - **Board Certification:** Confirm specialty board certifications via the American Board of Medical Specialties (ABMS) or AOA, and for nurse practitioners via AANP or ANCC, if applicablencbi.nlm.nih.govncbi.nlm.nih.gov.
    - **DEA/CDS Registration:** Verify current federal DEA or Controlled Substances license (if provider prescribes controlled substances)verifiable.com.
    - **Work History:** Verify gaps and privileges – for each employment or hospital affiliation listed, confirm dates and whether privileges were granted or ever limited. Verify any hospital/clinic privileges and reasons for any suspensions or resignations.
    - **Clinical Competency Data:** Some organizations also verify specialty training quality (e.g. ACGME accreditation) and professional credentials through entities like the National Student Clearinghouse or FCVS (FSMB's portfolio service).

NCQA and The Joint Commission stress **primary-source verification** for diplomas, licenses, and certificationsncbi.nlm.nih.govverifiable.com. In other words, hospitals and payers must contact schools, boards, and certifying agencies directly; simply accepting a paper diploma is insufficientncbi.nlm.nih.gov. Specialized services (CVOs) may automate these checks, but in-house staff often handle PSV.

- **Database and Sanction Checks:** The credentialing team queries national databases for adverse actions:
    - **NPDB (National Practitioner Data Bank):** A federal repository of malpractice payments, licensure actions, adverse privileging or peer-review reports. A query to NPDB reveals reported malpractice settlements, loss of privileges, license revocations, etcncbi.nlm.nih.gov. (Each hospital or payer must query NPDB for each practitioner and cannot share the query results with another entitynpdb.hrsa.gov.)
    - **FSMB Board Action Data Bank/DocInfo:** The Federation of State Medical Boards maintains DocInfo, a database of U.S. physicians' licensure status and board disciplinary actions. Credentialers check DocInfo or state medical board sites for any actions.
    - **AMA Physician Masterfile / AMA Profiles:** The AMA's Physician Professional Data contains verified info on education, training, and certificationkomahonylaw.comama-assn.org. Many hospitals/payers subscribe to AMA Profiles to streamline credentialing (the AMA asserts its data helps "streamline the physician credentialing process"ama-assn.org).
    - **OIG and SAM:** The U.S. Office of Inspector General (OIG) exclusion list and the System for Award Management (SAM) debarment list are checked to ensure the provider is not barred from Medicare/Medicaid or federal programsncbi.nlm.nih.govverifiable.com.
    - **State & Federal Sanctions:** Check Medicare/Medicaid sanction lists, and state licensing board sanction lists for any administrative penaltiesverifiable.comverifiable.com.
- **Reference and Background Checks:** Peer references are contacted to attest to the provider's character and competence. Criminal background checks or fingerprinting may be performed to uncover any criminal history (some states encourage obtaining state and national criminal reports)ncbi.nlm.nih.gov. Gaps in employment/education must be explained by the applicant.
- **Committee Review and Decision:** Once all verifications are complete, the credential packet is forwarded to the **Medical Staff/Privileges Committee** or credentialing committee. The committee (often department chairs, senior providers, or an appointed board) reviews the verified credentials against bylaws criteria. The committee then recommends approval, denial, or request for additional informationhealthmanagementsolutionsinc.comkomahonylaw.com. In hospitals, the Medical Executive Committee and governing Board make final credentialing/privileging decisions. The applicant is informed of the decision and any granted clinical privileges.
- **Privileges and Onboarding:** Upon approval, the provider is granted membership (staff appointment) and specific clinical privileges. The provider is oriented to institutional policies and may be issued an ID badge, access credentials, and any required training.

The Joint Commission specifically requires identity verification at this stage (e.g. ID badge photo)jointcommission.org.

# 2. Re-Credentialing and Ongoing Monitoring

- **Periodic Re-Credentialing:** Most organizations re-evaluate provider credentials on a regular cycle (typically every 2–3 years). **NCQA** mandates re-credentialing at least once every three years (many plans use a 34–35 month cycle)verifiable.com. **The Joint Commission** recently changed its requirement to a 3-year reappointment/re-privileging cycle (or shorter if state law mandates)greeley.com. (Some states still require every 2 years – for example, California and Illinois mandate no longer than a 2-year cyclegreeley.com.) Organizations set reminder systems so providers reapply well before their credential expiration.
- **Recredentialing Steps:** The provider submits a reappointment application updating any changes (new licenses, certifications, sanctions, malpractice claims, CME credits, etc.). The organization re-verifies current licensure, DEA registration, board certification status, and queries NPDB, OIG/SAM again for events since last cycle. Work and privileges history are reviewed. Often performance (OPPE: ongoing professional practice evaluation) and outcomes (peer reviews, productivity) are summarized for the committee. The credentials committee reviews the updates and any new data, and makes a reappointment recommendation.
- **Ongoing Monitoring:** Between re-credentialing cycles, organizations continuously monitor providers. This includes reviewing any new adverse events (e.g. malpractice reports, new sanctions), tracking annual license/DEA renewals, and requiring providers to report major changes (e.g. new state licenses or loss of privileges). NCQA and JCAHO expect organizations to have systems (often automated) to flag expirations and sanctionsverifiable.comnpdb.hrsa.gov.
- **Provider Performance:** Hospitals incorporate OPPE and FPPE (focused professional practice evaluation) to monitor clinical performance. If concerns arise, expedited review and reporting (to NPDB if adverse) may occur. For payers, ongoing monitoring is less formal but may include claims pattern review and practitioner feedback.

# 3. Key Verification Sources and Entities

Credentialers rely on several authoritative sources for **primary-source verification**ncbi.nlm.nih.govverifiable.com:

- **State Licensing Boards:** Most states offer online directories showing license status and expiration. These official board sites are primary sources for licensure verificationncbi.nlm.nih.gov.
- **NPDB:** As noted, NPDB is a federal data bank of malpractice payments and adverse actionsncbi.nlm.nih.gov. Hospitals and payers query NPDB for each candidate.
- **FSMB (DocInfo / Board Action Data Bank):** FSMB collects multi-state licensing and discipline data. Credentialers use DocInfo or state board data to see any license sanctionskomahonylaw.com.

- **AMA/Physician Masterfile:** The AMA maintains a comprehensive database of physician education/training. Subscriptions to AMA Profiles allow quick access to verified physician dataama-assn.org.
- **Certification Bodies:** ABMS (for MD/DO specialties), AOA, AANP, ANCC, and other specialty boards maintain certification records. Verifying boards confirm board-cert status and expiration.
- **DEA/NPI Registries:** The federal DEA registry is checked for valid controlled-substance registrations. The NPI (National Provider Identifier) registry confirms basic identification info (name, taxonomy, practice address)verifiable.com.
- **OIG and SAM.gov:** The OIG exclusion list and SAM.gov debarment list are checked to ensure the provider isn't barred from federal programsncbi.nlm.nih.govverifiable.com.
- **Professional Databases:** Other sources include the National Student Clearinghouse (education verification) and specialty society listings. For example, FCVS (FSMB's credential service) aggregates a primary-source portfolio of physician credentialsfsmb.org, and the Uniform Application for Licensure facilitates multi-state licensing.
- **References and Peer Input:** Letters of recommendation and peer reviews (from directors of past training programs or department chiefs) supplement verification with qualitative assessments.

Each source provides "primary" evidence of qualifications. For example, NCQA explicitly requires license and certification verification via issuing bodies (boards, schools, ABMS, etc.)verifiable.com. Combined, these checks ensure a provider's background is fully vetted.

# 4. Timelines and Expiration Guidelines

- **License Renewals:** State medical/nursing licenses typically expire every 1–2 years (varies by state) and must be renewed. DEA licenses renew every 3 years. Board certifications often expire after 6–10 years depending on the specialty board (e.g. ABMS certification is usually 10 years). Organizations track these renewal dates to prevent lapses. (Telehealth licensing is especially time-consuming if multiple states are involved – many states join licensure compacts or offer streamlined renewals to ease this burdenruralhealthinfo.org.)
- **Credentialing Cycles:**
    - **Hospitals:** Historically used 2-year reappointment cycles, but The Joint Commission now allows up to 3 years unless state law is strictergreeley.comgreeley.com. Critical Access and rural hospitals often still use 2-year cycles to comply with federal/state rules.
    - **Health Plans/Payers:** NCQA requires re-credentialing at least every 3 yearsverifiable.com. Many insurers adopt a 36-month cycle. Some (especially Medicare Advantage plans) may do more frequent reviews or use automation for annual license checks.
    - **Recredentialing Window:** Payers often require providers to reapply 60–120 days before credential expiration to ensure timely renewal. The ACA does not set a federal deadline for credentialing by payers, but many insurers aim to complete network enrollment within 90–120 days of application.

- **Privileges Review:** Hospitals formally review assigned privileges with reappointment (and when granting new privileges). Privileges delineation may require proof of recent activity (e.g. a surgeon's case log) for each 2–3 year cycle.
- **Ongoing Monitoring:** Even mid-cycle, providers' licenses, DEA registrations, and sanctions are typically checked continuously (via automated data feeds, monthly NPDB updates, or at least annually). Any immediate adverse findings can trigger an ad-hoc re-review.

# 5. Accreditation and Regulatory Compliance

- **The Joint Commission (TJC):** Hospitals and many outpatient facilities seek TJC accreditation. TJC standards (Medical Staff chapter) mandate:
    - Primary source verification of credentials (education, training, licensure, certification) for all practitioners.
    - Verifying practitioner identity via photo IDjointcommission.org. TJC even allows remote ID verification for telehealth providersjointcommission.org.
    - Maintaining a credential file with all verifications and committee decisions.
    - Appointing qualified individuals (e.g. credentialing committees, Medical Executive Committee) to review applications.
    - Documenting decisions and providing appeal rights if privileges are denied.
    - Reassessing practitioner qualifications at least every 3 yearsgreeley.com (or more often if required by state law).

  Compliance with TJC also involves post-credentialing monitoring (OPPE/FPPE) and evidence of meeting approved standards.

- **NCQA (for Health Plans and Patient-Centered Medical Homes):** Health insurers and networks often pursue NCQA recognition. NCQA Credentialing Standards require:
    - Credentialing all licensed independent providers, with a formal application and PSV of license, DEA, education, training, work history, professional liability claims, sanctions (state and Medicare/Medicaid), and the signed applicationverifiable.com.
    - Using specified primary sources (state boards, board certification bodies, OIG, NPDB, etc. as listed)verifiable.com.
    - Recredentialing every 3 years (34–35 month cycle recommended)verifiable.com.
    - A credentialing committee and written policies for decision-making and appeals.
    - Non-discrimination (must not exclude providers for accepting Medicaid/Medicare)verifiable.comverifiable.com.
- **Other Accrediting Bodies:** Organizations accredited by DNV-GL or state agencies generally follow requirements similar to TJC. Medicare Conditions of Participation (42 CFR §482.22) require a functioning medical staff with bylaws governing credentialing/privileging. Federally funded clinics (FQHCs) follow HRSA's health center program standards (e.g. validating credentials on file)bphc.hrsa.gov. URAC accredits health management companies and uses standards akin to NCQA.

# 6. Hospitals vs Insurers vs Telehealth: Key Differences

- **Hospitals/Clinics:** Credentialing is tied to **staff privileges**. The focus is on clinical competence: providers must meet hospital bylaws and demonstrate hands-on ability (e.g. volumes, clinical outcomes) before obtaining privileges. A multi-tiered review (department committee → Medical Exec → Board) is typical. Hospitals often require credentialing for all practitioners who deliver care onsite, and also assess ongoing performance (peer review, OPPE). Temporary privileges may be granted in emergencies. Many hospitals use credentialing software or delegate to CVOs, but ultimate decisions remain local.
- **Insurance Payers/Networks:** Credentialing is for **provider network participation**, not hospital privileges. Insurers (health plans, HMOs, PPOs) generally verify the same basic credentials (license, DEA, certification, NPDB, malpractice) but are less concerned with specific clinical volume. There is typically no committee of peers – decisions are administrative (network manager). NCQA standards apply, requiring credentialing of all licensed providers in the networkverifiable.com. Payers often rely on the CAQH ProView system or commercial CVOs to collect provider data. Recredentialing is done on a schedule (often 3 years) to meet accreditation requirements. Denials or terminations of network contracts are documented, and providers have rights to appeal network decisions under some state laws.
- **Telehealth Platforms:** Telemedicine services must still credential providers, but unique factors apply. Providers must be licensed in the patient's state (or operate under interstate compacts like the IMLC/NLC)ruralhealthinfo.org. During COVID, many states relaxed licensing and expedited credentialing to expand telehealthruralhealthinfo.org. Telehealth programs often use **credentialing by proxy**: the "originating" site (where patient is) may accept the "distant" provider's home hospital credentials in lieu of re-credentialingruralhealthinfo.org. Platforms may also require training in telemedicine best practices. Beyond licensure, telehealth credentialing still follows hospital-like PSV for documents. However, companies that are telehealth-only (not hospitals) may rely on health plan credentialing (i.e. needing provider to already be credentialed by a hospital) and then perform minimal re-verification. In short, telehealth combines hospital credentialing rigor with added licensing logistics (multi-state)ruralhealthinfo.orgruralhealthinfo.org.

**In summary**, medical credentialing in the U.S. is a multi-step verification process required for all practicing healthcare providers. Initial credentialing gathers and verifies comprehensive education, licensure, certification, and background information (often using NPDB, AMA, FSMB, and state databases)komahonylaw.comverifiable.com. Re-credentialing repeats key verifications on a periodic cycle (usually 2–3 years)verifiable.comgreeley.com. Accrediting bodies like The Joint Commission and NCQA prescribe core standards (primary source verification, identity proofing, committee review, defined cycles)jointcommission.orgverifiable.com. While hospitals emphasize privileging and peer review, payers focus on provider data for network contracts, and telehealth adds interstate licensing considerations. Ultimately, all credentialing pathways share the goal of ensuring that providers are qualified, vetted, and continuously monitored to safeguard patient care qualityncbi.nlm.nih.govncbi.nlm.nih.gov.

**Sources:** Authoritative guidelines and analyses from The Joint Commission, NCQA, HRSA, FSMB, AMA, and peer-reviewed summariesncbi.nlm.nih.govncbi.nlm.nih.govkomahonylaw.comverifiable.comgreeley.comruralhealthinfo.org, among others.