

PEACE OF MIND

EXPERTISE

CHOICE

THE MEDPRO GROUP DIFFERENCE

## Guideline

# Credentialing and Privileging



This document does not constitute legal or medical advice and should not be construed as rules or establishing a standard of care. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

MedPro Group is the marketing name used to refer to the insurance operations of The Medical Protective Company, Princeton Insurance Company, PLICO, Inc. and MedPro RRG Risk Retention Group. All insurance products are underwritten and administered by these and other Berkshire Hathaway affiliates, including National Fire & Marine Insurance Company. Product availability is based upon business and/or regulatory approval and may differ among companies.

# Contents

<b>Introduction.....</b>	<b>1</b>
<b>Objectives .....</b>	<b>1</b>
<b>Credentialing and Privileging Foundations.....</b>	<b>2</b>
<b>The Credentialing/Recredentialing Process.....</b>	<b>3</b>
<b>Structure .....</b>	<b>3</b>
<b>Application Process .....</b>	<b>4</b>
<i>Preapplication .....</i>	<i>4</i>
<i>Application .....</i>	<i>5</i>
<i>Applicant Identification .....</i>	<i>6</i>
<i>Application Processing.....</i>	<i>6</i>
<b>Special Credentialing Considerations .....</b>	<b>7</b>
<i>Telemedicine Providers.....</i>	<i>7</i>
<i>Applicants Who Have Collaborative or Supervisory Agreements.....</i>	<i>7</i>
<i>Expedited Credentialing.....</i>	<i>8</i>
<i>Disaster Situations.....</i>	<i>8</i>
<b>Credentialing Red Flags.....</b>	<b>8</b>
<b>Negligent Credentialing .....</b>	<b>9</b>
<b>Privileging Requirements (Initial and Ongoing).....</b>	<b>10</b>
<b>Professional Practice Evaluation Monitoring.....</b>	<b>11</b>
<b>Focused Professional Practice Evaluation.....</b>	<b>11</b>
<b>Ongoing Practice Performance Evaluation .....</b>	<b>11</b>
<b>Performance Monitoring Methods.....</b>	<b>11</b>
<i>Prospective Proctoring .....</i>	<i>12</i>
<i>Concurrent Proctoring.....</i>	<i>12</i>
<i>Retrospective Evaluation .....</i>	<i>12</i>

*External Review* ..... 12

**Conclusion** ..... **12**

**Endnotes** ..... **13**

## Introduction

Credentialing is the process that healthcare organizations use to assess and confirm practitioners' qualifications. This process ensures that individuals who are providing care are qualified to do so. Privileging is the process that organizations use to authorize each licensed or certified practitioner's specific scope of patient care services. Privileging is performed in conjunction with credentialing and involves evaluating an individual's clinical qualifications and/or performance.

Credentialing and privileging were mainly associated with hospitals in the past. Now these processes also are essential at other types of healthcare facilities, such as ambulatory surgery centers, long-term care organizations, healthcare practices, and healthcare staffing agencies.

Credentialing and privileging have become complex processes for various reasons, including providers' expanding scopes of practice, the varying requirements of third-party payers (e.g., the U.S. government and private health insurance plans), and organizational standards (accrediting bodies). This guideline will examine some of the important aspects of the credentialing and privileging processes.

## Objectives

The objectives of this guideline are to:

- Discuss organizational responsibility for, and the importance of, credentialing and privileging
- Describe the various elements of the credentialing and privileging processes and how they apply within healthcare organizations
- Review special considerations for credentialing and privileging as well as potential "red flags" associated with these processes
- Describe strategies to prevent negligent credentialing claims
- Discuss requirements for initial and ongoing privileging
- Examine performance monitoring criteria and methods

## Credentialing and Privileging Foundations

Healthcare organizations are charged with providing the proper environment and adequate resources to support safe patient care. Paramount to this charge is having medical staff bylaws that define minimum credentialing and privileging requirements for validating the qualifications and competency of providers. Each organization's medical staff should adopt its medical staff bylaws and all revisions to them, and the governing board should approve them.

Medical staff bylaws should provide the framework for administrative procedures and processes to ensure practitioners provide safe and competent care. For credentialing and privileging, bylaws should specifically address:

- The preapplication and reapplication process and grounds for denying applications.
- The process for handling incomplete applications. Any unclear data or information gaps in applications must be addressed as part of the organization's due diligence process for employing competent providers.
- Appointments for less than 2 years.
- Limitations and rights for practitioners granted temporary, emergency, disaster, or locum tenens privileges.
- The effect of application completion (i.e., by completing the application, the candidate agrees to all the conditions and expectations listed).
- Membership categories and those that may be granted medical staff privileges.
- Medical staff committee structure, including individuals designated as peer reviewers.
- A physician assistance program or committee for handling impaired or disruptive providers.

### Credentialing for Healthcare Practices

Healthcare practices that wish to do their own credentialing need formal credentialing processes that are overseen by their governing bodies (e.g., the practice's board or the owning physician).

When developing the written policies that will govern credentialing and privileging, healthcare organizations should consult their legal counsel to ensure that all policies are consistent with

state laws and professional requirements. Further, organizations should ensure a fair process is in place to review grievances with any of the processes.

Organizations should review governing processes every 2 years. Legal counsel should review updates or changes before the approval process is activated through the medical staff and the organization. The approval of the governing body is always the final step.

“Organizations should ensure a fair process is in place to review grievances with any of the processes.”

Healthcare organizations also should have an established process in place to track and monitor license and credential expiration dates for healthcare providers. Credentialing management systems maintain a detailed database of credentialing and privileging information and can track it in an automated fashion.

## The Credentialing/Recredentialing Process

### Structure

Healthcare organizations should complete the credentialing process for each practitioner before allowing them to provide patient care services. Additionally, the organization should perform the initial granting of privileges in a timely manner, with the ultimate approval authority vested in the governing board.

The healthcare organization should verify the provider’s education, training, certificates, peer recommendations, and licensure from the primary sources (or by using an accrediting agency’s approved “designated equivalent sources” or other regulatory agency or third-party payer requirements).

“When contracting with third-party CVOs, healthcare organizations are responsible for oversight of the services provided.”

Some governing boards may choose to use an approved credentials verification organization (CVO) to validate provider qualifications. Organizations may want to work with their CVOs to outline an expedited process for gathering and validating information in the event of an emergency. When contracting with third-party CVOs, healthcare organizations are responsible for oversight of the services provided.

Recredentialing and the revision or renewal of a provider's privileges should occur every 2–3 years. Like the initial granting of privileges, approval of subsequent privileges is vested in the governing board, which may review recommendations or delegate the responsibility. The responsible party should complete the privileging process according to approved policies and procedures.

Credentialing and recredentialing processes should be consistent for all types of healthcare providers across the organization to avoid allegations of discrimination. The approach should be comprehensive and criteria based.

## Application Process

Healthcare organizations typically use a two-step application process. The first step is completion of a preapplication to ensure that providers meet basic qualifications for membership at the organization (as outlined in the medical staff bylaws).

### *Preapplication*

The preapplication process saves time and resources by identifying candidates who do not meet the minimum requirements for staff membership prior to the full application process.

Preapplication documents should clearly state that they are not applications.

Preapplication questions minimally address:

- Disciplinary actions or sanctions by licensing boards, payers, or professional organizations
- Unrestricted licensure
- Criminal history
- Board certification, if required
- Clinical specialty and any specialty-related requirements
- Health status
- Malpractice coverage and claims history (closed and open claims)

The preapplication may also require candidates to submit curricula vitae (CV) with their preapplication responses. Preapplications and applications should comply with the Americans



with Disabilities Act (ADA). Organizations should consult their legal counsel about ADA compliance.

### *Application*

If applicants meet the minimum requirements in the preapplication process, the organization may send them the full application. Although some states have standardized credentialing applications, all applications should include the effect of application completion wherein the applicant agrees to all the conditions and expectations listed.

Provisions in the application typically require practitioners to:

- Agree to provide continuous care to their patients.
- Confirm receipt of the organization's bylaws, rules and regulations, and/or applicable policies.
- Agree to exhaust administrative internal remedies prior to litigating adverse credentialing decisions.
- Notify the organization in writing if they become the subject of certain actions (e.g., investigation or complaint by the state licensing board).
- Agree to unconditionally release the organization's representatives (and those who provide information to the organization) from any and all liability for obtaining, reviewing, and evaluating applicant information for the purpose of staff membership.
- Agree to maintain professional liability insurance (if the organization does not provide it) and to provide proof of coverage annually.
- Agree to provide any change in home or office address and phone number, and affirm that any notice sent to the addresses on file will be deemed to have been delivered.
- Agree to provide information on current health status and vaccinations.
- Agree to submit to unannounced mental or physical exams as requested by the organization's designees. Failure to do so may result in suspension or termination of privileges without a right to a hearing.
- Agree to provide a written request for specific privileges.

- Affirm that all statements are truthful and complete to the extent of their knowledge. Misstatements or omissions may be grounds for immediate suspension or revocation of the application.

### *Applicant Identification*

The application should require a copy of a government-issued ID with the applicant's photograph. It is also recommended that the organization send a copy of the photo ID or a photograph when requesting references for the applicant. Sending the image may ensure that the applicant has not misappropriated the identity of another provider.

Further, it is highly recommended — and mandatory in some states — to perform national and state criminal background and sex offender checks on all providers. Criminal background checks are a basic employment and credentialing practice to ensure any issues or concerns are discovered prior to granting appointment and privileges.

“Criminal background checks are a basic employment and credentialing practice to ensure any issues or concerns are discovered prior to granting appointment and privileges.”

A background check is different from verification of application information. Organizations usually hire a reliable firm to provide a comprehensive search of court records — both criminal and civil — at the county, state (including surrounding states), and federal level. Failure to perform these checks could put healthcare organizations at risk for negligent credentialing claims.

A separate and specific consent might be required for performing background checks. Working with a reputable service will assist with this process.

### *Application Processing*

Healthcare organizations should collect information from primary sources (e.g., the National Practitioner Data Bank) to verify each practitioner's current licensure status, training, experience, competency, and ability to perform the requested privileges. Primary source verification should occur within 180 days of credentialing review.<sup>1</sup>

Secondary sources — such as credential verification from another facility, copies of a credential verification, or confirmation from a source that verified the credential — should be used only if

primary sources no longer exist.<sup>2</sup> Additionally, organizations might want to consider conducting an online search for any additional information about the applicant.

Ensuring that all providers meet the threshold criteria set forth in the application and that any questions about their credentials, behavior, references, training, and education are resolved will help filter out potentially troublesome candidates.

The organization's bylaws should specify the process for review and approval of applications and reapplications. All credentialing and recredentialing recommendations and decisions should be documented and ultimately approved by the governing board.

## **Special Credentialing Considerations**

### *Telemedicine Providers*

The Centers for Medicare & Medicaid Services (CMS) allows the governing body of an organization whose patients are receiving telemedicine services to rely on credentialing and privileging decisions made by “distant-site telemedicine entities,” such as teleradiology groups and ambulatory surgery centers.<sup>3</sup>

State licensing boards and accrediting bodies also have specific definitions and standards regarding telemedicine. Healthcare organizations should ensure their credentialing and privileging policies adhere to those requirements.

### *Applicants Who Have Collaborative or Supervisory Agreements*

State laws may require certain practitioners — such as physician assistants, nurse practitioners, and other advanced practice providers (APPs) — to have collaborative practice or supervisory agreements. These documented agreements help clarify provider roles and responsibilities, and they also may include specific information about scope of practice, prescribing authority, and supervision requirements.

When an applicant is reviewed, any collaborative or supervisory agreements also should be reviewed and become part of the applicant's credential file. The organization should document that the required collaborating, supervising, or proctoring is provided. The organization also should verify and document that privileges for APPs do not exceed those of their supervising or collaborating physicians.

### *Expedited Credentialing*

Some healthcare organizations might find that a need arises for expedited credentialing. These organizations should develop policies and procedures addressing expedited credentialing for temporary privileges. Policies and procedures should identify circumstances in which expedited credentialing is appropriate and establish criteria for granting temporary or short-term privileges.

### *Disaster Situations*

Healthcare organizations should establish a credentialing and privileging process for use during disasters for volunteer healthcare providers who are not members of the organization's medical staff. The process should comply with medical staff bylaws, policies and procedures, and federal and accrediting body requirements.<sup>4</sup>

## **Credentialing Red Flags**

The following list offers some credentialing “red flags” — that is, potential circumstances that may serve as warning signs when credentialing practitioners:

- Reluctance by the applicant to give permission to contact previous employers or organizations
- Reluctance by the applicant or the applicant's references to provide specific information
- No response to a reference inquiry
- Voluntary or involuntary relinquishment of licensure/registration or medical staff membership
- Limitation, reduction, or loss of clinical privileges
- Unexplained or unaccounted gaps in service
- Frequent changes in employment locations or resignations from medical staff
- Reports of problems in an applicant's professional practice
- Short tenures at organizations (high mobility)
- Evidence of substance abuse issues (consider the nature of the issue and any corrective actions that the applicant took)

- History of board of medical examiner investigations or prior professional disciplinary actions
- Any gaps in insurance coverage due to differences in insurance types, “bare” periods, or inadequate dollar amounts in either primary coverage or aggregate policies
- Evidence of an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the practitioner
- Any claims or investigations of fraud, abuse, or misconduct from professional review organizations, third-party payers, or government entities
- Evidence of poor performance evaluations
- Incomplete application information

## Negligent Credentialing

Negligent credentialing refers to a type of liability in which an incompetent or unqualified healthcare provider injures a patient, and the healthcare organization is directly responsible to the patient because of a failure to properly conduct the credentialing process.<sup>5</sup> Many states recognize this type of liability, which was part of one of the largest malpractice awards in U.S. history.<sup>6</sup>

Overcoming a negligent credentialing claim can be very costly for healthcare organizations; however, various strategies potentially can help avoid negligent credentialing allegations. For example:

- Make sure the credentialing process is comprehensive and that credentialing materials are reviewed with a detailed and critical eye.
- Thoroughly investigate all red flags and unusual circumstances in a timely manner.
- Keep current on standards for the use of medical technology, devices, and treatments to ensure qualified providers are using them in permitted ways.
- Maintain all credentialing materials in an organized fashion in case of a problem or audit.
- Monitor and review healthcare provider performance on an ongoing basis, including technical performance and adherence to organizational policies/procedures.<sup>7</sup>

## Privileging Requirements (Initial and Ongoing)

Organizations should have clearly defined, objective, and evidence-based processes to determine whether sufficient clinical performance information is available to decide whether to grant, limit, or deny privileges that a practitioner requests.

Privileging of each licensed or certified healthcare practitioner should be specific to each of the healthcare organization's care delivery settings. (For example, performing a procedure in a hospital setting might involve a different level of risk than in an office setting.) Considering the care delivery setting is particularly important for managing risk within a healthcare network or among hospital-owned physician practices.

Information regarding each practitioner's scope of privileges should be updated when changes in scope occur. Privilege information should be readily available to all who might need to know the status. This might include making the information available on the organization's computer system so that appropriate departments and staff can review the materials when necessary.

The decision to grant, limit, or deny an initial request for, or renewal of, privileges should be communicated to the requesting

practitioner within the timeframe specified in medical staff bylaws or office policy. This information should also be disseminated and made available to all appropriate internal or external individuals or entities (as defined by the bylaws or policy).

The healthcare organization should have a fair hearing and appeal process for practitioners who are denied one or more clinical privileges.

### Privileging and Practice Setting

Some physicians choose not to apply for hospital privileges for various reasons. Physicians who choose to perform surgical procedures in their practices should be credentialed and privileged to do so. Some state regulations require privileging through a state board of medical examiners to perform surgical procedures in physician offices. Physicians should ensure they are aware of and comply with state regulations.

## Professional Practice Evaluation Monitoring

New medical staff members and those who have newly granted privileges should undergo a performance monitoring or proctoring period. Accrediting agencies require a performance monitoring period, and it is a CMS Condition of Participation for hospitals. As part of a performance monitoring process, organizations should consider:

- Identifying specific evaluation criteria
- Determining an appropriate monitoring plan
- Deciding on an appropriate timeframe for monitoring
- Identifying any circumstances that require monitoring by an external source

The subsequent sections describe some methods for performance evaluation and monitoring.

### Focused Professional Practice Evaluation

Focused professional practice evaluation (FPPE) is a process used to confirm a practitioner's current competence at the time new privileges are granted, either at initial appointment or as a current member of the medical staff.

FPPE has more frequent and intense monitoring than ongoing professional performance evaluation (OPPE; see below). The organization's medical staff should determine criteria for appointing the proctors (or reviewers) who evaluate a healthcare provider.

### Ongoing Professional Performance Evaluation

OPPE begins when competency is established. This process includes ongoing assessment of an existing medical staff member's performance based on quantitative and qualitative data. The organization's bylaws or policies should identify which members of the medical staff will have primary oversight of this performance evaluation process.

### Performance Monitoring Methods

Organizations can use various methods to monitor a practitioner's performance, including prospective proctoring, concurrent proctoring, retrospective evaluation, and external review.

### *Prospective Proctoring*

In prospective proctoring, the healthcare provider being evaluated presents potential cases and proposed treatment plans to the proctor (either verbally or in writing) and/or completes a written or oral examination or case simulation.

### *Concurrent Proctoring*

In concurrent proctoring, the proctor observes the healthcare provider performing a procedure or reviews the healthcare provider's medical management during a patient's hospital stay or clinic visit.

### *Retrospective Evaluation*

Retrospective evaluation involves the proctor performing a postcare review of a patient's health record. The proctor may also interview personnel directly involved in the care of the patient.

### *External Review*

Many organizations are turning to external reviews to ensure unbiased evaluations, particularly when there is a perceived conflict of interest or a need for objectivity about possible disciplinary action. A second opinion or outside perspective also is useful when:

- The pool of "like" practitioners is small, or no appropriate peer is available
- A physician under review is making an appeal, or the possibility of litigation is likely
- Staff is inexperienced with technology, a disease process, or a procedure
- There is nonconcurrence regarding a clinical outcome/course of treatment

## **Conclusion**

Healthcare organizations are responsible for validating the qualifications and competency of their medical staff members through credentialing and privileging. These processes are closely tied to reimbursement, accreditation standards, and state and federal laws. Failure to adhere to solid credentialing and privileging procedures might result in a costly negligent credentialing claim against an organization.

Although credentials and privileges will vary among providers (depending on their backgrounds, qualifications, areas of practice, and practice settings), having detailed and consistent



credentialing and privileging processes is imperative. Further, organizations should consider establishing thorough performance monitoring processes to evaluate practitioner competency at initial appointment and over time at specific intervals.

For more information about this topic, see MedPro's [Risk Resources: Credentialing and Privileging](#).

## Endnotes

---

<sup>1</sup> National Association Medical Staff Services. (2019, March [updated]). *NAMSS ideal credentialing standards industry roundtable report*. Retrieved from [www.namss.org/Portals/0/Docs/Advocacy/NAMSS\\_Ideal\\_Credentialing\\_Standards\\_2019.pdf](http://www.namss.org/Portals/0/Docs/Advocacy/NAMSS_Ideal_Credentialing_Standards_2019.pdf)

<sup>2</sup> Ibid.

<sup>3</sup> 42 U.S.C. § 482.12; 42 U.S.C. § 482.22; 42 U.S.C. § 485.616

<sup>4</sup> ECRI Institute. (2020, November 20 [reviewed]). Medical staff credentialing and privileging. *Healthcare Risk Control*. Retrieved from [www.ecri.org](http://www.ecri.org)

<sup>5</sup> Watkins, A. E. (2005). *Negligent credentialing lawsuits: strategies to protect your organization*. Retrieved from [http://hcmarketplace.com/media/supplemental/3664\\_browse.pdf](http://hcmarketplace.com/media/supplemental/3664_browse.pdf)

<sup>6</sup> Crane, M. (2013, January 3). Malpractice risks with NPs and PAs in your practice. Medscape. Retrieved from [www.medscape.com/viewarticle/775746](http://www.medscape.com/viewarticle/775746)

<sup>7</sup> Owens, K., & Russo, S. (2018, September 1). Best practices to avoid negligent credentialing claims. *Relias Media*. Retrieved from [www.reliasmedia.com/articles/143147-best-practices-to-avoid-negligent-credentialing-claims](http://www.reliasmedia.com/articles/143147-best-practices-to-avoid-negligent-credentialing-claims)

[medpro.com](http://medpro.com)