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— GUIDELINE —

Credentialing and Privileging



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Introduction

Credentialing is the process by which a healthcare organization assesses and confirms the qualifications of a practitioner. This process ensures that individuals who are providing care are qualified to do so.¹ Privileging is the process of authorizing a licensed or certified healthcare practitioner's specific scope of patient care services. Privileging is performed in conjunction with credentialing and includes the evaluation of an individual's clinical qualifications and/or performance.

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

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 some strategies to prevent a negligent credentialing claim
- 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 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 of 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 can no longer just use the credentialing processes of local hospitals or ambulatory surgery centers. Rather, these practices 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.

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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.

Healthcare organizations should also 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 have the ability to track it in an automated fashion.

The Credentialing/Recredentialing Process

Structure

The credentialing process for healthcare providers should be completed prior to an individual being allowed to provide patient care services. Additionally, the healthcare 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”² or other regulatory agency or third-party payer requirements).

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 at least every 2 years. Like the initial granting of privileges, approval of subsequent privileges is vested in the governing board,

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which may review recommendations or delegate the responsibility. The responsible party should complete the privileging process according to approved policies and procedures.

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 the candidate to submit a curriculum vitae (CV) with his/her 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 the applicant meets the minimum requirements in the preapplication process, the organization may send him/her a full application. Although some states have standardized credentialing applications, all applications should include the effect of application completion wherein the applicant agrees to all of the conditions and expectations listed.

Provisions in the application typically require the practitioner to:

- Agree to provide continuous care to his/her 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 he/she becomes 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 not provided by the organization) 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 his/her knowledge. Misstatements or omissions may be grounds for immediate suspension or revocation of 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 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.

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.

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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 120 days at the time of credentialing review.³

Secondary sources – such as credential verification from another facility, copies of a credential verification, or confirmation from a source that verified the credential – should only be used if primary source queries are unavailable.⁴ Additionally, organizations might want to consider conducting an online search, for any additional information about the applicant.

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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.⁵

State licensing boards and accrediting bodies also have specific definitions and standards in regards to 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 the 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.⁶

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 taken by the applicant)
- 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, and 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 a patient is injured by an incompetent or unqualified healthcare provider and the healthcare organization is directly responsible to the patient because of a failure to properly conduct the credentialing process.⁷

Many states recognize this type of liability, which was part of one of the largest malpractice awards in U.S. history.⁸ Overcoming a negligent credentialing claim can be very costly for healthcare organizations; however, a number of strategies potentially can help avoid negligent credentialing claims. For example:

- **Exceed minimum credentialing requirements.** Explore other avenues in addition to accrediting and licensing organizations' credentialing requirements. Data from abuse and sex offender registries as well as legal records can provide additional valuable information about healthcare practitioners.
- **Enlist a third party.** Using an experienced third-party vendor can supplement and enhance the credentialing process.
- **Be prepared.** Collect and organize materials properly so the credentialing staff have all necessary records and proof of due diligence ready to review in case of a problem or audit.
- **Continually monitor employees.** Perform background and credentialing checks regularly.⁹

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 make a decision to grant, limit, or deny privileges requested by a practitioner.

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.

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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 have the ability to 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 persons 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

It is recommended that new medical staff members and those who have newly granted privileges 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 Practice Performance Evaluation (OPPE; see below). Proctors (or reviewers) who evaluate a healthcare provider should be appointed based on criteria determined by the organization's medical staff.

Ongoing Practice Performance Evaluation

OPPE begins when competency is established. This process includes the ongoing assessment of an existing medical staff member's performance based on effective use of data in the decision-making. 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 competency of their medical staffs 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.

Resources

- [American Board of Medical Specialties: ABMS Member Boards](#)
- [American Nurses Credentialing Center](#)
- [Centers for Medicare & Medicaid Services: Conditions of Participation: Governing Body \(42 C.F.R, § 482.12\)](#)
- [Centers for Medicare & Medicaid Services: Conditions of Participation: Medical Staff \(42 C.F.R, § 482.22\)](#)

- Centers for Medicare & Medicaid Services: State Operations Manual, Appendix A: Survey Protocol, Regulations and Interpretive Guidelines for Hospitals
- Federation of State Medical Boards
- Health Resources and Services Administration: Health Center Program Site Visit Protocol: Credentialing and Privileging File Review Resource
- MedPro Group: Risk Perspectives in Telehealth: Credentialing & Privileging
- National Association Medical Staff Services: The Ideal Credentialing Standards: Best Practice Criteria and Protocol for Hospitals
- National Consortium of Telehealth Resource Centers: Things to Consider When Developing a Credentialing & Privileging Process for Telehealth
- National Practitioner Data Bank
- The Joint Commission: Ambulatory Care Program: The Who, What, When, and Where's of Credentialing and Privileging
- U.S. Department of Health and Human Services Office of Inspector General: Exclusions Program

Endnotes

¹ Health Resources and Services Administration. (2018, August 20). *Health center program compliance manual*. Retrieved from <https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/hc-compliance-manual.pdf>

² National Association Medical Staff Services. (2014). *NAMSS comparison of accreditation standards 2014*. Retrieved from www.namss.org/Portals/0/Education/CertPrepResources/namss_comparison_of_accreditation_standards_2014.pdf

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⁴ Ibid.

⁵ Billings, G. (2011, May). *Telehealth Credentialing and Privileging Final Rule from Centers for Medicare and Medicaid Services*. Center for Telehealth and e-Health Law. Retrieved from <http://ctel.org/wp-content/uploads/2011/05/2011-CTeL-Report-Telehealth-Credentialing-and-Privileging-Final-Rule.pdf>

⁶ ECRI Institute. (2017, November). Medical staff credentialing and privileging. *Healthcare Risk Control*.

⁷ Watkins, A. E. (2005). *Negligent credentialing lawsuits: strategies to protect your organization*. Retrieved from http://hcmarketplace.com/media/supplemental/3664_browse.pdf

⁸ Crane, M. (2013, January 3). Malpractice risks with NPs and PAs in your practice. Medscape. Retrieved from www.medscape.com/viewarticle/775746

⁹ HireRight. (2010). 4 best practices to mitigate the risk of negligent credentialing. Retrieved from www.hireright.com/blog/2010/11/4-best-practices-to-mitigate-the-risk-of-negligent-credentialing/

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