

CREDENTIALING AND PRIVILEGING

Medical Protective Clinical Risk Management Department

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INTRODUCTION

The U.S. Department of Health and Human Services' definition for credentialing is "the process of assessing and confirming the qualifications of a licensed or certified health care practitioner." Credentialing is an essential process that healthcare organizations and practices must perform to ensure those providing services are qualified to do so.

The process has become more complicated over time due to the expansion of providers' scopes of service, the requirements of third-party payers (e.g., the U.S. government and private health insurance plans), and organizational standards (accrediting bodies).

The companion piece to credentialing is "privileging," which is the process of authorizing a licensed or certified healthcare practitioner's specific scope of patient care services. Privileging is performed in conjunction with an evaluation of an individual's clinical qualifications and/or performance.

In the past, credentialing and privileging were mainly associated with hospitals. Now, these processes are required at healthcare facilities, ambulatory surgical centers, and long-term care organizations.

This guideline will examine some of the important aspects of the credentialing and privileging processes.

OBJECTIVES

The purpose of this guideline is 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;
- Discuss requirements for initial and ongoing privileging; and
- Examine performance monitoring criteria and methods.

1 Health Resources and Services Administration. (2001, 2006). Credentialing & privileging of health center practitioners. Policy Information Notice 2001, 16. Potrioved from http://bphc.brsa.gov/policiesrogulations/

practitioners. Policy Information Notice 2001-16. Retrieved from http://bphc.hrsa.gov/policiesregulations/policies/pin200116.html

BACKGROUND

Credentialing 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.

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 process and grounds for denying applications;
- Reapplication requirements and grounds for denying reapplications;
- Incomplete applications;
- Appointments for less than 2 years;
- Limitations and rights for practitioners granted temporary, emergency, disaster, or locum tenens privileges; and
- The effect of application completion (i.e., by completing the application, the candidate agrees to all of the conditions and expectations listed).

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.²

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.

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.

² It is suggested that organizations 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.

Recredentialing and the revision or renewal of a provider's privileges should occur at least every 2 years. Similar to 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 will 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:³

- Disciplinary action or sanctions by licensing boards, payers, or professional organizations;
- Unrestricted licensure;
- Criminal history;
- Board certification, if required;
- Clinical specialty and any specialty-related requirements; and
- Health status.

The preapplication may also require the candidate to submit a curriculum vitae (CV) with his or her preapplication responses.

Application

If the applicant meets the minimum requirements, the organization may send him or her a full application. Although some states have standardized credentialing applications, all applications should include the effect of completion of the application.

³ Preapplications and applications should comply with the Americans with Disabilities Act (ADA). Consult with your legal counsel if you have questions about ADA compliance.

Provisions in the application typically require the practitioner to:⁴

- Agree to provide continuous care to his or 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 or 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 provide access to medical records of patients treated in the organization for ongoing review of competency and quality.
- 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 or 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 when requesting references for the applicant. This will help ensure that the applicant has not misappropriated the identity of another provider.

Further, it is recommended — and mandatory in some states — to perform a background check on all providers. 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.

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⁴ Same as previous.

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

Application Processing

The organization should collect information regarding each practitioner's current licensure status, training, experience, competency, and ability to perform the requested privileges.

Ensuring that all providers meet the threshold criteria 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 set out 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

Because accrediting bodies have specific standards in regards to telemedicine, it is important to incorporate those standards to ensure compliance.

Applicants Who Have Collaborative or Supervisory Agreements

State laws may require certain practitioners, such as physician assistants and nurse practitioners, to have collaborative practice or supervisory agreements. These agreements help clarify provider roles and responsibilities and may include specific information about scope of practice, prescribing authority, and supervision requirements.

When an applicant is reviewed, any collaborative or supervisory agreements should also be reviewed and become part of the applicant's credential file.

⁵ Telehealth Policy Resource Center (n.d.). Credentialing & privileging. Retrieved from http://telehealthpolicy.us./credentialing-privileging

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;
- Voluntary or involuntary relinquishment of licensure/registration or medical staff membership;
- Limitation, reduction, or loss of clinical privileges;
- Gaps in service;
- Short tenures at organizations;
- Evidence of an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the practitioner;
- 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; and
- Evidence of poor performance evaluations.

PRIVILEGING REQUIREMENTS (INITIAL AND ONGOING)

Organizations should have clearly defined 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.

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.

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. As part of a performance monitoring process, organizations should consider:

- Identifying specific evaluation criteria;
- Determining an appropriate monitoring plan;
- Deciding an appropriate timeframe for monitoring; and
- 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. 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**. 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. The proctor observes the healthcare provider performing a procedure or reviews the healthcare provider's medical management during a patient's hospital stay and/or clinic visit.
- **Retrospective evaluation.** The proctor performs a postcare review of a patient's medical record and 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 is also 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;
 or
 - 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.

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.

RESOURCES ON CREDENTIALING

- Centers for Medicare & Medicaid Services (CMS): State Operations Manual, Appendix A: Survey Protocol, Regulations and Interpretive Guidelines for Hospitals — http://www.cms.gov/Regulations-and-Guidance/Guidance/Guidance/Manuals/downloads/som107ap a hospitals.pdf
- CMS: Conditions of Participation: Governing Body (42 C.F.R, § 482.12) —
 http://www.ecfr.gov/cgi-bin/text-idx?SID=47edfe9cf20bcbea44ffe665595328f6
 &node=42:5.0.1.1.1.2.4.2&rgn=div8
- CMS: Conditions of Participation: Medical Staff (42 C.F.R, § 482.22) —
 http://www.ecfr.gov/cgi-bin/text-idx?SID=47edfe9cf20bcbea44ffe665595328f6
 &node=42:5.0.1.1.1.3.4.2&rgn=div8
- Federation of State Medical Boards http://www.fsmb.org/index.html
- Health Resources Service Administration: Credentialing & Privileging of Health Center Practitioners — http://bphc.hrsa.gov/policiesregulations/
 policies/pin200116.html
- National Association for Medical Staff Services http://www.namss.org/
- National Practitioner Data Bank http://www.npdb-hipdb.hrsa.gov/
- Office of Inspector General: Exclusion Program http://oig.hhs.gov/exclusions/index.asp