



NAMSS Ideal Credentialing Standards Industry Roundtable Report

Background

On May 8, 2014, the National Association Medical Staff Services (NAMSS) convened a roundtable of notable industry representatives to introduce and discuss best practice standards for the initial credentialing of independent practitioner applicants in medical facilities. At present, practitioner credentialing, while required within multiple areas of the healthcare industry, is time-consuming, inefficient, and depletes resources that would otherwise be available to deliver higher quality patient care.

NAMSS has identified and vetted the essential data elements to recognize where standardization would create a more efficient and effective process. NAMSS' assessment includes a thorough review of the current credentialing system to identify efficiencies and deficiencies.

The Ideal Credentialing Roundtable participants represented the following 16 entities: the American Board of Medical Specialties, American College of Physician Executives, the American Hospital Association, the AMA-Organized Medical Staff Section, the American Society for Healthcare Risk Management, the Council for Affordable Quality Healthcare, the Centers for Medicare & Medicaid Services, the Federation of State Medical Boards, the Healthcare Facilities Accreditation Program, the Health Resources and Services Administration, the Medical Group Management Association, the National Association for Healthcare Quality, the National Patient Safety Foundation, The Joint Commission, and URAC.

Verification definitions

Every effort should be made to primary-source verify all elements when applicable. Accrediting organizations stipulate that certain information must be primary-source verified. If the primary source is unresponsive to material requests, the applicant is responsible for contacting the primary source. The application remains incomplete until it is verified at the primary source. If a primary source no longer exists, secondary sources may be appropriate, in accordance with facility and accrediting organization rules. All information to support the following 13 criteria should be primary-source verified within 180 days of review.

Primary Source Verification: Obtains and verifies a credential directly from the original issuing entity.

Designated Equivalency Sources: Approved entities that verify credential data through the primary-source. Approved designated equivalency sources vary by accrediting organization and state regulation.

Secondary Sources: May include credential verification from another facility, copies of a credential verification, or confirmation from a source that verified the credential. Secondary sources should only be used if the primary source no longer exists, in accordance with facility policy and accreditation standards. Per accrediting standards and facility regulations, secondary sources are unacceptable for many data elements.

Standards

The standards identify 13 essential criteria for credentialing an initial practitioner applicant. Identifying and focusing the process on the 13 criteria is the initial step towards improving credentialing efficiencies and effectiveness.

Each health facility and system should establish specific qualifications for medical staff membership and clinical privileges that reflect practitioner competency for an initial applicant. They should incorporate the 13 criteria, which NAMSS has identified as best practice essential elements in its Ideal Credentialing Standards, into their rules and regulations, credentialing policies and procedures, or other governance documents to ensure that the credentialing process is objective, systematic, and without discrimination or bias.

Just as credentialing confirms the data provided by a practitioner on their application, it may also detect information that determines or raises suspicion regarding professional competence, malevolence, behavioral problems, or other red flags that would prohibit a health facility and system from credentialing, and/or privileging an applicant. Red flags do not automatically preclude a practitioner from becoming credentialed or receiving clinical privileges; however, they should be investigated to the satisfaction of the medical staff.

Examples of potential red flags:

- Resignation from a medical staff at any time in an applicant's career.
- Reports of problems in an applicant's professional practice.
- All past or pending state licensing board, medical staff organization, or professional society investigative proceedings.
- Unexplained or unaccounted time gaps.
- No response to a reference inquiry from an applicant's past affiliation.
- Disciplinary actions by medical staff organizations, hospitals, state medical boards, or professional societies.
- Any claims or investigations of fraud, abuse and/or misconduct from professional review organizations, third-party payers, or government entities.
- Insufficient or unverified coverage from a professional liability insurance policy.
- Pattern of jury verdicts and settlements for professional liability claims (which should still be individually reviewed).
- Inability to maintain a medical practice within the facility's service jurisdiction for any amount of time.¹

The Ideal Credentialing Standards for Initial Practitioner Applicants: Best Practice Criteria and Protocol for Healthcare Facilities

NAMSS credentialing best practices for initial practitioner applicants include an evidence-based evaluation that should verify the following 13 specific criteria from primary sources as the data will generate the information necessary to assess an applicant's professional competence and conduct, as well as help identify practitioners that need further investigation or are not suitable to be credentialed.

1. Proof of Identity

- Government-issued photo identification
- NPI number
- I-9 documentation listed as List A or List B or List C as defined on form
- VISA card or Employment Verification card

Verifying a practitioner's identity with government-issued documentation and an identifiable photograph ensures that his/her identity is correct. This step coincides with criterion 13: Professional References, which stipulates that references should attest that the photo accompanying the facility reference request is the applicant. Valid government-issued photo identification, in addition to any of the other three documents listed above, can be used to verify an applicant's identity.

Primary Sources: Government-issued identification.

2. Education and Training

- Complete list (domestic and foreign) of medical school, training programs, internship, residency, and fellowship enrollment and completion dates, as well as clinical degrees and other relevant experience in MM/YY format
- Completion status
- Explanation of any time gaps greater than 60 days
- Fifth Pathway certification, if applicable
- ECFMG validation

All listed education and training entities that confirm training or education must include start and end dates, as well as evaluation according to ACGME competencies. Applicants are required to submit a written explanation of any time gap greater than 60 days. Time gaps shed light on details of an applicant's education and training experience that are not explicit in self-reported materials. Explanations of these gaps, or lack thereof, may provide insight into an applicant's past that may be critical to the credentialing decision/recommendation. Applicants should also submit a written explanation of any instances of discipline, suspension, probation, or reprimand.

Primary Sources: May include but should not be limited to state regulation and applicable professional and training schools or residency training programs, National Student Clearinghouse, AMA, AOA, ECFMG, FSMB, and state medical boards.

3. Military Service

- DD214 if recently discharged (i.e. within the past 12 months). If currently serving, comprehensive list of military experience, including military branch and enlistment dates.

Similar to education and training history, verifying an applicant's military experience provides insight into an applicant's work history and overall professional competency. The details derived from the above information provide a thorough overview of an applicant's performance. Enlistment time gaps may not be as straightforward as education and training gaps, but should not be overlooked and may require further investigation, including a written explanation by the applicant.

Primary Sources: DD214, National Personnel Records Center (NPRC), verification from the applicable military branch, and current duty station.

4. Professional Licensure

- Complete list and/or copies of all professional licensure including the issuing state, license type, license number, status, and issue and expiration dates

The applicable state licensing agencies verify the validity, dates, and status of licenses listed on an application. Licenses allow practice within the scope of each license held, however, facilities can restrict this scope through privileging. MSPs should also query the Federation of State Medical Boards (FSMB) for any unreported licenses.

MSPs should directly investigate surrendered licenses or license sanctions, restrictions, revocations, suspensions, reprimands, or probations by a licensing entity, if applicable, or the National Practitioner Data Bank (NPDB). Applicants should also submit a written explanation of any instances of discipline, suspension, probation, or reprimand.

Primary Sources: State licensing boards and FSMB.

5. DEA Registration and State DPS and CDS Certifications

- Complete list and/or copies of DEA, DPS, and/or CDS certificates including issuing state, status, registration number, and issue and expiration dates

Primary Sources: DEA, National Technical Information Service, state DPS, state CDS.

6. Board Certification

- Complete list of Board-specialty certifications held including original dates; recertification dates; and participation, if applicable, in Maintenance of Certification.

The applicable certifying Board is the primary source for this verification. Board-certification verification must adhere to specific maintenance of certification requirements, if applicable.

Primary Sources: Directly from the board or display agent, such as ABMS, AMA, or AOA.

7. Affiliation and Work History

- Chronological, comprehensive list of all facilities in which a practitioner has worked or held clinical privileges (e.g. academic appointments, hospitals, practice groups, surgery centers, etc.), including start date, date on staff, employment or staff status, verification of standing, and end date for at least the past 5 years for work history and 5 years for

affiliation history – or as far back as necessary per any conflicting information or suspicious indicators.

- Explanation of any time gaps greater than 60 days

A practitioner’s application and resume/curriculum vitae should be checked against primary sources. A practitioner in good standing should have no adverse professional review action taken by an employer or work affiliation. The Health Care Quality Improvement Act defines “adverse actions” as “reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.”² NAMSS Practitioner Affiliation Sharing Source (PASS) has two options for letters attesting to good standing that assert that neither the practitioner’s staff membership nor clinical privileges have been involuntarily reduced, restricted, suspended, revoked, denied, or not renewed.³

Applicants must provide a written explanation for any instances of discipline, suspension, probation, or reprimand as well as work history time gaps greater than 60 days. Affiliation history should include the start and end months and years (MM/YY-MM/YY). Obtaining a complete work history is ideal, but MSPs should verify at minimum the past 5 years of work history and the past 5 years of affiliation history to help assess current competency.

Affiliation and Work History is currently an element that is only verified based on what a practitioner divulges on the application form or curriculum vitae. NAMSS recognizes this can cause unknown gaps in essential information that may relate to a practitioner’s clinical competence. NAMSS continues to work with industry partners to promote PASS that allows hospitals and other healthcare entities to directly report affiliation data. An ideal standard is to have all of the practitioner’s professional affiliations and practice history confirmed instead of what is voluntarily reported.

Primary Sources: NAMSS PASS or verification from applicable facilities.*

** NAMSS PASS is a secure, online database that provides quick, easy, and inexpensive access to the affiliation history of the practitioners you credential and is the first and only universal resource for tracking practitioner affiliation history*

8. Criminal Background Disclosure

- Federal, state, and county databases

Background checks include conducting a County Criminal Search and National Criminal Search to check an applicant’s criminal activity within the past seven (7) years at minimum. MSPs should query each County Criminal Search for all counties in which the applicant has resided and worked. Collectively, the County and National Criminal Searches use an array of databases to collect information such as sex-offender data and terrorist activity.

Frequent adverse incidents throughout an applicant’s work history, felony convictions, criminal history, and rehabilitation history may require additional, more extensive review. Criminal background checks should occur during initial credentialing.

Primary Sources: National, state, and county criminal databases, (facility-approved government body vendor).

9. Sanctions Disclosure

- Federal and state, if applicable

Temporary and permanent sanctions or licensure restrictions are relevant. The type of licensure restriction is important to consider. For instance, a physical limitation may preclude performing surgery, but not other types of clinical practice. Explanations should accompany any sanctions from certifying boards, payers, CMS, or licensing agencies. NPDB's Continuous Query issues alerts for new and monthly reports of all CMS sanctions, federal sanctions, state sanctions, and restrictions on licensure, certification, or scope of practice. The Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) maintains and provides monthly updates on practitioners currently barred from participating in CMS and/or other federal healthcare programs. The System for Award Management (SAM) monitors federal agency debarments, including those from OIG.

Primary Sources: NPDB, OIG, SAM, FSMB.

10. Health Status

- Verifying whether the applicant has or ever had any physical or mental condition that would affect his/her ability to practice.

Primary Sources: Applicant attestation; practitioner's application; physical, if applicable.

11. NPDB

The NPDB provides healthcare-specific information on state and federal criminal convictions and civil judgments, as well as malpractice history and hospital sanctions. The Data Bank must be queried during the initial credentialing process in accordance with the provisions of the Health Care Quality Improvement Act.

Primary Source: NPDB.

12. Malpractice Insurance

- Comprehensive list of insurance carriers, including coverage dates and coverage types
- List of open, pending, settled, closed, and dismissed cases
- Current certificate of insurance

The applicant should provide a listing of all current and past malpractice insurance carriers within at least the past five years, including coverage dates, coverage types, and policy numbers. MSPs should query relevant databases to verify an applicant's complete malpractice history and ascertain the background, status, and nature of any malpractice cases associated with the applicant. The MSP should verify that the applicant holds current professional liability coverage with limits that meet or exceed their organization's requirements.

Primary Sources: Current and past malpractice carriers, NPDB.

13. Professional & Peer References

- Professional references noting current competence

Professional authorities who have worked directly with the applicant within the past two years – such as training program directors and department chairs or chiefs – who can authoritatively speak to an applicant’s experience, as well as peer references within the same professional discipline, are ideal references.

The Accreditation Council for Graduate Medical Education (ACGME) recommends six best-practice standards for assessing an applicant’s competencies: patient care, medical knowledge, practice-based learning and improvement, systems-based practice, professionalism, and interpersonal skills and communication.⁴ Those providing references should consider ACGME’s list when assessing an applicant’s ability to competently perform requested privileges as delineated on the peer reference request.

Primary Sources: Letter or form signed and dated from the professional reference.

Next Steps: Additional Process Reforms Needed

Currently, administrative protocol accounts for between 15-30 percent of all healthcare spending.⁵ Price Waterhouse Cooper estimates that reducing administrative redundancies could save hospitals an estimated \$40 million each year.⁶ In response to Sections 1104 and 10109 of the Affordable Care Act and to reduce administrative burdens, the National Committee on Vital Health Statistics (NCVHS) developed recommendations to digitize and standardize the practitioner credentialing process.⁷

NCVHS cited redundant forms, the lack of automation, and the unique process that each facility requires as the critical obstacle to simplifying and streamlining the practitioner credentialing process.⁸ The time that medical service professionals (MSPs) must devote to processing redundant credentialing forms alone is approximately 20 hours per provider each year. A 2012 estimate projected that a standardized credentialing system could save the U.S. healthcare system close to \$1 billion each year.⁹

While verifying the 13 essential data elements for initial practitioner credentialing will create efficiencies at many healthcare facilities, significant reform is still required in how the data verification is paid for as this drives significant expense.

As most practitioners apply to multiple facilities simultaneously, their data is also being verified by each individual facility simultaneously. When practitioners move to additional facilities the same static data needs to be verified by those new facilities even when the already verified data is static. Facilities are repeatedly paying to verifying the same information. Repeated verification on data that is static results in significant wasteful spending. The healthcare system should assess the value of additional process efficiencies that would not require the repeated

verification of static data. The 13 criteria defined in the standard serve as the basis for defining the data that require verification for an initial application. The additional expense associated with verifying static information that provides no new information about a practitioner or his/her competency should be considered for elimination in the future

Technology should be utilized to ensure static data does not need to be re-verified once it has been confirmed once by the primary source. In addition, other reforms could be considered such as creating a national clearinghouse to verify all practitioners' data so that the same data is not being paid to be verified over and over by multiple entities. NAMSS will hold future meetings to discuss reforms that could bring additional efficiencies to practitioner credentialing and thereby save the healthcare system significant resources.

⁶ CNA HealthPro. Medical Staff Credentialing: Eight Strategies for Safer Physician and Provider Privileging. Pg. 5. VP O9, Issue 3. 2009. http://www.cna.com/vcm_content/CNA/internet/Static%20File%20for%20Download/Risk%20Control/Medical%20Services/MedStaffCredentialing.pdf

² "Public Law 99-660: Health Care Quality Improvement Act of 1986." (100 Stat. 3743). Date: 11/14/86.

³ Option 1: "Good Standing" means that no adverse professional review action as defined in the Health Care Quality Improvement Act has been taken regarding this practitioner. That means that there has been no reduction, restriction, suspension, revocation, denial, or non-renewal of the practitioner's staff membership or clinical privileges. A "restriction" is defined to mean that a mandatory concurring consultation requirement has been imposed upon the practitioner (i.e., the practitioner must obtain a consult and the consultant must approve the course of treatment in advance). Option 2: "Good Standing" means as follows: 1. Our Hospital evaluates the six ACGME general competencies (patient care, medical/clinical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and system-based practice) as part of our appointment, reappointment, and privileging processes; 2. No adverse professional review action as defined in the Health Care Quality Improvement Act has been taken regarding this practitioner. That means that there has been no reduction, restriction, suspension, revocation, denial, or non-renewal of the practitioner's staff membership or clinical privileges. A "restriction" is defined to mean that a mandatory concurring consultation requirement has been imposed upon the practitioner (i.e., the practitioner must obtain a consult and the consultant must approve the course of treatment in advance); and 3. Our Hospital is unaware of any health issues that might affect the practitioner's ability to practice safely and competently.

⁴ The Accreditation Council for Graduate Medical Education. <https://www.acgme.org/acgmeweb/>

⁵ Robert Wood Johnson Foundation and ConsumersUnion. "Addressing the Rising Health Care Costs: A Resource Guide for Consumer Advocates." November 2013. Pg. 20. http://consumersunion.org/healthcosts/HealthCareCosts_BriefingBooklet-DigitalVersion.pdf.

⁶ PricewaterhouseCoopers' Health Research Institute. The Price of Excess: Identifying Waste in Healthcare Spending. 2010. <http://pwchealth.com/cgi-local/hregister.cgi/reg/waste.pdf>

⁷ National Committee on Vital and Health Statistics. Letter to Secretary Kathleen Sebelius, Department of Health & Human Services. March 2, 2012. <http://ncvhs.hhs.gov/120302lt3.pdf>

⁸ Ibid.

⁹ David Cutler, Ph.D., Elizabet Wikler, B.A., and Peter Basch, M.D. "Reducing Administrative Costs and Improving the Health Care System." N Engl J Med 2012; 1875-1878. Nov. 2012.