Credentialing, Recredentialing, and Privileging: The Basics and Beyond

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What We Will Cover

- Overview of Credentialing/Privileging
- Federal and State Regulations,
- Joint Commission Hospital Standards
- Primary Source Verification
- Appointment and Privileging Criteria
- “Red Flags”
- Privileging
- Peer Review/Due Process
- Roles and Responsibilities
- Understanding Negligence in Credentialing

Difference Between Credentialing and Privileging

Credentialing involves verification of a practitioner’s “credentials” Privileging involves documentation and evaluation of the actual patient care, treatment, or services that will be provided at your facility

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Credentialing, Recredentialing, and Privileging Basics

Why do we do it?

- To protect patients
- Risk management – negligent credentialing
- Accreditation/Regulatory requirements

Review Of Application

- Each question should be answered legibly
- Signed and dated
- No unexplained time gaps since medical or professional school

What is a COMPLETE Application?

- Needs to be defined in Bylaws or MS Policy
- No blanks, all attachments present
- No gaps
- All verification/information received
- No inconsistencies identified
- Current competency documented
Remember!
THE BURDEN OF PROOF IS ON THE APPLICANT

Credentialing Process for Hospitals Established in
• Bylaws
• Rules & Regulations
• Policies & Procedures

CMS Regulations and Interpretative Guidelines for Hospital
Medicare Conditions of Participation
Hospital and CAH

- CoPs require criteria for determining privileges and for applying the criteria:
  - Individual character
  - Individual competence
  - Individual training
  - Individual experience
  - Individual judgment

Hospital IG §482.22(a)(2) Medical Staff

- The individual’s credentials to be examined must include at least:
  - A request for clinical privileges
  - Evidence of current licensure
  - Evidence of training and professional education
  - Documented experience
  - Supporting references of competence

Hospital §482.22(a)(2)

- MS must examine the credentials of all eligible candidates for MS membership and make recommendations to the GB on the appointment of these candidates in accordance with State law, including scope-of-practice laws, and MS bylaws, R&R
- A candidate who has been recommended by the MS and who has been appointed by the GB is subject to all MS bylaws, R&R, in addition to the requirements contained in this §482.22
Questions?

Comments!

Joint Commission
Hospital Standards for
Medical Staff
Credentialing and
Privileging

MS.06.01.03 - Credentialing

• Applicants credentialed using a defined process
• Bylaws outline the credentialing process
• Credentialing process based on MS recommendations approved by GB
• Verification of identity
Credentialing, Recredentialing, and Privileging Basics

**MS.06.01.03 – Credentialing – Cont.**

- Credentialing process includes requirement for verification of relevant training, current competence, and current licensure
- Verification must be in writing and must come from the primary source, if possible; or from a CVO
- Verify licensure at the time of initial granting, renewal, and revision of privileges, and when the license expires

**MS.06.01.05 – Privileging – Cont.**

- Criteria based on MS recommendations and approved by the governing body
  - PSV for current licensure/certification, relevant training
  - Evidence of physical ability to perform the requested privileges
  - Data from professional practice review from the other organization where the applicant currently has privileges, if available
  - On renewal, review of the applicant’s performance within the hospital
  - Recommendations from peers and/or faculty
- Hospital consistently evaluates each criterion for all practitioners with like privileges

**MS.06.01.05 – Privileging – Cont.**

- Before recommending privileges MS evaluates
  - Challenges to any licensure or registration
  - Voluntary and involuntary relinquishment of any license or registration
  - Voluntary and involuntary termination of medical staff membership
  - Voluntary and involuntary limitation, reduction, or loss of clinical privileges
MS.06.01.05 – Privileging – Cont.

• Before recommending privileges MS evaluates
  – Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
  – Documentation as to the applicant’s health status
  – Relevant practitioner-specific data as compared to aggregate data, when available
  – Morbidity and mortality data, when available

• Privileging process includes attestation that there are no existing health problems that could affect ability to perform requested privileges
  – Evaluation is documented in credentials file
    • Applicant's statement that no health problems exist that could affect his or her practice
  – Statement should be confirmed
  – Initial applicants health status confirmed by
    • Director of a training program
    • Chief of services
    • Chief of staff at another hospital at which the applicant holds privileges,
    • MD/DO approved by the medical staff
  – When in doubt about an applicant’s ability to perform privileges requested, an evaluation by an external and internal source may be required by the medical staff

• NPDB on initial grants of privileges, on renewal of privileges, and when new privileges are requested (HCQIA requires every 2 years)
  • The hospital must have a process to determine whether it has adequate clinical performance information to make its decision regarding the granting, limiting, or denial of privileges
MS.06.01.05 – Privileging – Cont.

• Peer recommendations include current information in writing regarding
  – Medical/clinical knowledge
  – Technical and clinical skills
  – Clinical judgment
  – Interpersonal skills
  – Communication skills
  – Professionalism

MS.07.01.03 – Peer Recommendations

• Include requirements of MS.06.01.05
• Obtained and evaluated for all new applicants for privileges
• Used on renewing privileges if there are insufficient practitioner-specific data available
• Practitioner in same professional discipline with personal knowledge of the applicant’s ability to practice

MS.06.01.05 – Privileging – Cont.

• Completed privilege applications are acted on within the specified time period specified in the bylaws
• When changes in clinical privileges are made, information regarding the practitioner’s scope of privileges is updated
Questions?

Comments!

Applying Criteria for Membership and Privileges

- Criteria for granting/denying privileges must be consistently applied
Exercise

Using the Sample Medical Staff Bylaws Language for Medical Staff Appointment and Sample application, determine whether the applicant should be sent an application based on bylaws requirements.

See page 3 - 10

Primary Source Verification

- Information received directly from the issuing source
  - Written
  - Phone (name of organization, date, person contacted, questions asked, response, the name of the person receiving the response)
  - Fax
  - Approved web site
- Can be Internal, Centralized, Delegated
Designated Equivalent Sources

- Agencies determined to maintain specific item(s) of credential information identical to the information at the primary source
- Primary source may designate another organization as its agent in providing information to verify credentials

Verification of Individual Elements

- Education
- Training
  See sample letters page 14

Verification of Individual Elements

- Experience
- Work History
  See sample letters page 22
Closed/Hard to Reach Facilities

- Consider using “secondary sources”:
- Written statement from leader of closed organization or successor organization
- Another hospital that has documented primary source verification of the applicant’s credentials

Verification of Individual Elements

- Licensure

Verification of Individual Elements

- Sanctions Disciplinary action
  - Licensure
  - OIG List of Excluded Individuals/Entities
    - exclusions.oig.hhs.gov
  - System for Award Management
    - sam.gov

See P&P page 31
Verification of Individual Elements

Peer Recommendations

See sample letter page 18

Verification of Individual Elements

Liability History/Proof of Coverage

See sample letter page 35

Verification of Individual Elements

• Health Status/Ability to Perform Procedures
  – Attestation
  – Physical exam
Verification of Individual Elements

Board Certification

Verification Of Identity

See sample policy page 39

Questions ?

Comments !
Clinical Privileges

Privileging

Process used to identify, document, and approve the specific procedures and treatments that may be performed in a specific setting

History/Background

• Only admitting privileges were granted and only to physicians
• Fewer treatment options were available so most practitioners could competently perform them
History/Background

- In the 1950’s, the ACOS recommended the laundry list approach
- Many physicians had not completed residencies, so skills varied
- As technology advanced, hospitals began establishing lists of all procedures that could conceivably be performed

Privileges - Today

- Privileges are granted within area of practice
- They are not a right
- Applicant must prove qualifications through documentation of training, experience, competence

Privileging Systems

- Categories or Levels
- Lists or “Laundry Lists”
- Core
- Combination

See samples starting on page 41
“Special Privileges”

- Require additional skills/training
- May differ depending on when technology was developed
- Contractual considerations

Adding New Privileges

- Who will be able to do it?
- What training/experience is required?
- Are there any other requirements?
  - CME, board certification, training course, peer recommendations
- Will proctoring be required?
- How will we follow up/review quality?
- Is there a transference of skill?

See worksheet page 61

Sample Privilege Form Language

The procedures/privileges listed on this form reflect what most physicians with specified training and experience can request & the hospital can support. Your ability to perform each procedure/privilege will be assessed.
Sample Privilege Form Language

Core or Category
If you do not wish to request or perform a procedure/privilege appearing on this list, please cross it off the list and initial (or write in below).

List
Please limit your requests to those procedure/privileges that you will be performing at this facility.

Communicating to Stakeholders

• Practitioners
• Hospital Staff
• Department chief
• External entities

See sample policy and procedure page 28

Temporary Privileges and Expedited Credentialing: Meeting Patient Need without Compromising Patient Safety

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Temporary Privileges – TJC

Under certain circumstances TP can be granted for a limited period of time:

- Fulfill an important patient care, treatment, or service need
- Applicant with complete application raising no concerns awaiting review and approval of the MEC and governing body
Patient Care Need
TJC – Verify:

• Current licensure
• Current competence
• NPDB also required per HCQIA

TJC – TP - New Applicant

Verify:  
• Current licensure  
• Relevant training or experience  
• Current competence  
• Ability to perform the privileges requested  
• Other criteria required by medical staff bylaws  
• NPDB

“Must have’s”  
• Complete application  
• No successful challenges to licensure or registration  
• No involuntary termination of MS appointment  
• No involuntary limitation, reduction, denial, or loss of clinical privileges

TJC - Temporary Privileges

• Limited to 120 days for new applicants  
• Specific limitation of days for important patient care need not addressed – time limited and spelled out in Bylaws  
• Recommended by MS President or designee  
• Granted by CEO or designee
Evaluate “Red Flags” on an individual basis. Don’t be afraid to ask for additional information!!

Red Flags

• Loss of licensure / DEA
• Loss of appointment or privileges
• Frequent moves (excluding military)
• Excessive professional liability judgments or settlements
Red Flags

- Information on the application that differs from information received from respondents
- Negative responses from references
- Adverse actions by health plan due to quality of care or professional conduct
- Unexplained Gaps

John Anderson King, DO aka Christopher Wallace Martin

- 80-84 – DO at U of New England College of Osteopathic Medicine
- 7/84 - 6/85 – Internship Cuyahoga Falls General Hosp
- 7/85 - 10/85 – Anesthesia residency Med College Georgia
- 1/86 - 6/86 – Anesthesia residency Monmouth Med Center NJ
- 7/86 - 1/87 – Anesthesia residency Western Reserve OH
- 1989 – Resigns from Walker Regional MC, Jasper, AL after privileges suspended
- 11/90 – 2/92 – OB/GYN residency Albert Einstein, Philadelphia (not completed)
- 5/93 – 5/95 – Ortho residency Hillcrest HC, OK City, OK (not completed)
- 1993 – 1997 – Ortho residency Lincoln Mental Health Center, Bronx, NY
- 1997 – 1999 – Jackson Hospital, Marianna, FL
- 2000 – 2002 – Doctors Hospital, Groves, TX

NY Medical Board – Dr. King

- The Hearing Committee sustained the charge finding the physician guilty of having been disciplined by the Alabama State Board of Medical Examiners for unprofessional conduct: endangering the health of patients; gross or repeated malpractice or gross negligence, and being unable to practice medicine with reasonable skill and safety due to lack of basic medical knowledge or clinical competency.
Actual Disciplinary Actions

- License to practice medicine in the state of LA was placed on probation for a period of three (3) years.
- Dr. is prohibited from prescribing controlled substances for the treatment of non-cancer-related chronic pain or obesity nor shall he receive remuneration from, have ownership interest in or association with any clinic or practice setting or arrangement that advertises or holds itself out to the public as a clinic or practice for the care and/or treatment of patients for the management of chronic pain or obesity.
- Dr. shall not enter into or continue in a collaborative or supervisory practice agreement with a mid-level provider, e.g., nurse practitioner or physician assistant
- Dr. shall provide a copy of the Order to each hospital, clinic, facility or other employer or prospective employer at which or for whom he provides services as a physician in this state

Actual Disciplinary Actions

By Order Terminating Probation dated and effective January 5, 2014, the license of REB, PA, to practice as a physician assistant in this state was reinstated without probation; conditioned upon his continued compliance with respect to on-going monitoring and maintenance of abstinence.

Actual Disciplinary Actions

- Inappropriately and unnecessarily performing breast exams
- Engaged in a sexual relationship with a patient for approximately thirty (30) days in 2005
- License on probation for 10 years
Actual Disciplinary Actions

- Licensee failed to notify the Board of a change in work address, and practiced for a period of time without a valid license.
- License publicly reprimanded

Actual Disciplinary Actions

- Failure to appropriately account for federally-funded vaccines provided free of charge to indigent children.
- While participating in the federal program, Licensee administered the free vaccines to private patients and billed patients or their insurance companies for the vaccines.
- Board Action: License is Publicly Reprimanded.
- Licensee must take and complete a Board-approved course in medical ethics.

Actual Disciplinary Actions

- Failure to register each place of practice where she distributed controlled sub.
- Licensure reprimanded.
Actual Disciplinary Actions

- Physician entered into a romantic and sexual relationship with a patient
- Prescribed controlled substances to the patient during the relationship
- Entered into a financial arrangement with the patient to aid his psychiatric practice, when the patient attempted to end relationship, he struck her in the head with channel lock pliers twenty to thirty times and left her bleeding in his office

RED FLAGS

Work Session

Questions?

Comments!
Roles and Responsibilities

Typical Review and Approval Process – Roles and Responsibilities

<table>
<thead>
<tr>
<th>Step</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Credentialing expert - Verification of credentials</td>
</tr>
<tr>
<td>Step 2</td>
<td>Department chair or service chief review and recommendation</td>
</tr>
<tr>
<td>Step 3</td>
<td>Credentials committee review and recommendation</td>
</tr>
<tr>
<td>Step 4</td>
<td>Medical executive committee review and recommendation</td>
</tr>
<tr>
<td>Step 5</td>
<td>Governing body review and final decision</td>
</tr>
</tbody>
</table>

Interviewing Applicants

- Credentials Committee, MEC, Department Chair, MS President
- Use structured interview form

See sample interview questions page 62
Documenting Recommendations and Actions

• Document recommendations made and actions taken in each step of the process
• Documentation included in meeting minutes or on an approval form. Include the reasons for the recommendation or decision

See sample forms and minutes pages 63-64

Peer Review Defined - AMA

Medical peer review is the process by which a professional review body considers whether a practitioner’s clinical privileges or membership in a professional society will be adversely affected by a physician’s competence or professional conduct. The foremost objective of the medical peer review process is the promotion of the highest quality of medical care as well as patient safety.
Peer Review vs. Quality Assessment/Performance Improvement

There is a difference...

QA vs PI/QI

**QA**
- Inspection
- Measure performance against predetermined standards and benchmarks
- Focus is on identifying outliers (bad actors) and improving performances so they meet standards

**PI/QI**
- Prevention
- Focus is on improving processes and reducing variations so performance increases for all staff
- If problems are identified, attention directed to the process, not individuals

Documents and References

**Peer Review**
- HCQIA
- State Regulations (Medical Practice Acts)
- Accreditation Standards
- Bylaws
- Medical Staff
- FPPE/OPPE/Peer Review P&P

**PI/QI/QA**
- CMS Regulations
- State Regulations
- Bylaws
- Medical Staff/Hospital QAPI plans

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Peer Review Committee Tips

• Peer review process should be defined, understood, accepted and adhered to
• For quality of care issues, case is reviewed by a “like” specialist
• Reviewers are unbiased without conflict of interest
• Peer review committee meets regularly to assure timely review and response to issues
• Follow-up after the subject physician provides input
• Reviews should be non-accusatory and professional
• Know when to send peer review cases out to an independent reviewer

DUE PROCESS

Health Care Quality Improvement Act

• Provide adequate notice and a hearing to the physician involved
• If timely request for a hearing, the professional review body must provide the physician notice of the hearing, including a list of witnesses expected to testify on the professional review body’s behalf.
• The hearing cannot be scheduled for less than 30 days after the date of the notice
Health Care Quality Improvement Act

- The HCQIA permits hearings to be held before an officer, panel or an arbitrator
- After the hearing the physician involved advised of recommendation(s) in writing
- In the case of determining whether to grant, suspend, or revoke a privileges or MS membership, board makes the ultimate determination

Questions?

Comments!

Understanding
Negligence in
Credentialing
What is Negligence?

Conduct that is culpable because it falls short of what a reasonable person would do to protect another individual from a foreseeable risk of harm.

Theories of Liability

- Corporate Liability
- Governing Body Authority
- Respondeat Superior
- Apparent or Ostensible Agency

Elements of Negligence

- Duty to Exercise Due Care
- Breach of Duty
- Injury
- Proximate Cause
- Injured party must be able to establish that the injury resulted in compensable damages

4D's: Deviation from Duty Directly causes Damages
Duty to Exercise Due Care

- State licensing regulations
- Accreditation standards
- Medical staff and facility bylaws, R&R, policies
- Case law

Examples of Breach of Duty

- Failure to follow own bylaws, regs, etc
- Failure to address concerns identified in the credentialing & recredentialing process
- Adopting an unreasonable policy

Setting a Precedent

- Establishes a new legal principle based on a certain set of facts
- Finding is thereafter authoritative
Precedent-Setting Cases

- Darling v. Charleston Community Memorial Hospital, 33 Ill. 2d 326, 211 N.E. 2d 253, 1965
- Johnson v. Misericordia Community Hospital, 294 N.W. 2d 501, 97 Wis. 2d 521 (Wis. 1981)

Recent Cases

- Frigo v. Silver Cross Hospital and Medical Center, No. 1-05-1240 (Ill. App. July 26, 2007)
Providing Information

- Provide correct information when answering verification requests
- Don’t omit key information when answering verification requests
Decreasing the Chance

Medical Staff involvement in all phases of credentialing and privileging

• Follow all policies, procedures, bylaws
• Audit bylaws, rules & regulations, and policies
• If you are not in compliance with bylaws
  – Determine if required
  – Change if not required
ACPE 2006 Survey Patient Trust and Safety

Is there a doctor in your community that you would avoid because you think he or she makes medical mistakes?

Patient Responses | Physician Responses
--- | ---
20% Yes | 77% Yes
78% No | 23% No
2% Don't know

Mongan Institute for Health Policy at Mass. General Hospital 7/2010 Study

• 64 percent agreed that physicians should always report impaired or incompetent colleagues
• 17% had direct personal knowledge of impaired colleague, but only 67% reported

Reasons for not Reporting

• Felt someone else was taking care of the problem
• Thought nothing will happen
• Fear of retribution

“Our findings cast serious doubt on the ability of medicine to self-regulate with regard to impaired or incompetent physicians”
Questions?

Comments!