

NAMSS
Consolidated Standards
AAAHHC, HFAP, NCQA, TJC, URAC
and DNV

(Includes primarily standards not listed in the NAMSS
Comparison of Accreditation Standards)

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Summary of Selected AAAHC Core Standards related to Credentialing and Privileging

Governance

The governing body addresses and is fully and legally responsible for the operation and performance of the organization. This can be done directly or by appropriate professional delegation.

The governing body must meet at least annually and keep minutes or other records as may be required for the orderly conduct of the organization.

Credentialing

Credentials must be verified according to the procedures established in bylaws, rules and regulations. Provisions must be made for expeditious processing of applications for clinical privileges. There must be a procedure for obtaining primary or secondary source information.

Credentialing is a three-phase process to assess and validate qualifications to provide services.

1. Establish minimum training, experience, and other requirements for physicians and other healthcare professionals
2. Establish a process to review, assess, and validate an individual's qualifications, including education, training, experience, certification, licensure, and any other competence-enhancing activities against the organization's established minimum requirements
3. Carries out review, assessment, and validation outlined in the organization's description of the process

The governing body must:

- establish and is responsible for a credentialing and reappointment process and applying criteria uniformly to all individuals who provide patient care
- approve mechanisms for credentialing, reappointment, and granting of privileges, suspending or terminating clinical privileges, including provisions for appeal of such decisions
- review and make decisions on initial appointment, reappointment, and assignment or curtailment of clinical privileges based on peer evaluation (must be consistent with state law), although it may delegate the review and recommendation of applications to a medical director or committee if so documented
- have specific criteria for initial appointment and reappointment of physicians and dentists
- make provisions for processing of clinical privileges applications within timeframes specific in bylaws and/or policies

Ongoing Monitoring

The organization monitors and documents the currency of date sensitive information on an ongoing basis (at expiration, appointment and reappointment, at a minimum). These credentials include licensure, DEA, board certifications and professional liability insurance (if required),

Privileging

The organization has its own independent process of credentialing and privileging that includes review and approval by the governing body.

Appointment or privileges may not be approved solely on the basis that another organization, such as a hospital, took such action, although this information can be used in consideration of the application.

The governing body provides a process for the initial appointment, reappointment, assignment or curtailment of privileges and practice for allied health care professionals. The process is consistent with state law and includes primary or secondary source verification of education, training, experience and competency, as well as licensure or certification, as applicable.

Summary of Selected HFAP Medical Staff Standards

APPLICATION AND REAPPLICATON REQUIREMENTS (Standard 03.01.15)

Meeting attendance is evaluated at time of reappointment against the requirements of the medical staff bylaws.

FAIR HEARING PROCESS (Standard 03.01.19)

The hospital shall have a fair hearing plan for members of the Medical Staff (which may include non-physician practitioners as determined by the Governing Body).. Individuals involved in Peer Review activities shall be impartial peers and shall not have an economic interest in and/or a conflict of interest with the subject of the Peer Review activity. Impartial peer would also exclude individuals with blood relationships, employer/employee relationships, or other potential conflicts that might prevent the individual from giving an impartial assessment, or give the appearance for the potential of bias for or against the subject of the Peer Review.

The fair hearing plan outlines the circumstances under which a practitioner may request (or waive) this mechanism:

- Denial.
- Modification or changes in appointment/reappointment category.
- Initial or re-granting of privileges with final review/action by the Governing Body.

REQUIRED COMMITTEES (Standard 03.02.01)

There are two required committees: Medical Executive and Utilization Review. A Credentials Committee is not required but may be established to perform the function.

In small hospitals, designated members of the professional staff or the staff serving as a committee-of-the-whole may perform these functions.

TIME FRAME FOR PROCESSING APPLICATIONS (Standard 03.06.08)

A recommendation shall be made to the Medical Executive Committee (MEC) within 60 days of receipt of completed application. The recommendations of the Credentials Committee (function) will be based on individual practitioner's qualifications and competency at the time the privileges are requested. All recommendations to the Medical Executive Committee (MEC) shall contain a delineation of the privileges to be extended to the applicant.

ONGOING PROFESSIONAL PRACTICE EVALUATION (Standard 03.15.01)

Ongoing professional practice evaluation (OPPE) information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), and/or to revoke an existing privilege prior to or at the time of renewal.

The Medical Staff have a process to monitor the competency of its members. Through an ongoing review of performance measurements, negative trends are tracked and

trended in a manner that allows the leadership to identify performance issues and implement strategies that will effect change. Prospective and real-time evaluation is important to ensure the delivery of safe and competent care. The Medical Staff develop an ongoing professional practice evaluation plan that is applicable to all practitioners with privileges granted by the governing body. The plan for the evaluation of each practitioner's professional practice is clearly defined. This medical staff approved plan addresses each of the following:

1. Reasons for ongoing professional practice performance evaluations
2. Identification of performance indicators specific to each department of the medical staff
3. Data collection methods
4. Individual(s) responsible for data collection
5. Sources of data, e.g., medical records
6. Frequency of data collection
7. Methods for evaluation and analysis of data
8. Confidentiality and security of data
9. Individuals that may access individual practitioner's professional practice data
10. Explanation that data will be used as a measure of competency and will be reviewed at time of reappointment to determine eligibility
11. Evaluation of low volume practitioners
12. Triggers for additional, focused monitoring Processes are established to ensure the confidentiality and security of the ongoing professional practice

FOCUSED PROFESSIONAL PRACTICE EVALUATION (Standard 03.15.02)

The organized medical staff defines the circumstances requiring additional, focused monitoring and evaluation of a practitioner's professional performance. Indications for focused professional practice evaluation (FPPE) include:

- All initial privileges granted
- All new privileges granted following initial appointment
- Unacceptable levels of performance or quality of care concerns

The FPPE process is designed to be a fair, balanced, and educational approach to ensure the competency of the staff. FPPE is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff. The individual is provided written notification of the FPPE with a copy in the individual's credential file. The Medical Staff Bylaws clearly define the FPPE process and addresses each of the following:

- Criteria (triggers) for conducting focused performance monitoring.
- Methods for determining the duration of focused performance monitoring.
- Indications for an external reviewer.

The department chair is responsible to assign the focused evaluation. The focused evaluation may be defined as either a period of time (e.g., six months) or a specific number of cases. The focused evaluation may be extended, as defined in the Bylaws.

Data sources for the focused evaluation are defined and may include:

- Chart review.
- Direct observation.
- Simulation.
- Discussion with others involved in the care of each patient.

The Medical Staff Bylaws define the unacceptable levels of performance that trigger the need for focused performance monitoring. Triggers may be a single incident or evidence of a clinical practice trend.

Summary of Selected TJC Standards Related to the Medical Staff

MS.06.01.03 – Credentialing

Information specific to the applicant's current licensure status, training, and current competence must be gathered by the hospital using a defined credentialing process that is based on medical staff recommendations, approved by the governing body, and documented in the medical staff bylaws. Verification must be in writing and must come from the primary source, if possible, or from a CVO. (Note: Joint Commission also includes some designated equivalent sources that may be used in lieu of primary source.) The identity of the applicant must be verified. This can be accomplished by viewing either a current picture hospital ID card or a valid picture ID issued by a state or federal, agency such as a driver's license or passport.

MS.06.01.07 – Analysis and Use of Information

The medical staff must review and analyze all relevant information received regarding current licensure status, training, experience, current competence, and ability to perform the requested privileges through a clearly defined process. The organization develops and consistently applies criteria that will be considered in the decision to grant, limit, or deny a requested privilege. These criteria are based on recommendations by the medical staff and approved by the governing body. Criteria must be directly related to the quality of health care, treatment, and services or, if criteria are not related to quality of care, there must be evidence that the impact of the resulting decisions on the quality of care, treatment, and services has been evaluated. The governing body or its delegated committee has final authority for granting, renewing, or denying privileges. Privileges cannot exceed two years.

MS.06.01.09 – Privilege Decision Notification

The privileging decision must be communicated to the requesting practitioner within a time frame specified in the medical staff bylaws. In the case of a denial, the applicant must be told the reason for denial. The privileging decision must be distributed and made available to all appropriate internal and/or external persons or entities, as defined by the organization and applicable law. The practitioner must be notified of available due process or, when applicable, the option to implement the fair hearing and appeal process.

MS.06.01.11 – Expediting the credentialing and privileging processes

If it chooses, the governing body can use an expedited process for initial appointments and for reappointments to the medical staff and when granting privileges. The governing body may delegate these decisions to a committee consisting of at least two voting governing body members. Expedited credentialing may not be used if the applicant's application is incomplete or the medical staff executive committee makes a final recommendation that is adverse or has limitations. Criteria developed by the medical staff for the expedited process must be followed.

The following situations should be evaluated on a case-by-case basis and usually lead to ineligibility for expedited credentialing:

- the applicant has a current or previously successful challenge to licensure or registration;
- the applicant has had an Involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges; or
- the applicant has had an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment.

Note that this standard does not state that these issues definitely make the practitioner ineligible. Joint Commission allows the organization to consider each specific case.

MS.07.01.01 – Recommendations for Staff Membership/Appointment

The medical staff makes recommendations to the governing body for medical staff appointment as part of its oversight of the quality of care, treatment, and services provided by privileged practitioners. The medical staff must develop and utilize criteria for medical staff membership. These criteria should be designed to assure the medical staff and governing body that patients will receive quality care, treatment, and services. Appointments and subsequent reappointments cannot exceed a period of two years.

MS.10.01.01 – Fair Hearing and Appeal Process for Adverse Privileging Decisions

The medical staff must have a fair hearing and appeal process for addressing adverse decisions regarding reappointment, denial, reduction, suspension, or revocation of privileges that relate to quality of care, treatment, and service issues. A fair hearing and appeal process allows the practitioner the opportunity to defend him or herself against the adverse action before an unbiased hearing panel of the medical staff. In addition, the practitioner has the opportunity to appeal the decision of the hearing panel to the governing body. The hearing and appeal procedure must be fair and must include a mechanism to schedule a hearing, procedures for the hearing to follow, the composition of the hearing committee as a committee of impartial peers, and a governing body mechanism to appeal adverse decisions. The process may differ for medical staff members and those nonmembers who are granted privileges.

MS.12.01.01– Continuing Education

Hospital-sponsored educational activities must be prioritized by the medical staff. These activities should relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital and on the findings of performance improvement activities.

Summary of NCQA Health Plan Credentialing Standards

CR 1: Credentialing Policies

A well-defined credentialing and recredentialing process is utilized to evaluate and select licensed independent practitioners (LIPs) to provide care to members.

Credentialing policies and procedures specify:

- Types of practitioners to credential and recredential
- Verification sources used
- Credentialing and recredentialing criteria
- Process for making credentialing and recredentialing decisions
- Process for managing credentialing files that meet the organization's criteria
- Process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner
- Process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from information they provided to the organization
- Process for ensuring that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision
- Medical director or other designated physician's direct responsibility and participation in the credentialing program
- Process used for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law
- Process for ensuring that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification and specialty.

Credentialing standards apply to all LIPs or groups of practitioners who provide care to members and practitioners who are licensed, certified or registered by the state to practice independently. They also apply to practitioners with an independent relationship with the organization, meaning the organization employs, contracts with, or otherwise directs its members to the practitioner for care.

The organization's policies must describe the sources used to verify credentialing information. Information must come from the primary source, a contracted agent of the primary source, or other NCQA-accepted sources listed for the credential.

The organization determines which practitioners can participate within its network. It must credential practitioners before the practitioners provide care to members. There must be a process for making credentialing decisions. The criteria required to reach credentialing decisions must be defined and must be designed to assess a practitioner's ability to deliver care.

Credentialing policies and procedures must:

- describe the process used to determine and approve files that meet criteria (all practitioner files can be presented to the Credentialing Committee or the organization may designate approval authority of clean files to the medical director or to an equally qualified practitioner)
- specify that the organization does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes
- have a process for preventing and monitoring discriminatory practices including taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes including at least annual monitoring for discrimination in credentialing and recredentialing practices
- describe the process for notifying practitioners when credentialing information obtained from other sources varies substantially from that provided by the practitioner
- specify that the time frame for notifying applicants of initial credentialing decisions and recredentialing denials does not exceed 60 calendar days from the Credentialing Committee's decision (not required to notify practitioners regarding recredentialing approvals)
- describe the medical director's or other designated physician's overall responsibility and participation in the credentialing process
- describe the process for ensuring confidentiality of information collected during credentialing
- describe the process for making sure that information provided in member materials and practitioner directories is consistent with the information obtained during the credentialing process, e.g. specialty, board certification

The organization must notify the practitioner about the right to review information submitted to support his/her credentialing application, to correct erroneous information, and to be informed of the status of their credentialing or recredentialing application.

The organization's policies and procedures must include system controls that are in place to ensure the security and confidentiality of credentials information, whether files are paper or electronic. The method(s) in which verifications are received, along with how the organization stores, reviews, tracks and dates the information must be documented. Changes to credentialing data must be tracked and include how the changes were made, which staff made the change and why the change was made. Staff allowed to access credentialing data, make changes and delete information must be identified, as well as when it is appropriate to change or delete data. Credentialing information must be kept secure by limiting access and preventing unauthorized access, changes or release of information. Appropriate management of passwords must be in place, including use of strong passwords, not writing down passwords, using IDs and

passwords that are unique to each user, password changes when requested by staff or if compromised, and review and oversight to ensure passwords are changed or disabled when appropriate. External entities that store, modify or create credentialing data on the organization's behalf are held to these same requirements. The organization must perform audits to ensure policies and procedures are followed and to identify and evaluate any security risks. Auditing methods, staff performing the audits and how often must be identified, as well as the level of oversight of the auditing department.

CR 2: Credentialing Committee

There must be a Credentialing Committee which utilizes a peer-review process to make recommendations regarding credentialing decisions. The Credentialing Committee's makeup must have representation from a range of participating practitioners.

The committee must be given the opportunity to review the credentials of all practitioners credentialed or recredentialed who do not meet the organization's established criteria, and to offer advice. The organization must consider this advice. The committee must give thoughtful consideration to the credentialing elements before making recommendations and document discussions in minutes.

The Credentialing Committee may review all files or it may give the medical director (or approved qualified physician designee) authority to evaluate and approve files. Policies and procedures must describe the process used to determine what applications meet the organization's criteria and must assign the medical director (or designee) the authority to determine that the file is "clean" allowing the medical director to evaluate and approve to the file. The file must include evidence of this evaluation and approval. The medical director's approval date is considered the "credentialing decision date." Even if a review board or governing body reviews a decision after the Credentialing Committee, NCQA considers the decision made by the Credentialing Committee to be final. Credentials must be verified within the specified time limits and must be valid at the time of the Credentialing Committee's or medical director's review and approval.

Provisional Credentialing

Provisional credentialing can be used when it is in the best interest of members to have the practitioner available before the initial credentialing process is complete. NCQA accepts provisional credentialing under the following conditions:

- There is PSV of a current, valid license to practice
- There is written confirmation of the past five years of malpractice claims or settlements from the malpractice carrier, or NPDB query
- There is a complete application and signed attestation
- The same process for presenting provisional files to the Credentialing Committee or medical director is followed
- Provisional status cannot last for more than 60 calendar days at which time the full credentialing process must be completed

- A practitioner can only be provisionally credentialed once

CR 3: Credentialing Verification

Requirements are outlined in the NAMSS Comparison of Accreditation Standards

CR 4: Recredentialing Cycle Length

Requirements are outlined in the NAMSS Comparison of Accreditation Standards

CR 5: Ongoing Monitoring and Interventions

Requirements are outlined in the NAMSS Comparison of Accreditation Standards

CR 6: Notification to Authorities and Practitioner Appeal Rights

When an organization has taken actions against a practitioner for quality reasons, it offers the practitioner a formal appeal process and reports the action to the appropriate authorities.

The organization has written policies and procedure for:

- the range of actions available to the organization and
- making the appeal process known to practitioners

The organization's policies and procedures state that the organization reviews practitioner conduct that could adversely impact the health of its members and that the range of actions that may be taken to improve the practitioner's performance before termination are defined. In addition, policies must state that any final adverse actions be reported to the appropriate authorities.

CR 7: Assessment of Organizational Providers

The organization has written policies and procedures for the initial and ongoing assessment of providers with which it intends to contract.

The organization's policy for assessing health care delivery providers specifies that, before it contracts with a provider and at least every three years, it does the following:

- confirms that the provider is in good standing with state and federal regulatory bodies
- confirms that the provider has been reviewed and approved by an accrediting body
- conducts an on-site quality assessment, if the provider is not accredited

In lieu of an onsite visit, organizational policy may accept a CMS or state quality review if that review is no more than three years old and a copy of the survey report or letter is obtained stating the facility was reviewed and passed inspection and that report meets the quality assessment criteria of the organization.

The organization assesses at least hospitals, home health agencies, skilled nursing facilities, and free-standing surgical centers, and inpatient/residential/ ambulatory behavioral health facilities providing mental health or substance abuse services.

CR 8: Delegation of CR

If the organization chooses to delegate credentialing and recredentialing activities, there is evidence of oversight of the activity.

The written delegation document:

- is mutually agreed upon
- describes the delegated activities and responsibilities of the organization and the delegated entity
- requires at least semi-annual reporting to the organization
- describes the process by which the organization evaluates the delegated entity's performance
- specifies the organization's right to approve, suspend and terminate practitioner, providers and sites, even if the decision-making is delegated
- describes the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations

For new delegation agreements, the organization evaluates the delegate's capacity to meet NCQA requirements within the 12 months prior to implementing delegation. If the delegation agreement does not include an implementation date, NCQA considers the last signature date of the agreement to be the implementation date. The pre-delegation assessment process can be accomplished by a thorough review of policies and procedures and may also include a site visit and file audit depending on the organization's requirements. If delegating to an NCQA-accredited or certified organization, the pre-delegation assessment can be limited to only those elements not already recognized by NCQA.

For delegation arrangements in effect for 12 months or longer, the organization has audited files against NCQA standards annually for each year that the delegation has been in effect. The scope of the annual evaluation is based on compliance with the appropriate NCQA standards, the delegation agreement, and includes a review of the delegate's credentialing policies and procedures. A file audit must be performed to confirm appropriate verifications. The number of files audited must be the lesser of 5% or 50 files of which there are at least 10 initial credentialing files and 10 recredentialing files. The NCQA "8/30" methodology may be utilized in which only the first 8 files are audited if all credentialing elements score 100%. If any file element is out of compliance within the first 8 files, all remaining files must be audited for that element.

The delegate's report on delegated activities is evaluated by the organization at least semiannually. If the delegate is accredited by NCQA as a health plan or credentialing

(CR) organization, the only NCQA-required reporting is the names or files of practitioners or providers processed by the delegate.

At least once in each of the past 2 years that delegation has been in effect, the organization has identified and followed up on opportunities for improvement, if applicable. Sources of potential improvement opportunities include the pre-delegation assessment, ongoing reports, or the annual assessment.

Summary of URAC Health Plan Credentialing Standards

P-CR 1 – Practitioner and Facility Credentialing

The organization has a credentialing program that is used to verify professional qualifications of all participating providers. The scope of the credentialing program includes practitioners listed in the directories who are participating providers and are providing health care services, as well as facilities and non-physicians as applicable.

Facilities that provide covered health care services to consumers should also be credentialed, including acute care inpatient facilities, surgery centers, home health agencies and skilled nursing facilities. Additionally, if the organization chooses to list practitioners who provide services at a contracted facility in its provider directory, it must credential those practitioners even if the organization does not contract directly with the practitioner.

The following credentials must be collected for health care facilities that are credentialed by the organization:

- State licensure
- Medicare or Medicaid certification status via OIG
- Copy of the facility's liability insurance policy declaration sheet
- Any other information necessary to determine if the facility meets the network-based health benefits plan participation criteria
- A signed and dated attestation statement and authorization to collect information necessary to verify the information in the credentialing application.
- Accreditation status (TJC, AAAHC, CARF, etc.)

Credentialing may be delegated to a contracted network, group or clinic. If this occurs, delegation oversight is required and the delegated entity must be performing credentialing according to the URAC standards.

The credentialing process must be completed before listing a practitioner or facility in the paper or online directory.

P-CR 2 – Credentialing Program Oversight

The organization's senior clinical staff person is responsible for oversight of clinical aspects of the credentialing program. This should be an M.D. or D.O. unless it is a specialty network, in which case the senior staff person from the network can provide oversight.

P-CR 3 – Credentialing Committee

There is a credentialing committee that:

- Has as a member at least one participating provider who is a practitioner and with no other role in organization management
- Discusses if providers meet reasonable standards of care
- Utilizes clinical peer input when discussing standards of care for a specific type of provider
- Has final authority to:
 - Approve or disapprove applications
 - Delegate the authority to approve clean applications to the senior clinical staff person. This designation must be documented and include reasonable guidelines (“Clean applications” do not need to go to the Credentialing Committee);
- Keeps minutes of all committee meetings including documenting all actions
- Gives the organization guidance on the overall direction of the credentialing program to organization staff
- Evaluates the effectiveness of the credentialing program and reports such to organization management
- Reviews and approves credentialing policies and procedures
- Meets at least quarterly and as necessary to fulfill its responsibilities.

P-CR 4 – Credentialing Program Plan

The organization has a written description for its credentialing program that:

- Has been approved by the credentialing committee
- Defines the scope and objectives of the credentialing program and the roles and responsibilities of the credentialing committee, the medical director (or clinical director), and the credentialing staff
- Defines criteria for qualification as a participating provider
- Defines the information collected for each type of provider credentialed and how the information is verified
- Includes rules about maintaining and storing credentialing information and files
- Includes a statement that the organization will not discriminate against any provider
- Describes the credentialing committee approval process or approval by a senior clinical staff person of clean files, prior to being listed in any provider directory
- Describes how a provider is removed from provider directories if the provider ceases to comply with credentialing criteria or is not recredentialed within the time frame required by the organization's credentialing plan.
- Is reviewed and updated at least annually by the credentialing committee

P-CR 5 – Credentialing Application

Each applicant within the scope of the credentialing program submits an application that includes at least the following:

- Education and professional training, including board certification status
- State licensure information, including current license(s) and history of licensure in all jurisdictions
- Evidence of current DEA certificate or state controlled dangerous substance certificate, if applicable
- Proof of liability insurance and professional liability claims history
- History of sanctions, loss or limitation of privileges or disciplinary activity
- Hospital affiliations or privileges, if applicable
- Physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the practitioner's ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients;
- Signed and dated attestation statement regarding the completeness and accuracy of the application
- Signed and dated statement authorizing the organization to collect information necessary to verify the information in the application.

P-CR 6 – Credentialing Confidentiality

The organization ensures the confidentiality of credentialing information and limits access to credentialing files to authorized persons only.

P-CR 7 – Review of Credentialing Information

The organization has mechanisms to review credentialing information for completeness, accuracy, and any conflicting information.

P-CR 8 – Credentialing Communication Mechanism

There is a mechanism to communicate with providers about their credentialing status when requested and; prior to review, to accept additional information from providers to correct incomplete, inaccurate, or conflicting credentialing information.

P-CR 9 – Primary Source Verification

The organization performs primary source verification of state licensure and board certification or highest level of education. See details in the NAMSS Comparison of Accreditation Standards.

P-CR 10 – Consumer Safety Credentialing Investigation

There is a mechanism to conduct additional review and investigation of credentialing applications where the credentialing process reveals factors that may impact on the quality of care or services.

P-CR 11 – Credentialing Application Review

There is a mechanism to provide for review and approval of the credentialing application prior to the applicant's designation as a participating provider.

The only exception to this standard is when a provider is granted provisional participation status by the senior clinical staff person. This status must be time-limited and granted due to continuity or quality of care issues. The full credentialing process must be completed as quickly as possible.

P-CR 12 – Credentialing Timeframe

No credentialing application is submitted for initial review if it is signed and dated more than 180 days prior to credentialing committee review or if it contains primary or secondary source verification information collected more than six months prior to review.

P-CR 13 – Credentialing Determination Notification

The organization provides written notification to providers within 10 business days of the determination.

P-CR 14 – Participating Providers Credentials Monitoring

There is a process to monitor continuing compliance with criteria for network participation and mechanisms to respond in cases where a participating provider ceases to comply with criteria. The organization is expected to routinely monitor reports of disciplinary actions published by state licensing boards and the U.S. Department of Health and Human Services, Office of Inspector (OIG) or periodically query the National Practitioner Data Bank (NPDB).

P-CR 15 – Recredentialing

Participating providers within the scope of the credentialing program are recredentialed at least every 3 years.

P-CR 16 – Recredentialing & Participating Provider Quality Monitoring

The recredentialing process

- requires an application updating any information subject to change
- verifies through primary or secondary sources information that is subject to change
- considers information regarding the participating provider's performance within the organization, including information collected through the quality management program.

P-CR 17 – Credentialing Delegation

The organization complies with the Core Standards for any credentialing functions it delegates. The organization retains authority to make the final credentialing determinations. At least every three years, the organization must either conduct an on-

site survey of each entity that performs credentialing functions on behalf of the organization; or if not doing an on-site review, it requests and reviews random credentialing files that must be made available within a specified amount of hours or days of the request. The organization must provide an annual report on delegated credentialing oversight to the credentialing committee that includes findings from any oversight audits performed.

Summary of Selected DNV NIAHO Accreditation Standards for Hospitals related to the Medical Staff

MS.5 EXECUTIVE COMMITTEE

The medical staff shall meet at regular intervals and minutes shall be maintained. If the medical staff has an executive committee, a majority of the members of the committee shall be Doctors of Medicine or Osteopathy.

MS.8 APPOINTMENT

The medical staff bylaws shall describe the qualifications to be met by a candidate in order for the medical staff to recommend that the governing body appoint the candidate. Those qualifications shall include the following:

- Initial appointment to the medical staff:
 - Primary source verification of licensure, education, specific training, experience, and current competence;
 - Verification of ECFMG (as applicable);
 - Primary source verification of current Federal Narcotics Registration Certificate (DEA) number (if required);
 - Two peer recommendations;
 - Review of involvement in any professional liability action; and,
 - Receipt of database profiles from/through professional sources (e.g., AMA, AOA, NPDB, OIG, Medicare/Medicaid Exclusions).
- Reappointment to the medical staff:
 - Primary source verification of current licensure and any required certifications;
 - Federal Narcotics Registration Certificate (DEA) number (if required);
 - Review of involvement in any professional liability action; and,
 - Review of individual performance data for variation from benchmark
 - Receipt of database profiles from NPDB, OIG Medicare/Medicaid Exclusions

MS.9 PERFORMANCE DATA

Practitioner specific performance data is required to be evaluated, analyzed and appropriate action taken as necessary when variation is present and/or standard of care has not been met as determined by the medical staff. Performance data will be collected periodically within the reappointment period.

MS.10 CONTINUING EDUCATION

All individuals with delineated clinical privileges shall participate in continuing education that is at least in part related to their clinical privileges. This documentation shall be considered in decisions about reappointment or renewal or revision of clinical privileges. Action on an individual's application for appointment/reappointment or initial or subsequent clinical privileges is withheld until the information is available and verified.

MS.11 GOVERNING BODY ROLE

The governing body shall appoint members of the medical staff and approve clinical privileges after considering the recommendations of the existing members of the medical staff and ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.

The governing body may elect to delegate the authority to render initial appointment, reappointment, and renewal or modification of clinical privileges decisions to a committee of the governing body.

The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

A complete application shall be acted on within a reasonable period of time, as specified in the medical staff bylaws.

MS.12 CLINICAL PRIVILEGES

The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.

Appointment or reappointments to the medical staff and the granting, renewal, or revision of clinical privileges shall be made for a period defined by state law or if permitted by state law, not to exceed three years.

All individuals who are permitted by the organization and by law to provide patient care services independently in the organization shall have delineated clinical privileges.

There shall be a provision in the medical staff bylaws for a mechanism to ensure that all individuals with clinical privileges provide services only within the scope of privileges granted.

- There shall be a provision to authorize Qualified Licensed Practitioners to order outpatient services that are within their scope of service to order.

If available and/or required by the medical staff to hold or maintain clinical privileges, include a review of individual performance data variation from criteria determined by the medical staff to identify need for training or proctoring that may be required.

The medical staff bylaws shall provide a mechanism for consideration of automatic suspension of clinical privileges in any of the following instances:

- Revocation/restriction of professional license;

- Revocation/suspension/probation of Federal Narcotics Registration Certificate (DEA);
- Failure to maintain the specified amount of professional liability insurance; or,
- Non-compliance with written medical record delinquency or deficiency requirements.

The medical staff bylaws shall provide a mechanism for immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner's Medicare or Medicaid status.

The medical staff bylaws shall contain fair hearing and appeal provisions for any adverse actions regarding the appointment, reappointment, suspension, reduction, or revocation of privileges of any individual who has applied for or has been granted clinical privileges.