Credentialing and Privileging

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Darling v. Charleston Community Memorial Hospital
What Are Credentials?

The Merriam-Webster Dictionary defines credentials as:

- “certified documents showing that a person is entitled to credit or has a right to exercise official power”
- “something that gives a title to credit or confidence”

Why Do We Credential?

- Healthcare organizations are held legally responsible to assure providers are competent
- If credentialing is poorly done or not done at all...the hospital risks lawsuits, alleging negligent credentialing practices
- The claim of negligent credentialing derives from the legal doctrine of corporate negligence
  - This doctrine states that healthcare organizations have a an independent duty to provide safe care to patients
Credentialing

In healthcare, credentialing is:

- A process, based on recommendations of the organized medical staff, that involves a series of activities designed to collect, verify, and evaluate data relevant to a practitioner’s professional performance.
- It serves as a foundation for objective, evidence-based decisions, regarding appointment to the medical staff and recommendations to grant or deny initial and renewed privileges.

SIX “General Competencies”

- A sound and defensible credentialing program utilizes established performance criteria:
  1. Provide safe, quality patient care
  2. Demonstrate and apply knowledge of established biomedical, clinical, and social sciences
  3. Improve patient care practices
  4. Utilize interpersonal and communication skills
  5. Exhibit professional behaviors, ethical practices, and sensitivity to cultural diversity
  6. Understand the context and systems of healthcare
- These are observed and measured using various assessment methods.
Credentialing

A process by which an organization:

- Reviews
- Validates
- Evaluates

What?

- Education/clinical training
- Licensure
- Clinical experience
- Professional qualifications
- Disciplinary action (if present)

CoP §482.22

- CMS §482.22 states the medical staff must examine credentials of candidates for medical staff membership and make recommendations to the governing body on the appointment of candidates

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- CMS §482.12 states the governing board must appoint members of the medical staff after considering the recommendations of the existing members of the medical staff
Duty of Board to Act

• Board has ultimate authority with regard to appointment, reappointment, and any corrective action related to practitioners on the medical staff
  - CMS, state licensing requirements, and courts place this obligation on the Board

• Looks to the medical staff for its expertise in matters of training, competence, and ability

• Shouldn’t overturn medical staff recommendations without good reason. If medical staff is unable or unwilling to address a problem with a practitioner, the Board has a duty to act!

Duty of Board to Act (Continued)

The Board has the duty to:

- Ensure only competent practitioners are granted staff privileges
- Ensure patient safety from practitioners with a pattern of incompetence
- Act when a practitioner engages in a pattern of behavior deemed disruptive to hospital operations
- Prevent disruptive practitioners from interfering with the ability of hospital staff to perform their duties
Hospital, Medical Staff, and Board

Practitioner appointment:
• If the hospital has information relative to a practitioner’s appointment or reappointment, it is the hospital’s DUTY to provide that information
• The medical staff coordinator MUST provide the needed information for the MEC and Board to make appropriate decisions
• The Board has the ultimate liability for credentialing decisions - they CANNOT make the decision in a vacuum
• The Quality Director should be responsible for assuring this process is followed

Medical Staff Appointment: The Board’s Role

Establishment of Rules:
The Board evaluates applicants based on recommendations from the medical staff and administration

Submission of Application:
Applying practitioner submits a COMPLETED application - burden is on the applicant to provide all necessary information for evaluation of requests for appointment and privileges

Collection/Verification:
Admin support personnel collect information from “primary sources” - Board is responsible to ensure the process works
Medical Staff Appointment: The Board’s Role (Continued)

- Review/Recommendation: Appropriate medical staff departments/committees review the information and make a recommendation to the Board
- Approval, Grant, Denial: The buck stops with the Board

Hospital-Based Physicians

- Standard is even higher
- Many courts hold that because hospital, not patient, chooses the ER physician, the radiologist, anesthesiologist, or the pathologist, the hospital is automatically liable for those practitioners’ negligence, even if credentialing was done properly
- Hospital-based physicians...
- proceed with EXTRA
The Application

What is needed?

- Proof of education: Copy of the applicants diplomas and/or certificates from an accredited university
- Board certifications
- Current license (state-specific, active and/or inactive)
- Work history
- Letter of health status
- Current inquiry from the National Practitioner Data Bank (NPDA, available online)

- Current Drug Enforcement Administration (DEA) license (available online)
- Current malpractice insurance policy
- Background check
- OIG check
- Information for peer references
- Continuing education information (CMEs)
- Picture ID (drivers license or passport)
- Quality information (if Joint Commission FPPE/OPPE)

Credentialing

- The candidate should provide information relative to:
  - Any disciplinary actions from prior employers
  - Voluntary or involuntary terminations
  - Previously successful or current pending challenges to licensure
  - Relinquishment of license, voluntary or non-voluntary

- If required by your organization, a signed:
  - Code of Conduct and Professional Behavior form
  - Confidentiality and Conflict of Interest Statement of Compliance form
Attestation

• To ensure a complete credentialing file, request the following signed attestations:
  • The practitioner received, read, and agrees to abide by the medical staff by-laws and the department rules and regulations
  • The practitioner has completed all CME’s needed to retain a valid state medical license, (for reappointment)
  • If required by the organization….the practitioner is board certified or will meet certification requirements following graduation from residency or fellowship training

Confirmation of Application

• Once the application is completed and submitted, the organization must:
  • Verify the person applying is indeed the same person identified in the credentials document
  • The individual has attained the credentials as stated in the credentials document
  • The credentials are current
  • There are no challenges to any of the credentials listed
    • Verification by primary sources is mandated by TJC
Expedited Credentialing

- Regulatory bodies permit expedited credentialing
- The Board must delegate authority to a subcommittee of at least two voting members of the Board (Governing Body)
- Include a medical staff member on the subcommittee
- Expedited ONLY at the Board level
- Can be utilized to prevent using temporary privileges
- Cannot be utilized unless there is evidence of proper authority in bylaws
- Approvals only – no denials

Expedited Credentialing

- Applicants not eligible if:
  - Current or prior successful challenges to licensure or registration
  - Prior involuntary medical staff membership, termination, or limitation, reduction, denial, or loss of privileges at another facility
  - Unusual pattern or excessive number of malpractice judgments
  - Any concerns with current competency
Who and Why Do We Credential?

• We credential physicians and allied health professionals to:
  - Establish a presence of a specialized professional background.
  - Grant the practitioner membership to the medical staff

Pitfalls to Credentialing

• The downsides to credentialing:
  - Ensures the healthcare organization is held legally responsible for providers competence
  - If poorly done or not done the hospital risks lawsuits alleging “negligent” credentialing practices
  - The claim of “negligent” credentialing derives from the legal doctrine of corporate negligence
    - This doctrine states the healthcare organizations have an independent duty to provide safe care to patients
What Is Negligent Credentialing?

The hospital is liable when the credentialing bodies (Credentials Committee, Medical Executive Committee, Board of Trustees) knew or *should have known* that the applicant failed to meet the requirements for staff membership or lacked the qualifications for clinical privileges but still allowed him/her to practice.

When Does Negligent Credentialing Happen?

- Initial appointment and reappointment
- Incomplete application – what you don’t know WILL hurt you!
- Failures in verification
- Confusing medical staff membership with privileges
- Temporary privileges
Negligent Credentialing
A Putnam General Hospital Case Study
Dr. King

Background

• In early 2002, Putnam General Hospital determined that there was a critical need for another orthopedic surgeon in the community
• Putnam retained Comprehensive Healthcare Staffing of Norwalk, Conn., in October 2002 to recruit such an orthopedic surgeon
• Eight days thereafter, through assistance provided by Comprehensive Healthcare Staffing, Putnam General signed Dr. John King to a one-year contract
Background

• Following an internal investigation, Putnam General ultimately suspended King’s clinical privileges eight months following his initial appointment.

• By September 2003, Dr. King had surrendered his license to practice medicine in West Virginia, and more than 120 medical malpractice lawsuits had been filed based upon his brief stint at Putnam General.

Putnam’s Credentialing Process

• The majority of Putnam General’s verification process, concerning Dr. King’s initial application, involved cross checking his on-line AMA profile.

• The AMA profile listed Dr. King as having graduated from the Meharry Medical College in Nashville, when he was actually a graduate of the University of New England College of Osteopathic Medicine.

• The profile also listed Dr. King as a medical doctor in orthopedic surgery, when, in fact, he is a doctor of osteopathy.
The AMA listed Dr. King as having trained as a resident at five different institutions in three disparate specialties.

However, from 1985 through 1987, King dropped out of two residency programs in anesthesiology before completing a third.

Although Putnam did contact one of the institutions where King failed to complete a residency, the hospital failed to follow up after the residency institution wrote “n/a” as a response to whether the residency had been completed.

Putnam’s Credentialing Process

Putnam also failed to act on a letter received from an institution merely stating that King “failed to complete the residency program.”

Putnam did receive confirmation from Hillcrest Health Center that King completed the first two years of a residency program, but the dates did not correspond with the dates provided in King’s application.

Putnam failed to determine that Hillcrest terminated Dr. King in 1995 for “marginal performance.”
Putnam’s Credentialing Process

- Putnam also failed to follow up with Walker Regional Medical Center, where King resigned pursuant to an investigation concerning falsifying patient records.
- Similarly, Putnam failed to discover that, while working at Jackson County Hospital, King was arrested and charged with the theft of two hospital operating room log books.
- Finally, King failed to disclose several malpractice lawsuits, which for reasons that could not be determined, were not listed on the NPDB.

Negligent Credentialing Lawsuit

- An action was filed by several of Dr. King’s patients against Putnam General Hospital in Putnam County Circuit Court, based on its credentialing of Dr. King.
- On July 31, 2007, the jury quickly returned a verdict against the hospital, based on its credentialing of Dr. King.
**Negligent Credentialing Lawsuit**

- The jury found that:
  - the Hospital failed to follow the standard of care in granting Dr. King clinical privileges
  - the Hospital would not have granted privileges to Dr. King if the hospital had followed the required procedures
  - the hospital’s conduct in credentialing Dr. King constituted “recklessness and gross negligence as to evidence a conscious disregard for the safety of its patients”

**Negligent Credentialing Lawsuit**

- Although no monetary damages were awarded in this case, the verdict allowed Putnam General to be named as a co-defendant in the 122 medical malpractice lawsuits filed against Dr. King
- The verdict also allowed the plaintiffs in the 122 malpractice cases to seek punitive damages against the hospital
Negligent Credentialing Lawsuit

- As of July 1, 2008, Hospital Corporation of America (the parent company of Putnam General Hospital) agreed to settle most of the 122 lawsuits
- None of the lawsuits have gone to trial

Negligent Credentialing Lawsuit

- The amounts of each settlement have been sealed in order to maintain confidentiality, except for the cases involving minors
- To date, the Circuit Court of Putnam County has approved thirteen (13) settlements involving minors, totaling $12.3 million dollars
The Plaintiff’s Attorney’s Responsibility

• He/she must prove:
  • The organization had a legal duty to select and retain competent practitioners
  • In granting staff privileges to the practitioner, the organization failed to meet established standards of credentialing and privileging
  • The practitioner was negligent in treating the patient and caused injury while practicing under the privileges that were granted
  • The negligent granting of medical staff privileges caused or contributed to the plaintiff’s injuries

Red Flags

• “Risk indicators” exist that must be looked for when reviewing a candidate’s application
• Be diligent in looking for the following “red flags”
  • Frequent change of address
  • Expired Board Certification (reduction in clinical competency?)
  • Numerous affiliations in a short time period (not for telemedicine)
  • Highly trained specialist willing to relocate to a rural area
  • History of disciplinary actions by medical staff organizations, hospitals, state medical boards, or professional organizations
  • Resignation from a medical staff
Red Flags (Continued)

- Past or pending investigative proceedings
- Claims or investigations of fraud or abuse by third party payors, e.g. Medicare, Medicaid, commercial insurance companies
- NPDB should be on continuous search
- Health problems
- Malpractice insurance issues (obtain information on all cases with claims)
- Criminal and other background checks, including MVR to check for DUIs
- Requesting privileges outside of specialty

Reappointment

- Regulatory bodies (i.e. TJC, CMS, DNV et. al.) require practitioners be reappointed every two years - must occur from the date of their first appointment
- Create an Excel spreadsheet to keep track of every practitioner’s due date. Most start the reappointment process at least 90 days before the date due; some organizations give the practitioners their first notice at 120 days with reminders every 30 days
Temporary Privileges

• Legal Opinion
• For years, hospitals have used temporary privileges pending the application process, thinking this makes things easier
• The fact is that liabilities, created by use of temporary privileges in this context, make things much harder, not easier

Temporary Privileges (Continued)

• Why is avoidance of temporary privileges a best practice?
  • You are acting without all of the information when you grant temporary privileges pending application process
  • Once the physician is “in,” it is hard to get him out – easier to do your due diligence on the front end than try to undo the deal when you find out the bad news later
  • Hard to say “no” to a colleague once he/she is in your community
Temporary Privileges (Continued)

- Temporary privileges may only be granted when there is an emergency patient care need that mandates an immediate authorization to practice, for a limited period of time. An example would be a situation in which the sole medical staff member in a particular specialty leaves the community before another physician has been fully credentialed to fill the patient need.

- Temporary privileges may NOT be granted for convenience pending the application process for appointment, nor may they be granted to extend a practitioner’s privileges pending the reappointment process.

Temporary Privileges (Continued)

- For complete applications, the expedited credentialing process outlined in the Board bylaws may be used if incorporated into the Board and medical staff bylaws.

- Temporary privileges may NOT be used in lieu of this process.

- The CEO or his/her designee, upon recommendation of the Chief of Staff or his/her designee, may grant temporary privileges.
Temporary Privileges (Continued)

- Information required:
  - Completed application, including photograph and signed consent and release
  - Completed delineation of privileges form
  - Proof of current licensure (verified through primary source)
  - Proof of current DEA certificate (verified through primary source)
  - Proof of malpractice insurance as required by medical staff bylaws (verified through primary source)
  - Professional liability claims history

Temporary Privileges (Continued)

- Information required:
  - Data bank query
  - OIG sanction check
  - Verification of education and training
  - Verification of privileges at physician's primary hospital
  - Verification that there are no current or prior successful challenges to licensure or registration
Temporary Privileges (Continued)

- Temporary privileges may be granted for an initial period, not to exceed thirty (30) days. Such privileges may be renewed for successive periods, not to exceed thirty (30) days, but only upon the practitioner establishing his/her qualifications to the satisfaction of the CEO and Chief of Staff or department chair. In no event, shall the temporary privileges exceed one hundred and twenty (120) consecutive days of service within a calendar year.

One-Case Privileges

- Upon receipt of a written request, an appropriately licensed person, who is not an applicant for membership nor a member of the medical staff, may be granted temporary privileges for the care of one (1) patient.
- Such privileges are intended for isolated instances in which award of such privileges are shown to be in an individual patient’s best interest.
One-Case Privileges (Continued)

• Who may grant...
  • CEO, upon recommendation of Chief of Staff and chair of applicable department
  • This category can only be used if this category is in the medical staff bylaws

One-Case Privileges (Continued)

Information required:

• Current curriculum vitae
• Proof of current licensure (verified through primary source)
• Proof of current DEA certification (verified)
• Proof of malpractice insurance as required by medical staff bylaws (verified through primary source)
• Professional liability claims history
One-Case Privileges (Continued)

Information required:

- Data bank query
- OIG sanction check
- Verification of privileges at physician’s primary hospital
- Verification of education and training

One-Case Privileges (Continued)

- The letter approving such privileges shall include the name of the patient to be treated, the specific privileges granted, and the date privileges are granted
- Practitioners granted one-case privileges shall attend to the patient, for whom privileges were granted, within thirty (30) days of the request for one-case privileges
- Term - intended for one case only. No practitioner should be granted one-case privileges on more than five (5) occasions in any calendar year
Locum Tenens Privileges

• **Term** – Locum tenens privileges may be granted for an initial period, not to exceed thirty (30) days. Such privileges may be renewed for successive periods, not to exceed thirty (30) days, but only upon the practitioner establishing his/her qualifications to the satisfaction of the CEO and Chief of Staff or department chair. In no event, shall locum tenens privileges exceed one hundred and twenty (120) consecutive days of service within a calendar year.

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Telemedicine

• Do not recommend using credentialing done by radiology group – conflict of interest
• JC MS13.01.01 – Telemedicine practitioners who are responsible for the care, treatment, and services via telemedicine are subject to the credentialing and privileging process of the originating site.
Telemedicine Requirements

• **LD.04.03.09** – Care, treatment, and services are safely and effectively provided through written agreement

• **MS.13.01.01** – Licensed independent practitioners who are responsible for the care, treatment, and services to the patient via telemedicine link **are subject to the credentialing and privileging process of the originating site**

• Hospitals need to assess how they credential telemedicine functions to determine what additional steps should be taken to endure compliance

• More flexibility when working with a distant-site hospital – can rely on the credentialing and privileging

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Telemedicine Requirements

• Make sure certain elements are included in the written agreement:
  • Whether the physician is privileged at the distant-site hospital
  • The physician currently holds a license in the state in which the hospital, whose patients are receiving telemedicine services, is located
  • The hospital has evidence of internal review of the distant-site physician’s performance and sends the distant-site hospital this performance information (including adverse events that may result from the telemedicine services) and any complaints the hospital may have received about the distant-site physician
  • Evidence that the credentialing and privileging process complies with Medicare Conditions of Participation
  • Medicare Conditions of Participation require the governing body of the hospital to make all privileging decisions based upon the recommendations of its medical staff after the medical staff has thoroughly examined and verified the credentials of the practitioners applying for privileges
Grandfathering

• Can be “risky” business
• The Frigo vs Silver Cross Hospital and Medical Center
• Clearly outlined in the medical bylaws
  • Requires collective judgment of leadership and the medical staff
  • Supporting rational and data should be in the practitioners credential file

It Goes Without Saying!

• Never process an incomplete file for approval
• Know to “speak up” if there are:
  • Issues with an application
  • If someone wants to approve/give temporary privileges
  • If you are asked to do anything that violates state, federal, or regulatory standards
**Evidenced-Based Indicators**

- Provides an objective process when granting, denying, or renewing practitioner privileges
  - Morbidity and mortality data
  - Comparative practice patterns
  - Patient complaints
  - Adverse occurrence trends
  - Case review results
  - Peer review recommendations

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**Core Privileging**

- Preselected groups of procedures and/or treatments relevant to the medical specialty
- Defined by the medical staff and tailored to the organization’s needs and capabilities
- Evaluate the practitioners individually...even if they are grouped together
Privileges

• The “privilege list” should only list procedures that can be performed at the facility where the practitioner is requesting privileges
• The facility must have the equipment and staff to support the procedure in order for it to appear on the privileging form

Collect Data

• Peer Review/OPPE/FPPE
• Process needs to include:
  ▪ Periodic chart review
  ▪ Direct observation
  ▪ Monitoring of diagnostic and treatment techniques
  ▪ Discussion with peers
• More data indicators:
  ▪ Involvement in adverse and sentinel events
  ▪ Appropriateness of treatment
  ▪ Test and procedure requests
  ▪ Length of stay
  ▪ Use of blood and blood components
  ▪ Drug usage
Reporting the Data

- Data collected needs to be reported during quarterly department reviews
- If risk of potential conflict exists, outsource the review to an external peer review organization
- For contracted services (e.g. emergency medicine, radiology), include quality indicators / peer review in the contract
- For telemedicine (e.g. Radiology), include quality indicators/peer review in the contract

Leadership’s Role

- Review medical staff bylaws for appropriate language and compliance with national standards regarding credentialing and reappointment
- After the Medical Staff Executive Committee (MEC) reviews and approves the practitioner, the application goes to the Board for final review and decision
- The Board should:
  - Conduct a thorough review of the candidates qualifications, focus on education, training, licensure, and medical malpractice history
  - Review grandfathering provisions and other organizational practices related to the process and ensure they are well documented in the medical staff bylaws
  - Establish an oversight committee
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THANK YOU

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