Credentialing

Introduction

Any healthcare entity involved in recruiting healthcare practitioners has heard of credentialing, but often it is a misunderstood concept and a neglected task. Many liability issues community health centers face could be eliminated with proper credentialing. Anyone conducting credentialing activities has heard of the infamous Dr. Swango, a physician allegedly tied to the murder of his patients and who was not credentialed properly.

The Bureau of Primary Health Care requires that "all Health Centers assess the credentials of each licensed or certified healthcare practitioner to determine if they meet Health Center standards."

Credentialing can be defined as the process of assessing and confirming the qualifications of a licensed or certified healthcare practitioner. The Joint Commission on Accreditation of Healthcare Organizations calls it "the process of obtaining, verifying and assessing the qualifications of a healthcare practitioner to provide patient care services in or for a health care organization."

Credentialing is a comprehensive process of confirming qualifications, including their personal identification, health fitness, medical licensure, board certification, medical education and training, malpractice history, hospital privileging and history, Drug Enforcement Administration licensure and Medicare/Medicaid sanctions. Each of these requirements is discussed in this credentialing plan, along with samples of documentation and the associated costs and resources.

Credentialing should be the first step in the recruitment process, which is why one entire section of this recruitment and retention manual is devoted to it. Credentialing is crucial in hiring a qualified, capable healthcare practitioner who will be an asset to the health center and will work to continually improve the quality of healthcare it provides.

Recredentialing, or the rechecking of credentials, should be done at least every two years. Recredentialing is more inclusive than credentialing in that current competence is based on peer review and performance-improvement data and is beyond the initial recruitment process. Therefore, recredentialing is not addressed in this plan. It is recommended that health centers seek guidance from the Bureau of Primary Health Care, the National Association of Community Health Centers and the Joint Commission on Accreditation of Healthcare Organizations for an appropriate recredentialing plan.

What is privileging?

Privileging, as defined by Joint Commission on Accreditation of Healthcare Organizations, is the "authorization granted by the appropriate authority (such as a governing body) to a practitioner to provide specific care services in an organization within well defined limits, based on the following factors, as applicable: license, education, training, experience, competence, ability to perform privileges and judgment."

For many health centers, privileging is the process of authorizing the specific scope of patient care services for each practitioner. In many cases, "the scope of a practitioner's privileges is described in his or her job description or as part of his/her employment contract."[1] Ultimately, health centers are responsible for ensuring the practitioner possesses the requisite skills and expertise for the patient services he or she will provide and for the procedures he or she will perform as a primary care practitioner. Privileging is not covered in detail in this plan, since individual practitioner's privileging varies based on the health center's "scope of project" as approved by the Bureau of Primary Health Care. While privileging is part of the credentialing process, it exceeds the credentials verification tasks and procedures and, therefore, it is recommended that each health center consult legal counsel regarding proper privileging procedures. However, a good privileging policy and its related forms are included here.

In addition, a new practitioner seeking hospital privileges will complete an intensive privileging process based on each hospital's bylaws and its own credentialing and privileging policies. It is possible that the health center could carry out its due diligence and still have issues to deal with at an individual hospital. In those cases, privileges could be granted to perform primary care services at the health center, but not at the community's hospital.

Who should be credentialed?

Licensed Independent Practitioners, which are defined as physicians, dentists, nurse practitioners, physician assistants, nurse midwives and any other individual permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.[2]

Other Licensed or Certified Health Care Practitioner, which are defined as individuals who are licensed, registered or certified but are not permitted by law to provide patient care services without direction and supervision. This includes laboratory technicians, social workers, medical assistants, licensed practical nurses and dental hygienists. Health centers should be advised that often there are state or local laws governing certification and licensure for this group and that they may vary from state to state[3].

Requirements for the two categories vary with the most stringent requirements applying to the licensed independent practitioners. Rather than writing the credentialing plan for two separate entities, this credentialing plan is written for the most inclusive. It is recommended that the most stringent be applied to other licensed or certified healthcare practitioners when appropriate, applicable and available.

Why credential practitioners?

1. There are many local, state and federal laws that require credentialing of practitioners. Health centers are at risk of litigation and for losing their license to operate as a business and a federal qualified health center if they don't implement a proper credentialing process and provide due diligence in doing so.

2. It protects health centers and patients alike. Proper credentialing provides assurance that the health care the patient receives will be of the highest quality and will conform to national medical practices. Also, it protects health centers legally and assures continued funding, as well as patient satisfaction with the quality of care. (Note: of the 780,000-plus physicians, it is estimated that 5 percent (or 39,000) have significant "problems").

3. It is required by Bureau of Primary Health Care for federally qualified health centers, as documented through periodic performance reviews. Comprehensive credentialing policies and procedures are required by the Bureau in order to be approved and funded as an federally qualified health center and will need to be addressed in Health Resources and Services Administration grant submissions. Subsequently, credentialing policies and procedures will be reviewed by the Bureau through periodic performance reviews.

4. It is required if a health center is seeking accreditation from the Joint Commission on Accreditation of Healthcare Organizations or Accreditation Association for Ambulatory Health Care. Credentialing is an important component in accreditation for ambulatory health centers such as federally qualified health centers. The Health Resources and Services Administration recommends that all federally qualified health centers strive for accreditation. Therefore, this is becoming an increasingly important reason.

Who should do credentialing and where does it take place?

1. The recruitment staff at the primary care association or the primary care office.

2. If a Primary Care Association or a Primary Care Office has a recruiter or other staff recruiting for its health centers, then the credentialing or pre-credentialing process should begin as soon as a potential candidate has been identified. A recommended pre-credentialing procedure for recruiters is included here.

3. The health center itself is required to credential all practitioners employed at their facilities.

4. Every hospital where the practitioner applies for privileges must conduct its own credentialing before granting clinical privileges. Hospitals usually add several verification steps that are not performed by health centers, including hospital affiliation verification letters and professional peer reference letters.

5. The Center for Medicare and Medicaid completes a credentialing and application process for healthcare practitioners. Upon completion, the practitioner is assigned a Unique Physician Identification Number (UPIN) and a Medicaid number, each of which is required to bill for Medicare and Medicaid services.

6. All managed care plans, including health maintenance organizations, other health insurance plans and some insurance companies have their own credentialing policies and procedures. Often, their approval process is more stringent and may even include economic credentialing.

7. State medical licensing boards do their own credentialing before approving a license in their state. Different boards have different procedures but usually include a National Practitioners Data Bank and Federation of State Medical Boards queries.

8. Credentialing verification organizations are convenient credentialing sources and can perform credentialing for hospitals, health plans and the health centers all at once.

9. Malpractice insurance carriers will not grant new malpractice insurance until the carrier completes such credentialing procedures as reviewing work history, past malpractice history and civil and criminal claims of malpractice and negligence.

10. Joint Commission on Accreditation of Healthcare Organizations, Bureau of Primary Health Care, and National Committee for Quality Assurance all have credentialing requirements, and these requirements often are inconsistent.

Some health centers complete their own credentialing. If a health center has 50 or more health care practitioners, it may even hire a full-time credentialist. In other health centers, human resources perform credentialing tasks. Others choose to outsource credentialing to a contracted consultant. Yet others use a credentialing verification organization. Even if the "official credentialing process" is contracted out, health centers may choose to verify medical and dental licensure, board certification and conduct a National Practitioners Data Bank query.

When should credentialing occur?

Credentialing must be completed on all new practitioners, but the exact timing of each step in the process is not completely defined. Pre-credentialing should take place when a candidate has been identified and a telephone or on-site interview is planned. At this time, a pre-application also may be completed, though this is optional. Credentialing should begin when a contract has been issued because the credentialing process can take three to nine months and the sooner the appropriate documentation is gathered, the sooner credentialing is complete and the sooner the new practitioner can begin seeing patients and billing for services.

Along with the contract, the following steps should be taken:

1. Include an official credentialing application. Use an approved application form.
2. Include application (and perhaps application fee) for medical and dental licensure in your state, if the licensed independent practitioner has not already obtained his or her license.
3. If candidate is a resident just starting out, include information for applying for Medicare and Medicaid. (Note: to verify a UPIN number, go to www.ecare.com).

The sooner a health center and recruiter begin credentialing, the sooner a practitioner will be able to practice.

How is credentialing performed?

Credentialing is completed by performing the following services and reviewing and obtaining the following forms:

1. A credentialing application with attestation to health status, current competence and truthfulness of the information.

2. License to Practice.

3. Education and Training.

4. Board Certification.

5. National Practitioner Data Bank and Health Integrity Protection Data Bank query ─ completed for state sanctions, quality sanctions, malpractice claims, Medicare and Medicaid sanctions, etc. (also the Federal State Medical Boards).

6. Medicare and Medicaid Sanctions through Health Integrity Protection Data Bank and the Office of Inspector General.

7. Federal Tort Claims Act and Malpractice Insurance.

8. Health fitness, current competence and current experience.

9. Drug Enforcement Agency registration, hospital admitting privileges, picture identification, background checks, immunization and PPD status and Life Support Training (and any other life support certification).

Although this is an extensive list, it includes all requirements. Since most health centers will want their new health practitioners to be approved by community hospitals and health plans, it is best to err on the side of total inclusion.

Credentialing is documented either by primary source verification, designated equivalent source or secondary source verification. Primary source verification is defined as proof of

credentials *directly* from the source. Examples are licensing boards (for current licensure) medical schools and residency programs (for educational credentials) and previous supervisors and colleagues (for current competence). Primary source verification is required for licensed independent practitioners for all of these instances. Designated equivalent sources are selected agencies that have been determined to maintain information identical to the information of primary sources. Examples are the American Medical Association Physician Masterfile, American Board of Medical Specialties for Board Certification Verification and Federation of State Medical Boards for all actions against a physician's medical license. Secondary source verification is a photocopy of an original credential (may or may not be notarized) when the copy is made from an original by the health center staff.

Who should officially approve the credentials and clinical privileges?

Once all the credentialing information has been gathered, the new practitioner must be appointed and approved by the health center's board of directors. The board may delegate its credentialing and privileging activities to an executive medical committee or it may review recommendations from either the clinical director or the chief executive officer. However, ultimately, the *board* is still responsible. The health center bylaws should describe the process for approval and the bylaws should indicate a time frame within which applications will be acted upon.

Cost

Along with being labor-intensive, credentialing can be expensive. Having another agency complete credentialing can cost anywhere from $30 to $500 per practitioner! Therefore, a health center may find it a better value to hire a full-time employee to be a credentialist, depending on the size of the center, its turnover rate and the number of new practitioners being hired. Something that should be considered is not only the hard dollars in service fees to complete credentialing, but also the cost of lost revenue when the new practitioners — especially physicians — are unable to bill and bring in new revenue.

Disclaimer: Many resources have been used to develop an accurate, comprehensive credentialing plan for this recruitment manual. Resources include, but are not limited to: Bureau of Primary Health Care's PIN 2002-22, National Association of Community Health Center' Information Bulletin #9, Joint Commission on Accreditation of Healthcare Organizations publications and National Committee for Quality Assurance publications. Every effort has been made to include all the credentialing requirements and to present the information in an objective, accurate manner.

REMEMBER: EVEN IF A HEALTH CENTER WANTS TO APPROVE A CANDIDATE, THE CANDIDATE ALSO MUST BE APPROVED BY THE COMMUNITY HOSPITALS AND LOCAL HEALTH PLANS OR THE HEALTH CENTER WILL HAVE MAJOR ISSUES!

Endnotes:

1. *"Credentialing and Privileging of Health Center Clinicians: Tips to Help Navigate the Legal Pitfalls",* National Association of Community Health Centers, Inc., Information Bulleting #9, March, 2004.
2. BPHC PIN 2002-22, as borrowed from JCAHO's 2002-2003 *Comprehensive Accreditation Manual for Ambulatory Care.*
3. BPHC PIN 2002-22, as borrowed from JCAHO's 2002-2003 *Comprehensive Accreditation Manual for Ambulatory Care*

Credentialing application

The credentialing application is an important aspect of the credentialing process. It provides the general information needed to acquire further information, such as the candidate's full name, Social Security number and date of birth. It also contains a release statement that allows the health center staff to gather confidential, sensitive information required for the credentialing process. The application includes the following:

1. Demographic information/personal data.
2. Attestation questions for:
    a. Sanctions or suspensions from any state health insurance programs (Medicare and Medicaid).
    b. Voluntary and involuntary suspension or revocation of medical and dental license.
    c. Letters of reprimand or concern.
    d. Suspension or revocation of Drug Enforcement Agency or narcotics license.
    e. Cancellation or denial of malpractice insurance, or any cases of increased rates due to the nature or volume of claims.
    f. Malpractice history for the last 15 years.
    g. Physical or mental health conditions or medications that may affect clinical judgment or motor skills.
    h. Physical or mental conditions which could affect the ability to exercise clinical privileges.
    i. Taking any medication or undergoing treatment for any health conditions.
    j. Dependency on alcohol or drugs.
    k. Felony criminal charges or convictions.
    l. Investigations by any medical staff, professional organization or licensing authority and any disciplinary actions taken.
    m. Termination of medical staff application.
3. Undergraduate and medical education.
4. Postgraduate training.
5. Employment ─ five-year work history.
6. Staff memberships (hospital privileges).
7. Board certifications.
8. Licenses.
9. Drug Enforcement Agency registration.
10. Continuing medical education.
11. Professional liability insurance.
12. Professional references that can attest to clinical experience and competence.
13. Attestation by the applicant of the correctness and completeness of the application (signature and date).

A major problem is that every health plan and every hospital creates its own application. This often requires that a new practitioner complete 10 to 15 different applications. Some states have attempted to pass legislation for a universal application and credentialing policy. Other states have attempted to do this voluntarily. At present, the Council for Affordable Quality Healthcare offers a universal credentialing data source for most health plan organizations. It was developed by many of the leading health plans. Dozens, including Aetna, CIGNA and many Blue Cross and Blue Shield plans already have joined the service, which means they all use the same credentialing information. The credentialing application is available online from the Council for Affordable Quality Healthcare. There is no charge for the service and candidates can enter the information themselves. For more information, visit www.caqh.org/cred.

A note about pre-credentialing applications: Many hospitals and health plans use a pre-credentialing application to begin the credentialing process. This is done for liability reasons and to safeguard against litigation in "any willing provider" states. If a major problem is identified on the pre-credentialing application, it is much easier to deny participation and membership and clinical privileges. If the recruiter or health center staff does pre-credentialing, then a pre-credentialing application probably is not necessary.

License to practice

Licensure, as defined by Webster's dictionary is "the formal permission from a constituted authority to do something as to carry on some business." Medical and dental licensure is probably the most important credential and should be the first step in pre-credentialing and the second step in credentialing, after a completed credentialing application. A physician or dentist cannot practice or provide any clinical services without a current license for the state in which he or she practices. This should also include medical director-type of services such as peer review, utilization and quality management, etc. The time it takes to receive a new license varies from state to state but can take *three to six months;* therefore the process should begin as soon as a candidate is serious about a recruitment opportunity.

Requirements for license to practice

Medical licensure. Physicians, whether allopathic, osteopathic or Foreign Medical Graduate require licensure for the state in which they practice. Therefore, primary source verification of the license is required. Primary source verification can include verification online, by mail or by phone but must be obtained directly from a licensing board, a credentialing verification organization that does primary source verification or by querying a report from the Federation of State Medical Boards. *The Federation can be very useful for physicians who have practiced in several states and for verifying state disciplinary actions. In addition, the Federation is a great resource for malpractice settlements. For more information on the Federation of State Medical Boards, visit www.drdata.org. Organizations who query the Federation are charged $7 per physician.*

Health centers may also like to add a *photocopy* of the practitioner's current licenses to his or her credentialing file. However, primary source verification still must be done to be compliant with Bureau of Primary Health Care and Joint Commission on Accreditation of Healthcare Organization standards.

Dental licensure. Dental licensure works differently in that after initial licensure, dentists may receive "licensure by credentials" or "reciprocity." Licensure by credentials: this is when the Board of Dentistry makes a determination that the applicant is licensed in a state that has equivalent licensure standards. Currently, this includes 46 states, Puerto Rico and the District of Columbia. Only five states do not recognize licensure by credentials. This is a plus when recruiting dentists, who are in short supply, because there aren't the added delays of obtaining new licenses.

Physician assistants. Physician assistants require medical licensure, although the licensing laws vary from state to state. Primary source verification by the state boards is recommended, even though they are not considered licensed independent practitioners. Most of the state medical boards make licensing information for physician assistants available the same way they do physicians.

Nurse practitioners. In most cases, nurse practitioners are licensed as registered nurses and, therefore, are not found in the medical board databases. Most states also certify nurse practitioners. However, primary source verification of nurse practitioner licensing is still recommended.

State boards do their own credentialing before granting a license. Their credentialing process usually includes primary source verification of medical or dental licenses in other states, a NPBD query and primary source verification of board certification; however, requirements vary from state to state licensing board.

Where to go for verification:
Health centers can go to www.docboard.org for a list of the state boards. Some state boards make it easy by providing online verification, but others require a phone call or a letter to request the information.

In addition, a credentialing verification organization (CVO) also will complete primary source verification licensing verification.

Cost:
Generally there is no cost for primary source verification of board licensure if the health center conducts the verification.

Credentialing Verification Organizations (CVOs)

Credentialing verification organizations are an excellent choice to provide credentialing and re-credentialing services for health centers. Because credentialing is labor-intensive and there are many negative consequences to doing credentialing the wrong way, many health centers have decided to utilize credentialing verification organizations. In addition, since many hospitals and health plans use credentialing verification organizations and there are elements of credentialing that can be considered subjective, health centers then know that the credentialing decisions made by the hospitals and health plans will at least be based on the same credentialing documentation.

Most credentialing verification organizations voluntarily seek accreditation by the National Committee for Quality Assurance and therefore credentialing is geared towards NCQA credentialing requirements.

NCQA certification is awarded to participating organizations on the basis of individual credentials elements. Organizations may be certified in some, none or all of the 10 credentials elements addressed in NCQA standards. The elements are:

- License to practice.
- Drug Enforcement Agency registration.
- Medical Board sanctions.
- Education and training.
- Malpractice claims history.
- Medicaid/Medicare sanctions.
- Work history.
- Practitioner application processing.
- Credentialing verification organization application and attestation content.
- Ongoing monitoring.

Health centers should credential the credentialing verification organization before signing a contract. Ultimately, the health center is still responsible for credentialing, especially when it comes to litigation.

However, be advised that all the Bureau of Primary Health Care requirements are not the same as the National Committee for Quality Assurance requirements and therefore there still may be elements the health center will need to complete.

Education and training

Requirements for education and training
Education and training verification is required by Bureau of Primary Health Care, the Joint Commission on Accreditation of Healthcare Organizations and the National Committee, for Quality Assurance. All levels of medical education and training should be verified, including, medical school graduation, residency and fellowships. This is another primary source verification requirement. Although all levels should be verified, the National Committee for Quality Assurance only requires primary source verification at the highest level of credentials attained by the practitioner. However, this is not recommended because hospitals will want primary source verification for all education and training. The Joint Committee for Accreditation of Healthcare Organizations requires primary source verification for all applicants appointed after January 1988. For applicants approved before 1988, a copy of the medical diploma suffices.

Foreign Medical Graduates from schools of medicine other than those in the United States and Canada must present evidence of certification.

Where to go for verification
There are probably more options for primary source verification for education and training than any other credentialing requirement. Verification of medical school graduation and completion of residency and fellowship training may be obtained from:

1. A telephone or letter confirmation where the education and training was completed.
2. The American Medical Association Physician Masterfile.
3. The American Osteopathic Association Physician Database.
4. State licensing agency if the state verifies education and training.
5. A credentialing verification organization.

Probably the best source for primary source verification for physicians and physician assistants is the American Medical Association profiles ─ they are easy to obtain (online) and as of April 2004, they are a designated equivalent source for American Board of Medical Specialties board certification information. There has been criticism that the file is not up to date but most physicians' information can be found there, all in one place, and that is handy for health centers with a lot of physicians to credential in a short amount of time. Verification of dental school and specialty training is available from the American Dental Association Master File.

Cost
American Medical Association physician profiles cost $29 for orders of one to two profiles and $27 per profile for orders of three or more profiles. Physician Assistant Profiles are less expensive at $16 per order. A sample of American Medical Association physician and physician-assistant profiles can be viewed on the Web at www.ama-assn.org.

Board certification

Board certification is defined as a status awarded by a professional association indicating that the healthcare practitioner has met specific standards of knowledge and clinical skill within a specified field. The board certification usually involves passing a written and oral exam. Approximately 85 percent of the licensed physicians in the United States are certified by at least one specialty board.

"Board eligible" is a term that is not recognized by most medical boards. This issue arises sometimes when a health center or health plan only hires or appoints physicians who are board certified. If a physician tells the recruiter or credentialist he is board eligible, it means he is not certified and probably never will be.

"Board qualified," on the other hand, is recognized by medical boards and means the physicians have applied to take and been accepted to take the board exam. This mostly happens with residents who have just completed their training.

Requirements for board certification

Board Certification is recommended by the Bureau of Primary Health Care, the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance. Primary source verification is required for board certification. The American Board of Medical Specialties is the umbrella organization for medical specialties. Twenty-four specialty boards are members of ABMS, including the American Board of Family Medicine and the American Board of Obstetrics and Gynecology. ABMS also is a prime source for primary source verification board certification, but it isn't necessarily the best method. An individual Dental Specialty Certification Board also may certify a dental specialist.

Where to go for verification

The following sources can be used for primary source verification:

1. The American Medical Association Physician Master file.
2. The American Osteopathic Association Physician Master file
3. Verification obtained *directly* from the individual specialty board.
4. American Board of Medical Specialties *Official Directory of Board Certified Medical Specialists*, (see www.abms.org) ABMS CertiFACTS online, (see www.certifacts.org) or ABMS Certifax service.
5. American Board Medical Specialties by phone (or facsimile) at 1-866-ASK-ABMS.

Cost
Cost can be tricky. Please check any of the prices or call the American Board of Medical Specialties and individual specialty boards before you make a final decision on which primary source verification source to use. At the time of this printing, some prices were:

- American Board of Medical Specialties CertiFACTS charges $1,395 per year for a subscription.
- American Medical Association profiles are $29 each.
- Some individual specialty boards will charge for online services.

To complete verification for free, try calling or faxing the American Board of Medical Specialties or each specialty board.

NOTE: *The American Board of Medical Specialties Certified Doctor Verification Program, available on the ABMS Web site, is for consumer reference only and is <u>not</u> a National Committee for Quality Assurance-approved source for credentialing verification.*

National Practitioner Data Bank & Healthcare Integrity and Protection Data Bank

The National Practitioner Data Bank was established through the Health Care Quality Improvement Act of 1986. The purpose of this databank is to restrict incompetent physicians, dentists and other healthcare practitioners from moving state to state without disclosure or discovery of previous medical malpractice payments and adverse action histories. The following items are included in the National Practitioner Data Bank:

- Medical malpractice payments.
- Licensure actions.
- Clinical privileges.
- Professional society membership actions.
- Drug Enforcement Agency actions.
- Medicare and Medicaid exclusions.

Currently, there are more than 230,000 malpractice payments reports, more than 40,000 state licensure actions, more than 11,000 clinical privilege actions and more than 30,000 Medicare and Medicaid exclusionary actions[1].

The Healthcare Integrity and Protection Data Bank was established through the Health Insurance Portability and Accountability Act. This databank was created to combat fraud and abuse in health insurance and health care delivery and to promote quality care. It is primarily a tracking system that may serve as an alert function to users that a comprehensive view of a practitioner provider or supplier's actions may be prudent.[2] The following items are included in this databank:

- Health care related criminal convictions.
- Health care related civil judgments.
- Medicare and Medicaid exclusions.
- Other adjudicated action taken against a healthcare practitioner by a federal or state government agency or health plan OR based on acts or omission that affect or could affect the payment, provision, or the delivery of a healthcare service.
- Licensure actions (such as revocations, suspensions, censures and probation).

Currently, the largest number of reports has been state-licensure actions with more than 100,000. Nurses have the highest number of reports (more than 70,000) followed by physicians (more than 28,000)[3].

Three statutes determine if an entity is eligible to query and report to the databanks. Currently, the public and organizations other than direct providers of patient care are unable to query and report. If a health center is not sure of eligibility, it should seek legal counsel. If the health center is ineligible to query, the staff should have the licensed independent practitioner provide the results of a self-query of the National Practitioners Data Bank.

Requirements of a NPBD and HIPDB query

The Bureau of Primary Health Care, the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance all include a National Practitioners Data Bank query as a requirement. It is a very important part of the credentialing process. The Healthcare Integrity and Protection Data Bank query also is important since it helps identify fraud (healthcare criminal and civil convictions). It also includes actions for more providers, including physicians, dentists, nurses, optical related practitioners, respiratory therapists, dental assistants and dental hygienists, psychiatric technicians and occupational therapists. Note: when an entity queries the National Practitioners Data Bank, it also is querying Healthcare Integrity and Protection Data Bank.

The Federation of State Medical Boards also can be used to identify state board sanctions, and malpractice liability claims. Even though technically it is duplicative to query both the National Practitioners Data Bank and the Federation of State Medical Boards, some have worried that one of the sources are missing information. So, to play it safe, they check both. Currently, the Human Resources Service Administration is investigating to see if a National Practitioners Data Bank and Healthcare Integrity and Protection Data Bank reports are consistent with the Federation of State Medical Boards reports[4].

Where to go for NPBD/HIPDB query

To register online for NPBD/HIPDB queries and to query practitioners go to www.npdb-hipdb.com.

Cost

The cost for each National Practitioners Data Bank query is $4.50.
The cost for each Federation of State Medical Boards query is $7.

Endnotes

1. Presentation by Cynthia Grubbs and Mark Pincus, "*NPBD/HIPDB: The Basics and Beyond",* the Division of Practitioner Data Banks, HRSA, 9/03.
2. Presentation by Cynthia Grubbs and Mark Pincus, "*NPBD/HIPDB: The Basics and Beyond",* the Division of Practitioner Data Banks, HRSA, 9/03.
3. Presentation by Cynthia Grubbs and Mark Pincus, "*NPBD/HIPDB: The Basics and Beyond",* the Division of Practitioner Data Banks, HRSA, 9/03.
4. Presentation by Cynthia Grubbs and Mark Pincus, "*NPBD/HIPDB: The Basics and Beyond",* the Division of Practitioner Data Banks, HRSA, 9/03.

Medicare/Medicaid sanctions

Health centers are required to determine if there are any Medicare or Medicaid sanctions against a new practitioner as part of the credentialing process. This is especially important for health centers because they tend to have large Medicaid and Medicare populations and, if a practitioner has been sanctioned, he or she is not allowed to provide clinical services to Medicaid or Medicare patients. And, as importantly, the health center is not allowed to bill for services if the practitioner is currently sanctioned. The U.S. Congress established a civil monetary penalty for institutions that knowingly hire excluded parties.

Where to go for verification

There are two ways to verify Medicare and Medicaid sanctions:

1. National Practitioners Data Bank query: www.npdb-hipdb.com.

2. The Department of Health and Human Services Office of Inspector General's "List of Excluded Individuals." This List of Excluded Individuals/Entities is a database that provides information to the public, health care providers, patients and others relating to parties excluded from participation in the Medicare, Medicaid and all Federal healthcare programs. The List of Excluded Individuals/Entities is available in an online searchable database or a downloadable database. Monthly updates are also available at www.oig.hhs.gov.

FTCA and malpractice

Credentialing for a new candidate's malpractice coverage and malpractice history is very different for Federally Qualified Health Centers. This is because of the Federal Tort Claims Act (FTCA), which offers:

- Immunity from lawsuits alleging medical malpractice.
- Malpractice liability protection for medical, surgical, dental and related functions.
- A place for a plaintiff's to make a claim.
- Coverage for Federally Qualified Health Center employees, officers, directors, governing board members and most contractors.
- Coverage for incidents that occur within the scope of the project (See PIN 2002-07), which are activities described in the grant application approved by Public Health Service (PHS) via Notice of Grant Award.

The Federal Tort Claims Act has shown an estimated annual malpractice premium savings for the 500 deemed health centers studied to be $164 million. The average savings per deemed health center was $274,000. From October 1994 through August 2003, there were 1,252 total claims — the number of losses totaled *164* with only *13* over $1 million.[1]

Requirements for FTCA

There are no specific Bureau of Primary Care requirements listed regarding Federal Tort Claims Act documentation in credentialing files. However, to receive FTCA benefits, health centers must credential all licensed or certified healthcare practitioners. Practitioners also must be privileged.

For further information, call: 1-866-FTCA-HELP. The Health Resources Services Administration has created a resource entitled: *Clinician's Handbook on the Federal Tort Claims Act.* For a copy of this publication, contact the Administration on the Web at www.hrsa.gov.

Although not required, it is recommended that even Federally Qualified Health Centers ask for five years of malpractice history on their credentialing application.

REMEMBER, THAT LOCAL HOSPITALS AND HEALTH PLANS WILL BE REVIEWING MALPRACTICE INFORMATION, AND IF A NEW PRACTITIONER IS UNABLE TO OBTAIN HOSPITAL PRIVILEGES OR CANNOT PARTICIPATE IN LOCAL HEALTH MAINTENANCE ORGANIZATIONS, the Health Centers may not *want* to hire the practitioner, even if the practitioner can be covered through Federal Tort Claims Act.

Important: malpractice history and liability insurance for non-FTCA health centers

For health centers that do not have coverage under the Federal Tort Claims Act, malpractice insurance for practitioners is an important component of credentialing and is not being covered in this credentialing plan. Professional liability insurance coverage and amounts of coverage must be confirmed directly with the carrier and the health center should include a copy of each practitioner's malpractice face sheet, preferably sent directly from the malpractice carrier.

IT IS RECOMMENDED THAT HEALTH CENTERS WHO DO NOT HAVE FEDERAL TORT CLAIMS ACT COVERAGE SEEK TRAINING/INSERVICE FROM A MALPRACTICE CARRIER.

There are reported cases of practitioners being denied malpractice insurance just because they changed jobs frequently — even though there were no judgments against them nor lapses in coverage. Malpractice insurance is principle therefore legal counsel is advised for health centers that do not have coverage under the Federal Tort Claims Act.

Health fitness, competence & experience

Health fitness, current competence and current experiences are three distinct credentialing requirements, but they are related and have a lot in common. For example, there are no outside sources or agencies except credentialing verification organizations that routinely provide primary source verification for these three elements and requirements vary between Bureau of Primary Health Care, the Joint Committee for Accreditation of Healthcare Organizations and the Health Resources and Services Administration. **However, the Bureau requires primary source verification for experience, competence and health status.**

Requirements for health fitness:

According to the Bureau of Primary Health Care: "Health fitness of ability to perform the requested privileges, can be determined by a statement from the individual that is confirmed, *either* by the director of a training program, chief of staff/services at a hospital where privileges exist, or a licensed physician designated by the organization.[1"] This pretty well sums up primary source verification for health fitness. The credentialing candidate is stating that he is fit to perform the required duties when he signs this section of the credentialing application form and employment contract. The primary source verification is obtained by either calling or receiving written verification by a colleague from one of the three categories listed above. Phone calls should be documented in the credentialing file. If calling, this can be part of a reference check. Most health centers will ask for three clinical references before hiring a practitioner and this is a very good hiring policy. Written letters should also be included in the file, if any are received.

Requirements for current competence and experience:

The Bureau of Primary Health Care requires primary source verification of current competency and experience. The candidate will address these issues in the attestation questions in the credentialing application, which is the first step. However, keep in mind that when you ask for references from a candidate, the candidates are going to give you names of colleagues who give them a favorable reference. It is advisable then to seek verification from the same sources you would for health status: the director of the candidate's training program and a chief of staff or department head at a hospital where the candidate had privileges. References from peers are imperative. In addition, letters confirming experience are especially important if a practitioner is requesting privileges for services that may not be within the normal scope of practice of that practitioner's specialty.

Although, there is nothing prohibiting primary source verification over the telephone, it is recommended that the primary source verification be in written form. If there is ever a potential malpractice claim regarding a quality-of-care issue, the written verification of clinical experience and competence can be very important. In fact, health centers may want to provide a six-month provisional period of appointment where a proctor (e.g. medical director or an unbiased peer at the center) reviews medical records and then provides a letter of recommendation as to the new practitioner's competence.

Current competence is a very important part of the credentialing and re-credentialing process and remains an ongoing process.

Endnote:

1. BPHC, PIN 2002-22

Picture identification, background checks, DEA registration, hospital admitting privileges, immunization and PPD status & life support training

All these requirements are grouped together because, according to the Bureau of Primary Health Care, the National Committee for Quality Assurance and the Joint Committee for Accreditation of Healthcare Organizations, they all require secondary source verification only, and not all of them are required by all three agencies. However, to be compliant with Bureau requirements, they all need to be part of the credentialing process.

1. Government picture identification: This is the way this requirement is written in most credentialing texts. In the past, a driver's license or passport would be acceptable. However, now that identity theft is on the rise, the Joint Committee for Accreditation of Healthcare Organizations now requires that applicants provide identification in the form of a birth certificate, passport or equivalent. If a health center plans on seeking JCAHO's accreditation, this should be considered. A copy of this identification should be included in the credentialing file.
2. Background checks: Background checks at this juncture are still an optional verification element within the credentialing process. A health center may decide to do a criminal background check on all its employees, licensed independent practitioners included, and this is probably a very wise idea. However, if any other type of background check is performed (such as a credit check) the health center will have to address what they would do if someone didn't "pass" and what defines "unacceptable." Decisions relating to criminal acts are much more definable. Note: JCAHO currently recommends but does not require background checks. The Bureau has not made any mention of background checks in its credentialing documents.
3. Drug Enforcement Agency registration: This is an important part of the credentialing process, even though it only requires secondary source verification. Secondary source verification probably was approved because it is so hard to get this information from a primary source. There is a Drug Enforcement Agency Web sit that credentialists can go to: www.deadiversion.usdoj.gov. However, there is currently no online verification system. There are companies that do Drug Enforcement Agency verification, but they are very expensive. Secondary source verification, therefore, is acceptable. A copy of the Drug Enforcement Agency certificate will suffice, however, the applicant should bring in the original certificate and the health center staff should make a copy of the original, and not accept a copy of the original from the applicant. The Drug Enforcement Agency registration applies not only to physicians but also mid-level practitioners, dentists and other practitioners in some states.
4. Hospital admitting privileges are required as a secondary source verification by the Bureau. In other words, as new practitioners receive hospital admitting privileges, a copy of the approvals should be included in the practitioners credentialing file.

5. Immunization and PPD: This requirement is not mentioned by the Joint Committee for Accreditation of Healthcare Organizations, but by the Bureau as a secondary source verification. Copies of a practitioner's current immunization history should be included in the credentialing file and in the center's human resources file. The Bureau will want to review the immunization records during its performance reviews.
6. Secondary source verification is required for life support training, if applicable and copies of training certificates should be kept in the credentialing file.