

Negligent Credentialing

Strategies for Reducing Hospital Risk

Todd Sagin, MD, JD

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Negligent Credentialing: Strategies for Reducing Hospital Risk is published by HCPro, a division of BLR.

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ISBN: 978-1-68308-116-6

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About the Author

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Introduction

Credentialing is one of the most important tools that healthcare organizations use to promote quality and safety in the care they deliver. Thoroughly vetting practitioners' qualifications and competence increases the likelihood that their care will be of high quality and rendered in a safe manner. Nevertheless, even competent practitioners make mistakes, and a bad outcome can occur in the face of excellent medical care. When patients experience poor outcomes, or when physicians feel mistreated by the credentialing process, lawsuits may surface. This book has been written to assist healthcare organizations in adopting strategies to reduce the risk of such lawsuits and to mitigate the consequences of ones that have already been filed.

In the United States, when patients or their families are dissatisfied with the outcome of a clinical condition or its treatment, they frequently turn to the legal system to file a tort claim against their healthcare providers. Historically, this action has come in the form of a malpractice suit against the patient's physician. In recent years, the limits of physician malpractice insurance coverage (and in some states, the caps on malpractice damages) have caused plaintiff attorneys to search for new targets with deeper pockets.

Corporations, such as hospitals and health systems, have greater resources than any individual physician and typically have insurance coverage that is not limited by medical malpractice caps. Therefore, by asserting a negligent credentialing cause of action against a medical staff and its hospital, plaintiffs can overcome limitations on medical malpractice damages and obtain compensation that far exceeds recoverable amounts under traditional medical malpractice claims.

The result has been a groundswell of corporate negligence claims against hospitals and other healthcare facilities. The alleged negligence can be for numerous supposed lapses, including the following:

- Failure to appropriately train or supervise staff
- Inadequate policies to ensure appropriate care
- Insufficient oversight (peer review) of privileged practitioners
- Failure to properly credential one or more of the institution's practitioners

The plaintiff's thinking behind this last allegation generally goes as follows:

- Dr. Smith's patient suffered a bad clinical outcome
- This outcome occurred because Dr. Smith took poor care of this patient and is guilty of malpractice

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- Dr. Smith is therefore an incompetent practitioner and not qualified to exercise privileges at Somewhere Hospital
- Somewhere Hospital must have performed deficient credentialing since an unqualified doctor (Dr. Smith) was appointed to its medical staff
- Somewhere Hospital (and its medical staff) is responsible for the patient's poor outcome because Dr. Smith would never have been in a position to provide the bad care had he not been granted privileges at the hospital

Because no official body tracks negligent credentialing lawsuits and most are filed in local jurisdictions in each of the 50 states, there are no accurate numbers on how many of these claims are filed each year across the United States. We do know, however, that the number is significant and rising. Most hospitals have had to defend at least one such case, and many have kept affiliated law firms quite busy responding to multiple legal complaints of negligence.

Defending against these actions is time-consuming, expensive, and a diversion from the important work done at healthcare institutions. These actions are also intimidating and burdensome to clinical and administrative staff who are required to respond to document requests from plaintiff attorneys and to provide testimony in depositions and trials. While most negligent credentialing claims are poorly substantiated and can be readily defended against, many hospitals settle them to avoid a costly trial.



Legal insights

The following terms may characterize, accompany, or otherwise relate to negligent credentialing claims:

- Corporate negligence
- Institutional negligence
- Negligent practitioner selection
- Negligent practitioner retention
- Negligent supervision, oversight, or monitoring

This book is written with the goal of helping healthcare organizations, medical staff and hospital leaders, medical staff professionals, and clinical practitioners understand the nature of negligent credentialing claims, how to respond to allegations, how to prepare when defending against these charges, and what steps can help head off such claims before they occur. The material is also relevant to hospital governing board members who ultimately make all credentialing decisions and who are accountable for the integrity of the institution's credentialing processes.

Of course, the best defense against assertions of negligent credentialing is to credential effectively in the first place. A wealth of publications that discuss good credentialing practices are readily available in the marketplace. This book will touch on some best practices to emulate and some significant pitfalls to avoid, but it is not intended as a thorough review of the credentialing field. Nevertheless, after reading the

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pages that follow, those who are involved in the credentialing of healthcare practitioners will be better prepared to engage in this activity with insight and confidence. They will also come to appreciate the legal landscape in which this work is done and approaches to mitigate legal risk in the litigious climate of today's America.

With this goal in mind, we will primarily discuss credentialing processes in hospitals and explore examples of negligent credentialing actions that target such facilities and health systems. However, many diverse types of healthcare organizations, including the following, credential and privilege practitioners and may be subject to negligent credentialing lawsuits:

- Ambulatory facilities (e.g., surgi-centers, urgent care offices, and diagnostic centers)
- Freestanding rehab units
- Nursing homes
- Managed care entities/health plans
- Accountable care organizations
- Clinically integrated networks
- Large group practices

Likewise, contemporary credentialing extends beyond the traditional physician population, typically encompassing practitioners such as the following:

- Podiatrists
- Dentists
- Clinical psychologists
- Advanced practice registered nurses (APRN) (e.g., nurse anesthetists and midwives, family practice APRNs, etc.)
- Physician assistants

Indeed, according to the Centers for Medicare & Medicaid Services (CMS), any practitioner who delivers a “medical level of care” must be credentialed to provide services in a healthcare facility. The number of non-physician practitioners who fit the bill is increasing steadily and adding to the credentialing burden for healthcare facilities. This growth is fueled by numerous factors, including the following:

- Shortages of physicians (both by specialty and geographic availability)
- Nurses wishing to move into more advanced clinical roles
- Greater patient access to healthcare insurance that covers non-physicians
- The financial hurdles to a traditional medical education for physicians

In spite of the evolving practitioner landscape, the vast majority of negligent credentialing claims are associated with malpractice allegations against doctors for care rendered in a hospital setting. Consequently, this book will focus primarily on hospital credentialing of physicians, with the intention that readers

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apply covered principles and best practices to the credentialing of any licensed practitioner and to any organization that formally vets the professionals who treat patients within its walls.

The credentialing process inevitably places health organizations between the proverbial rock and a hard place. Lax credentialing can lead to patient harm and negligent credentialing suits from the injured parties. However, diligence in credentialing may compel the governing body to deny or restrict a physician's privileges due to concerns about competence or professional conduct. In turn, this physician may file a suit challenging the healthcare organization's credentialing procedures and their implementation. Therefore, avoiding negligent credentialing means hospitals must not only carefully screen and monitor practitioners for competence, but they must also carefully follow their procedures for limiting or terminating doctors' clinical privileges when quality concerns arise. Such diligence demands close adherence to the processes outlined in medical staff bylaws or the termination provisions of employment contracts.

Regardless of the threat of legal actions from disgruntled practitioners or unhappy patients, every healthcare organization must align its credentialing activities with the overriding goal of promoting the safety and quality of care.

Section I

History and Context

Credentialing has been evolving constantly over the past century. In recent decades, the pace of change in credentialing practices has increased as a result of developments in policy, regulation, and court judgments. Although relatively new in concept, the legal claim of negligent credentialing has rapidly taken hold in a majority of the nation's jurisdictions. In Chapter 1 of this book, we explore how credentialing has been regulated over the years. With this history in mind, we then delve into the background and current status of negligent credentialing claims in Chapter 2.

1 The Regulation of Practitioner Credentialing

Credentialing a physician involves obtaining, verifying, and assessing that practitioner's qualifications and competence to practice medicine in a particular setting. This work is typically carried out by a hospital's organized medical staff and the credentialing support personnel hired by hospital management. Initial credentialing, which typically occurs when a physician first wishes to practice at a healthcare institution, involves a review of the practitioner's education, training, professional experience, and evidence of current competence.

In most hospitals, credentialing can result in medical staff membership with or without privileges. Privileging is a process that a healthcare entity uses to authorize a practitioner to perform a specific scope of patient care services and procedures based on documentation that he or she has current ability to perform those tasks competently and safely. Ultimately, the hospital governing board grants a physician medical staff membership and/or clinical privileges after receiving a favorable recommendation from the medical staff's credentialing bodies.

Despite its critical importance in ensuring a new candidate's eligibility for requested privileges, credentialing is more than a one-off activity that occurs only at initial appointment. A physician's ability to practice competently and safely must be continuously appraised, and his or her credentials periodically renewed. In hospitals, such renewal occurs at least once every two years. In health plans, credentials more typically are renewed at three-year intervals.

The Origins of Credentialing

Contemporary credentialing practices can be traced back to the early 20th century when healthcare leaders were anxious to earn public confidence in modern hospitals. In previous centuries, hospitals had functioned primarily as the last stop before death. In the late 1800s and early 1900s, dramatic advances in antiseptic practices, anesthesia, surgical technique, medical procedures, and laboratory testing moved healthcare forward by leaps and bounds.

But even as this stunning progress transformed hospitals into places of hope and recovery, medical training floundered. Practitioners were trained in a wide variety of settings sans common educational curricula and requirements. Consequently, many were poorly prepared to wield the increasingly effective tools of

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modern medicine. Nevertheless, as hospitals grew in standing as venues for treatment, it became increasingly important for clinicians to gain access to the “doctors’ workshop,” a moniker deriving from the hospital’s emerging reputation as a one-stop shop for the resources necessary to facilitate the practice of modern medicine, including the following:

- Technical tools (e.g., laboratories and radiology suites)
- Facilities (e.g., operating rooms)
- Staff (e.g., surgical nurses, anesthesiologists, pathologists, and lab techs)
- Beds for prolonged recoveries after surgery and treatments

By the middle of the 20th century, few physicians could establish a clinical practice without a hospital affiliation.

Practice standardization

The advances in medicine created a new breed of physicians who championed the standardization of practice. They argued for rigorous procedures to ensure that practitioners were qualified for their work. Among these pioneers was Dr. Jacob Frank, a Chicago general surgeon who, in a speech before the Chicago Medical Society in the early 1900s, argued:

Major surgery should only be performed by men well-qualified to this delicate and difficult task, that some means or methods should be found for the granting of certificates or licenses to duly-qualified surgeons, and that only the holders of such certificates or licenses should practice surgery. (Stephenson, 1981)

Another early 20th century surgeon, Dr. Ernest Codman (1869–1940), advocated for the advancement of hospital care through the measurement of outcomes and other performance metrics. His attempt to make a systematic study of the clinical consequences of advances in medical science positioned him as part of a larger group of physicians, surgeons, nurses, and administrators who were eager to bring industrial efficiency techniques to the practice of medicine.

Codman crusaded to reform surgical care by linking the standardization of care within hospitals to the creation of what he referred to as “true clinical science.” To accomplish this, he formulated what he called the “end result system,” which involved following up on patients post hospitalization to measure surgical and medical outcomes. In 1910, Codman launched a campaign to inspire hospitals across the nation to standardize their practices and adopt his system.

The efforts of Codman and his colleagues eventually resulted in a system of accreditation for hospitals in the United States and elsewhere. In 1915, Codman promulgated a document referred to as “The Minimum Standard,” which among other things, proposed that “membership upon the staff be restricted to physicians and surgeons who are (a) full graduates of medicine in good standing and legally licensed to practice in their respective states or provinces, (b) competent in their respective fields, and (c) worthy in character and in matters of professional ethics.”

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To meet this standard, a hospital would have to perform some type of assessment on those who wished to practice within its walls. Codman's colleagues were initially outraged by this prospect, and his membership on the medical staff at Massachusetts General Hospital was terminated.

“ *Let us remember that the object of having standards is to raise them.* ”
– Ernest Armory Codman, MD

Contemporary drivers of credentialing progress

Despite the contentiousness of Codman's recommendations in the Boston professional community, his ideas were compelling and spread rapidly. Medical staffs began to formalize their membership requirements and to increase the rigor with which they scrutinized those wishing to join. Initially, this vetting process was simply a review for admitting privileges. Once practitioners held these privileges, the scope of their services was considered a matter for the doctor and patient to determine. This stance slowly began to change with the explosion of medical and surgical specialties in the mid-20th century. Several drivers, including the following, have pushed credentialing to new levels of rigor and complexity:

- The growth of specialty-based professional societies
- Legal decisions rendered by the courts
- Increasing sophistication and importance of accreditation organizations
- The advent of managed care in the 1970s and 1980s and the subsequent involvement of payers in credentialing
- Regulations from the Centers for Medicare & Medicaid Services (CMS) and other federal entities

The following sections discuss these events in greater detail.

Growth of Specialty-Based Professional Societies

World War II saw an explosion of medical research, which in turn drove development of new clinical techniques. Because it took additional time to train for and master these new techniques, specialization became increasingly common among medical practitioners.

As new specialties emerged, so too did professional societies to meet the interests and needs of those who practiced them. Typically, these professional groups defined the criteria to identify oneself as a member, such as specific training, experience, and certification. Eventually, specialty boards were established to define the contents of residency training, administer requisite certification examinations, and regulate who could claim the mantle of specialist in a particular field.

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Today, most hospital privileging criteria are based, in part, on criteria established by the relevant specialty board and/or professional society. Indeed, the majority of hospitals in the United States require physicians to be board certified in some specialty in order to be active medical staff members.

Legal Decisions Rendered by the Courts

Hospitals in the United States evolved from municipal almshouses. For much of their history, hospitals operated under the doctrine of charitable immunity, which shielded them from paying civil damages to injured parties. Such immunity was intended to prevent lawsuits from impairing hospitals' charitable purposes and to prevent the needs of a few individuals from draining resources devoted to the many. This approach to protecting charitable work was recognized in many states as common law, which derives from judicial decisions, or is established through the adoption of state statutes. However, since the middle of the 20th century, the doctrine of charitable immunity has been constantly eroding as courts have circumscribed its use, and states have changed their laws.

The most significant legal case establishing a basis for negligent credentialing (and washing away the precedent of charitable immunity) was decided in 1965 by the Illinois Supreme Court. In *Darling v. Charleston Community Memorial Hospital* (described in more detail in Chapter 2), the court determined that a hospital has a duty to ensure the quality of patient care delivered by physicians on its medical staff. This ruling effectively transformed the hospital from an entity that merely provided a workshop for doctors to one that had some degree of responsibility for what happened within its walls.

Historically, the organized medical staff took the greatest interest in vetting new members. But the *Darling* case compelled hospital administrators and board members to give serious attention to the efficacy of doctors' credentialing activities. Since this landmark decision, there has been a constant flow of court cases dealing with hospital liability and corporate negligence. Today there is little question that hospitals have a legal duty to ensure the competence of the practitioners who work in their facilities.

Growth in the Sophistication and Importance of Accreditation Organizations

Hospitals that participate in government insurance programs (e.g., Medicare and Medicaid) must meet the Medicare *Conditions of Participation (CoP)*. To demonstrate compliance, a hospital may be inspected directly by a governmental body (e.g., a state-level agency acting on behalf of CMS) or by a private accrediting organization granted deeming authority to conduct these inspections on behalf of the government. Today there are four organizations with such authority to accredit hospitals:

1. The Joint Commission
2. DNV GL

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3. The Healthcare Facilities Accreditation Program (HFAP), which is now owned by the Accreditation Association for Ambulatory Health Care (AAAHC)
4. The Center for Improvement in Healthcare Quality (CIHQ)

Each of these accrediting bodies has specific requirements related to credentialing activities. However, because best industry practices in credentialing have been well-established, there is little variance in the credentialing expectations they set.

The influence of Joint Commission standards

The overwhelming majority of hospitals in the United States use The Joint Commission for accreditation. By extension, the accreditor's credentialing requirements have great impact on the way that hospitals carry out this work. The Joint Commission's credentialing and privileging standards for hospitals, which appear in the medical staff chapter of its *Hospital Accreditation Standards*, are updated annually and have become increasingly rigorous over the past two decades.

Privileging standards, in particular, have grown in importance. Today, the assignment of clinical privileges is based on evaluation of both the practitioner's credentials and his or her demonstration of *current* competence in the relevant clinical activities. This latter requirement, which prompts applicants to submit evidence of recent clinical experience that reflects adequate performance of the requested privilege(s), has been an important recent development. In the past, privileges were granted on the basis of *pedigree*—that is, the stature and sufficiency of a physician's education and training.

Joint Commission standards have also evolved over the years to emphasize criteria-based privileging. Under pressure from CMS, The Joint Commission upgraded its standards in the early part of this century to require a clear basis for the assignment of each privilege.

Contemporary Joint Commission standards address the following aspects of credentialing and privilege delineation:

- Credentialing and privileging at initial appointment
- The steps necessary at reappointment (e.g., a periodic reassessment of credentials and granted privileges)
- The procedures to follow when concerns arise about the continuing appropriateness of medical staff membership and granted privileges
- The granting of special privileges under specific circumstances, such as during disasters or when an important patient need warrants expedited vetting

All accreditation organizations generally address in their standards or requirements the following credentialing activities:

- Use of an organization-specific application to collect information about the applicant seeking membership and/or privileges
- Verification of certain information in the application

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- Time frames for the processing of applications
- Review and assessment of the information in the application by appropriate professional peers
- Authorization to practice or provide clinical services within the organization's facilities or under its auspices

Program-specific accreditation

Accreditation isn't restricted to the physical facilities where care is delivered. Many organized clinical programs must demonstrate compliance with qualifying criteria through the use of some type of certifying or accrediting activity. For example, states may require trauma programs to meet requirements written into statute and/or regulation. These requirements may include credentialing standards for practitioners, such as whether a participating practitioner must be trained in a specific specialty or be board certified. Hospitals may seek accreditation or certification as a center of excellence to elevate the reputation of a stroke center, orthopedic joint replacement program, or similar venture. Centers of excellence are designations that various healthcare entities issue to indicate a healthcare program's use of best practices and focus on rendering a superior level of care.

In recent years, healthcare organizations have been forming clinically integrated networks (CIN) and accountable care organizations (ACO) as a new way to integrate caregivers under changing healthcare reimbursement models. These new entities typically bring together physicians and healthcare facilities to deliver higher quality and more cost-effective care. Just as hospitals and health plans must vet and monitor the competence of physicians, so too must ACOs and CINs credential the practitioners who participate in their activities.

Accreditation beyond the hospital

Hospital-based organizations aren't the only healthcare entities that seek accreditation to validate their commitment to high-quality, compliant service delivery. Across the continuum of care, healthcare providers, suppliers, and payers seek accreditation to demonstrate adherence with various regulations.

Managed care payers, for example, require participants in their insurance networks to undergo credentialing. Relevant accreditation standards are generally established by the National Committee on Quality Assurance (NCQA).

Other accrediting bodies for healthcare sectors beyond the hospital include the following:

- The Commission on Accreditation of Rehabilitation Facilities (CARF)
- The AAAHC, which accredits ambulatory surgery centers and other outpatient facilities
- The Community Health Accreditation Program (CHAP), which accredits home health and hospice agencies

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Despite their varied focuses, these accreditation bodies all have requirements that address the credentialing of doctors and/or other clinical practitioners and support personnel.

Payer Involvement

The healthcare insurance industry has undergone significant change since it first became prominent during the Great Depression in the 1930s. Most healthcare insurers have transformed from passive intermediaries that facilitate payment of healthcare bills into entities with a range of roles, including the following:

- Guiding patients in seeking care and selecting providers
- Monitoring the quality of care
- Enforcing utilization standards
- Creating restrictive networks of clinical providers to whom they pay preferred rates
- Directly employing physicians

As indicated previously, managed care payers and health plans traditionally credential their panels of practitioners in accordance with the NCQA's accreditation standards. This is true regardless of whether they directly employ physicians or merely contract with them to participate in their health plan. It is not uncommon for payers to delegate this credentialing activity to other parties, such as a health system's credentialing department or a credentials verification organization (CVO). Regardless of whether they do credentialing in-house or outsource it to a third party, payers can be accused of negligent credentialing if they do not comply with the relevant accreditation credentialing standards.

The resurgence of economic credentialing

Payer initiatives to improve quality through reimbursement incentives (e.g., pay-for-performance bonuses and value-based reimbursement) are picking up speed across the country and driving many healthcare organizations to be more selective in whom they credential and privilege. So-called economic credentialing, which was more common during the peak of managed care in the 1990s, is now returning in new forms and with renewed credibility.

Although there is no universally accepted definition of economic credentialing, the term generally refers to the use of economic criteria in determining a physician's qualifications for initial or continuing hospital medical staff membership or privileges. This practice got a bad rap in the 1990s because it appeared to be a tactic used to increase the profits of managed care companies and to make quality of care a secondary concern. Interest in economic credentialing has returned in an effort to rein in out-of-control healthcare costs and because there is now a recognized relationship between over-utilization of health resources and poor quality outcomes.

Influential stakeholders

Payers are also influenced by private business-oriented entities such as The Leapfrog Group (www.leapfroggroup.org). Leapfrog reports safety and quality data on nearly 1,800 hospitals across the country with the goal of “empowering purchasers to find the highest-value care and giving consumers the lifesaving information they need to make informed decisions.” On behalf of large employers, Leapfrog and similar organizations champion greater value for the healthcare dollar. They advocate quality standards and push insurers and healthcare organizations to strengthen their efforts to achieve improved outcomes. This pressure, in turn, compels healthcare entities to look more closely at how well they and their credentialed practitioners perform on various performance metrics.

Sometimes, plaintiff attorneys argue that the quality metrics developed by organizations such as Leapfrog constitute the standard of care. In a negligent credentialing lawsuit, the plaintiff’s attorney may argue that a hospital was negligent if it granted privileges to a practitioner who failed to meet standards promulgated by Leapfrog or similar organizations. While this claim is not true, it does reflect the influence these entities have within the healthcare industry.

Federal Statutes and Regulations

CMS has established *CoPs* with which various healthcare organizations must comply to receive reimbursement for care of Medicare and Medicaid patients. The hospital *CoPs* contain specific language related to credentialing. In particular, they require facilities to maintain an organized medical staff that periodically conducts appraisals of its members and examines the credentials of candidates for medical staff membership. Based on these activities, the medical staff must make recommendations to the governing body on appointment of candidates.

The government periodically issues *Interpretative Guidelines* that give additional direction to healthcare organizations and accrediting bodies regarding credentialing activities. Indeed, many of the specific credentialing standards written by accrediting organizations such as The Joint Commission are a direct result of language in these guidelines. In recent years, CMS has pushed in its guidance for credentialing organizations to require evidence of current competence when granting privileges. It has also advocated the adoption of criteria-based privileging, which involves developing and adhering to specific, enumerated eligibility requirements when determining whether to grant a clinical privilege. Such requirements typically spell out the education, training, experience, and evidence of current competence necessary to hold a privilege. This type of direction from CMS pushes accreditation organizations to regularly update their standards.

Unified medical staff

In the spring of 2015, CMS modified the hospital *CoPs* to allow health systems to consolidate medical staffs across multiple facilities. When medical staffs unify, there is no need to perform credentialing institution by institution. Streamlining the appointment process can increase administrative efficiency and, even more importantly, reduce the risk of negligent credentialing actions stemming from inconsistent privileging decisions between a health system’s member facilities.

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Such inconsistent privileging decisions can occur when one hospital in a health system decides that a particular privilege should be granted to a physician, whereas another hospital in the same system decides that the doctor does not have the qualifications to hold this privilege. A similar inconsistency occurs when the medical staff at one hospital in a system recommends termination of a privilege for demonstrated incompetence. Potential liability is created if the system board does not then terminate the privilege for that practitioner at all of its hospitals where that doctor holds the privilege. Plaintiff attorneys try to capitalize on such disparities when there is a malpractice incident.



Key concepts in action

If a doctor has a bad outcome treating a patient at one hospital in the system, the plaintiff's attorneys may ask why the doctor could hold the privilege to deliver this care at one hospital when another hospital in the same system found that he was not qualified to do so. Obviously, competence doesn't vary with geography, and regardless, the hospitals may only be a few miles apart.

In short, disparate results from facilities under the authority of a single corporate parent (i.e., the overarching health system board) set up the potential for a negligent credentialing claim. Multi-hospital health systems should consider taking advantage of the new *CoPs* to unify medical staffs when it's practicable. When it's not, they should have mechanisms in place to ensure that a doctor working at two hospitals in the same system is not subject to differing privileging decisions. The hypothetical scenario on page 13 illustrates the potential fallout from misaligned vetting approaches within a health system.

The HCQIA

Of the credentialing-related federal statutes, the Health Care Quality Improvement Act of 1986 (HCQIA) has had arguably the most substantial impact. In the 1970s, healthcare was plagued by a malpractice crisis that became the subject of considerable discussion in Congress. Hospitals and physicians were under pressure to do more rigorous practitioner evaluations in the form of peer review and credentialing. However, the risk of lawsuits from disgruntled physicians who incurred privilege restrictions caused many hospitals to back away from this work.

In an effort to provide hospitals and medical staffs some protection against a rising tide of lawsuits, Congress enacted HCQIA—a seminal piece of legislation that has profoundly affected credentialing by improving physicians' willingness to engage in peer evaluation. The statute provides healthcare organizations and their peer review bodies immunity from monetary damages resulting from “adverse professional review actions” based on a practitioner's demonstrated incompetence or unprofessional conduct. HCQIA also authorized the creation of the National Practitioner Data Bank (NPDB). Discussed in more depth in Chapter 7, the NPDB has become a critical source of background information on applicants for healthcare organization membership and privileges.

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Compliance with due process provisions

In addition to providing protections to hospitals, HCQIA also outlines the due process requirements that must be offered to physicians who are subject to adverse credentialing decisions. If these are correctly followed, it is likely that the medical staff and hospital will be afforded HCQIA's immunity protections. Failure to do so can result in large judgments on behalf of aggrieved physicians who are denied privileges or medical staff membership.

When a medical staff and governing board are contemplating corrective action (i.e., the denial, restriction, or termination of a physician's medical staff membership and/or privileges based on demonstrated incompetence or unprofessional conduct), it is important that they strictly adhere to the due process steps outlined in HCQIA. In order to facilitate such compliance, most medical staff bylaws have a detailed section (often called a fair hearing plan) that outlines the steps to take when proceeding with corrective action. Medical staff, hospital, and board leaders should become intimately familiar with the steps outlined in the bylaws before taking any adverse professional review action against a physician. See the legal insights box on page 14 and the glossary in Appendix B for a definition of "professional review action."

Limitations

It is important to remember one protection that HCQIA does *not* include. The law does not protect peer review information, including credentialing documents, from discovery by lawyers who bring legal actions. When a negligent credentialing action is brought in a federal court, there generally is no ability to keep credentialing documents out of the discovery process.



Key concepts in action

If a physician claims that a hospital was negligent for allowing the medical staff to engage in illegal discrimination in denying him privileges, the matter is likely to be heard in federal court. In such a lawsuit, the physician's attorneys will usually be able to subpoena the credentialing records to help bolster their case. It is for this reason that plaintiff lawyers sometimes frivolously bring a federal discrimination claim against a hospital even when there is little to no evidence to suggest the validity of such an allegation. Plaintiff attorneys may also claim violations of federal antitrust laws as another tactic to elevate a negligent credentialing claim from state to federal court.

Credentialing Risks in Multi-Hospital Systems: A Cautionary Tale

ABC Health System comprises three hospitals that function under the authority of a health system governing board. The hospitals are located approximately 10 miles from one another in the same large metropolitan area.

Dr. Jones is a general surgeon who applied for clinical privileges to perform carotid endarterectomies at Acme Regional Hospital, the largest facility in the system. Acme ultimately decides against granting Dr. Jones these privileges because the physician does not meet the facility's established criteria. In particular, he does not satisfy its requirement for completion of a fellowship and board certification in vascular surgery. Acme also requires that applicants for this privilege have experience performing at least five carotid endarterectomies in the past two years. Although he also does not meet this requirement, Dr. Jones objects that his experience is adequate and that he has performed other vascular procedures in his many years as a general surgeon. However, the medical staff at Acme Regional refuses to make an exception to its criteria in order to accommodate Dr. Jones' privilege request.

Dr. Jones is also on the medical staff at Shoreline Hospital, a smaller facility in the ABC Health System. Dr. Jones has held privileges at Shoreline for many years and operates there one day per week. He has never performed carotid surgery at the hospital, but after failing to obtain privileges for this procedure at the health system's flagship institution, he applies for them at Shoreline. The credentials committee recommends approval of the request. The medical executive committee likewise supports this action and passes the request to the governing board for approval. Once the privileges are approved, Dr. Jones regularly admits his patients who need carotid surgery to Shoreline Hospital.

In his first year holding the new privilege, Dr. Jones performs six carotid endarterectomies. The case of George Libby does not go so well. After Dr. Jones performs an endarterectomy on Mr. Libby's carotid artery, Mr. Libby suffers a stroke. He is left without the ability to walk or speak, and his family brings a malpractice action against Dr. Jones. Their lawyer also recommends that they sue Shoreline Hospital and its parent health system for corporate negligence. In the legal complaint filed with the court, the Libbys argue that Shoreline and ABC Health System were negligent for allowing an incompetent surgeon to perform surgery on their family member. No specific basis for this allegation is included in the complaint.

During depositions taken in preparation for trial, the plaintiff lawyers take testimony from the chair of surgery at Shoreline Hospital. Under questioning, the chair admits that he had reservations about recommending Dr. Jones for carotid surgery privileges. He was aware that Dr. Jones had not been granted this privilege at Acme, and he personally felt that this was a good decision. However, he believed that he could not object to granting Dr. Jones carotid surgery privileges at Shoreline since he met the criteria to hold the privilege at the smaller facility. Based on this information, plaintiff lawyers request the privileging criteria from each hospital in the ABC Health System.

At trial, the credentialing expert for the Libby family explains to the jury how the health system board had not allowed Dr. Jones' request to perform carotid surgery at Acme. She argues that the board took this position because its medical staff has established that a physician without specific training and certification in vascular surgery should not do the procedure. She goes on to point out that this decision had been reached at Acme in order to provide safe, high-quality care to patients. The expert then argues that the health system board should not have allowed Shoreline Hospital to maintain a lower standard for the privileging of carotid procedures. According to the expert, "Dr. Jones did not suddenly become more qualified to perform carotid endarterectomies simply by driving the 10 miles from Acme to Shoreline Hospital." The Libbys' lawyers then tell the jury that if the standards for privileging at Acme had been applied at Shoreline, Dr. Jones would not have been granted the privilege to perform carotid surgery on Mr. Libby. However, by allowing the less rigorous criteria at Shoreline, the governing board had made it possible for Dr. Jones to injure Mr. Libby.

After deliberation, the jury finds that Dr. Jones has committed malpractice in his treatment of Mr. Libby. The jury also finds ABC Health System negligent for allowing Dr. Jones to perform carotid surgery at Shoreline when it knew (or should have known) that he was not qualified to do so at its flagship facility.



Legal insights

In order for credentialing or peer review decisions to qualify for immunity under HCQIA, they must be considered a professional review action, which is defined in 42 U.S.C. § 11151(9) as follows:

An action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (whose conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges ... of the physician.

Under HCQIA (42 U.S.C. § 11151(11)), a professional review body, which can be granted immunity from suits for damages, is defined as follows:

A healthcare entity and the governing body or any committee of a healthcare entity that conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.

HCQIA describes the following parties as “immunized participants” in peer review (42 U.S.C. § 11111(a)(1)):

- a. Professional review bodies
- b. Any person acting as a member or staff to the professional review body
- c. Any person acting under a contract or other formal agreement with the professional review body
- d. Any person who participates with or assists the professional review body

In order to qualify for immunity under HCQIA, peer review and credentialing actions must be taken under the following circumstances (42 U.S.C. § 11112(a)):

1. In the reasonable belief that the action was in the furtherance of quality healthcare
2. After a reasonable effort to obtain the facts of the matter
3. After adequate notice and hearing procedures are afforded to the physician under the circumstances
4. In the reasonable belief that the action taken was warranted by the facts known after reasonable effort to obtain the facts and after meeting the notice and hearing procedures required by #3

State statutes granting peer review privilege

Most negligent credentialing cases are tort claims that are heard in state courts. Whereas HCQIA stops short of protecting peer review documents from discovery, most states fortunately have adopted statutes that do offer such protection, which is typically referred to as *peer review privilege*. This nomenclature is used because these laws create a privilege to keep peer review material confidential where it would otherwise be discoverable by attorneys.

Since credentialing is generally considered a peer review activity, these protections usually apply to the credentials files of physicians and the minutes of credentials committees. Nevertheless, because each of the 50 states has its own statutes, the ability to protect credentials documents varies from locale to locale. Most states have substantial protections; however, a few do not.

The Regulation of Practitioner Credentialing

For those engaged in credentialing activities, it is important to understand the scope of the laws that provide peer review privilege in their state. In addition, regardless of such laws, keep in mind that judges will rarely be convinced to keep credentialing documents out of plaintiff attorneys' hands if the medical staff fails to handle the materials confidentially in the first place.

Other relevant federal statutes

In addition to HCQIA, federal laws like the Americans with Disabilities Act (ADA) and Age Discrimination in Employment Act (ADEA) also have relevance for the credentialing process. Medical staffs should adopt careful policies regarding the questions asked of applicants that bear on personal issues of current and past health, substance use, and physical impairments. Participants in the credentialing process (especially those who interview applicants) should be well trained to understand the constraints placed on them under the ADA, ADEA, and other similarly-focused laws.

The ADA

The ADA is a broad civil rights law that prohibits discrimination based on physical or mental disability. Provisions of the ADA clearly apply to employed physicians. Whether the law also encompasses independent members of a medical staff is more controversial. To date, only a few courts have applied the protections of the ADA to members of a medical staff who are not hospital employees. These courts have determined that the ADA may serve as the basis for a claim that a disabled physician has a right to staff privileges and to the use of the hospital's facilities for the benefit of the physician's practice.

Under the ADA, a disability includes the following:

- “A physical or mental impairment that substantially limits one or more major life activities”
- “Being regarded as having such an impairment”
- Having “a record of such an impairment”

The law places stringent limitations on when an employer can ask job applicants or employees disability-related questions or require a medical examination to detect a disability. Essentially, the ADA prohibits an employer from asking a potential employee whether he or she has a disability or about the nature or severity of a disability, unless such inquiry is job-related and consistent with business necessity. To demonstrate business necessity, the employer must show that the following statements are true:

- A medical examination is required to determine whether an employee can perform job-related duties
- The employer has some legitimate, non-discriminatory reason to question the employee's capacity to perform his or her duties
- The examination is a “reasonably effective method” of achieving the employer's asserted business necessity

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When a medical staff and governing board decide to limit or deny a physician's membership or privileges based on a disability, they must be careful not to trigger liability under the ADA. Usually it is wise to consult legal counsel whenever faced with a credentialing decision involving a practitioner with an impairment or disability. For more on credentialing considerations for such practitioners, see Chapter 7.

ADEA

The physician population, like the general U.S. population, is graying rapidly. In 2016, almost 40% of practicing doctors are older than 50. This trend has caused many medical staffs to consider age in the credentialing process. Aging policies that address the privileging of late-career practitioners are becoming more and more common.

Medical staffs and hospitals must be cautious that they do not violate the ADEA as they design and implement such policies. The statute was enacted to protect employees from age discrimination in the workplace. According to this statute, it is unlawful for an employer to “fail or refuse to hire or to discharge ... or otherwise discriminate” against an individual on the basis of age in regard to that person's “compensation, terms, conditions, or privileges of employment.”

The ADEA applies to persons who are age 40 or older. Generally, the courts have not applied the law where a physician is not an employee. As with other federal civil rights statutes, there are often parallel state laws and regulations that may differ in their terms and applicability. Therefore, it is imperative to seek out legal counsel when adopting procedures or policies that might raise objections based on claims of discrimination for age or physical or mental disability. Chapter 7 addresses the topic of late career physicians and their credentialing in more depth.

Patient Safety and Quality Improvement Act

In 2005, President George W. Bush signed into law another federal statute of significance for credentialing bodies. The Patient Safety and Quality Improvement Act, which amended the Public Health Service Act, established broad confidentiality and privilege protections for information pertaining to medical errors and other quality information that is voluntarily reported to so-called Patient Safety Organizations (PSO). In part, this legislation represented an effort to address the glaring hole in peer review protections created by the absence of a federal peer review privilege.

Many medical staffs take advantage of the law by participating in PSOs to protect credentialing data from lawyers interested in pursuing negligent credentialing claims. As PSOs have become more common and available, this option is certainly worthy of consideration. However, shielding credentialing information under the protections of a PSO can have unintended consequences. For example, the tactic may preclude a hospital's sharing of credentialing information when doing so may be helpful in responding to a negligent credentialing claim or in mediating a dispute over a physician's competence and privileges.



Key concepts in action

A plaintiff asserts negligent credentialing based on a contention that the medical staff failed to discover a physician's complete malpractice history and her history of privilege restrictions at another facility. Although the medical staff, which is participating in a PSO, was well aware of this information, it cannot use the credentials file to demonstrate this fact because the file must be kept confidential in accordance with PSO rules.

Juggling all applicable rules and regulations

As noted previously, in addition to federal laws, each state has its own peer review statutes, anti-discrimination/civil rights acts, anti-trust laws, and various regulations that can influence a healthcare organization's credentialing activities. The healthcare entity, in turn, should design credentialing policies and practices in careful accordance with this thicket of ground rules. Failure to do so can threaten accreditation, certification, licensure, and reputation, and can certainly add fuel to the ever-more common corporate negligence legal action.

Bottom Line

Contemporary credentialing and privileging practices are in a constant state of flux, driven by multiple factors, including the following:

- State and federal laws and regulations
- Case decisions
- Accreditation requirements
- The demands of payers, employers, and patients

In an era of increasing data transparency, the ready availability of information on the internet is also transforming credentialing and peer review. It is uncommon for attorneys who bring negligent credentialing lawsuits to keep abreast of the many changes in this constantly evolving field. They often call on "experts" who are similarly ignorant of all the nuances in appropriate credentialing. Nevertheless, the complexity of the credentialing field helps to fuel the rise of negligent credentialing litigation.

REFERENCE

Stephenson, G.W. (1981, February). The college's role in hospital standardization. *Bulletin of the American College of Surgeons*, 66(2), 18.

Negligent Credentialing Strategies for Reducing Hospital Risk

Todd Sagin, MD, JD

With negligent credentialing claims on the rise, the pressure on MSPs and medical staff leaders to reduce legal vulnerabilities in their vetting and governance processes is higher than ever. ***Negligent Credentialing: Strategies for Reducing Hospital Risk*** provides the context and strategy necessary to tamp down risk and take appropriate action when good faith efforts fail to prevent litigation. Drawing on his extensive medicolegal background, author Todd Sagin, MD, JD, offers practical guidance, accessible case summaries, and customizable tools for understanding key negligent credentialing concepts, avoiding top pitfalls, and contesting allegations.

This book will help you:

- Understand why today's healthcare climate is conducive to negligent credentialing suits
- Spot red flags in contemporary credentialing and privileging practices
- Fortify vetting processes with negligent credentialing–focused policies and procedures
- Prepare a swift and effective response should a negligent credentialing charge arise

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