7TH EDITION

VERIFY & COMPLY

Credentialing, Medical Staff, and Ambulatory Care Standards

- Kathy Matzka, CPMSM, CPCS
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CHAPTER 2

About the Authors

Kathy Matzka, CPMSM, CPCS, FMSP

Kathy Matzka, CPMSM, CPCS, FMSP, is a consultant and speaker with more than 30 years of experience in credentialing, privileging, and medical staff services. Matzka worked for 13 years as a hospital medical staff coordinator before venturing out on her own as an independent consultant, writer, and speaker. She is also one of the first recipients of the National Association Medical Staff Services (NAMSS) Fellow Designation, which is the pinnacle of achievement and acknowledgment for the medical services professional (MSP). It recognizes a career MSP who has made outstanding contributions to the profession through service as a leader, mentor, and educator.

Matzka has authored a number of books related to medical staff services, including the HCPro publications *Medical Staff Standards Crosswalk: A Quick Reference Guide to The Joint Commission, CMS, HFAP, and DNV Standards*; *Chapter Leader's Guide to Medical Staff: Practical Insight on Joint Commission Standards*; *Compliance Guide to Joint Commission Medical Staff Standards* (fifth and sixth editions); *The Clinician's Quick Guide to Credentialing and Privileging*; and *The Medical Staff Meeting Companion: Tools and Techniques for Effective Presentations*. She has also served as the contributing editor for *The Credentials Verification Desk Reference* and its companion website, *The Credentialing and Privileging Desktop Reference.*

She has performed extensive work with NAMSS' Education Committee, developing and editing educational materials related to the field, including the Certified Provider Credentialing Specialist (CPCS) and the certified professional medical services management (CPMSM) certification exam preparatory courses. She has also served as an instructor for NAMSS, and she further shares her expertise by serving on the News, Analysis, and Education Board for HCPro's Credentialing Resource Center.

A highly regarded industry speaker, Matzka has developed and presented hundreds of programs for professional associations, hospitals, and hospital associations on a wide range of topics, including provider credentialing and privileging, medical staff meeting management, peer review, negligent credentialing, provider competency, and accreditation standards.

Outside of her work, Matzka spends time with her family, listens to music, travels, hikes, fishes, and participates in other outdoor activities.

Stephanie Russell, CPMSM, CPCS

Stephanie Russell, CPMSM, CPCS, is the manager of medical staff services and education and credentialing at SwedishAmerican, a division of UW Health based in Rockford, Illinois. As an executive medical staff services professional for more than 30 years, with the past 24 years at SwedishAmerican, she has overseen medical staff affairs, including medical education, bylaws, regulatory compliance and accreditation, health system credentialing for both hospital and health plans, credentialing service contracts for outside entities, and delegation agreements and audits.

Russell is a NAMSS instructor and has made many presentations at state and national education conferences on topics related to credentialing, privileging, professional development, and regulatory compliance for both the National Committee on Quality Assurance (NCQA) and The Joint Commission. She has also been a collaborator and coach with Team Med Global for the past 10 years.

As a past member of the NAMSS board of directors and IAMSS board of directors, Russell has long displayed her leadership skills and innovative perspectives and is known for "asking the tough questions." She was also instrumental in creating the newest NAMSS course on leadership.

In addition to credentialing, Russell loves helping individuals be the best they can be. She is passionate about this industry and frequently tells her audiences that if you don't love what you do, find something else to do. Life is too short to work in a profession that you don't enjoy. Her email tag line is "enjoy the day—it's a gift," and she lives each day as if she's received a present.

Carol S. Cairns, CPMSM, CPCS

Carol S. Cairns, CPMSM, CPCS, has been in the unique position of seeing and participating in the development of the medical staff services profession for more than 40 years. In 1996, she founded Plainfield, Illinois–based PRO-CON, a consulting firm specializing in credentialing, privileging, medical staff organization operations, and survey preparation.

In 1991, Cairns became clinical faculty for The Joint Commission by collaborating in the development of an educational program on credentialing and privileging medical staff and allied health professionals. From 1996 to 2006, Cairns served the NCQA as a surveyor in the certification program for CVOs. Cairns was invited by the American Osteopathic Association to provide input into the development of the medical staff and allied health professional standards for the 2005 *Healthcare Facilities Accreditation Program Manual.*

Cairns is an advisory consultant for The Greeley Company, Inc., in Danvers, Massachusetts. In 2013, The Greeley Company recognized her professional contributions by establishing the Aspire Higher scholarship in her honor. The scholarship is managed by NAMSS and presented annually.

A faculty member for NAMSS since 1990, Cairns has presented at numerous state and national conferences. Program subjects include basic and advanced credentialing and privileging, Joint Commission standards and survey preparation, NCQA standards, allied health professionals, core privileging, and meeting management and documentation. She coauthored the initial NAMSS educational program for certification of provider credentialing specialists (CPCS) and the current Credentials 101 seminar, and she serves as faculty for both programs.

She also serves on the Advisory Board for HCPro's Credentialing Resource Center. She has authored and coauthored numerous publications for HCPro, including the previous six editions of *Verify and Comply.* She served as a coauthor of the third and fifth editions of *Core Privileges for Physicians: A Practical Approach to Developing and Implementing Criteria-Based Forms.* She has authored multiple books on credentialing AHPs, among them *A Guide to AHP Credentialing*, *Core Privileges for AHPs, and Solving the AHP Conundrum: How to Comply With HR Standards Related to Nonprivileged Practitioners*. Cairns also coauthored the first edition of *The FPPE Toolbox: Field-Tested Documents for Credentialing, Competency, and Compliance* and *The Medical Staff's Guide to Overcoming Competence Assessment Challenges.*

Acknowledgments

It's impossible to coauthor this book without acknowledging the contributions of the previous author, Carol Cairns, CPMSM, CPCS, to our field. Carol has been a mentor to me and to countless other medical services professionals who have had the pleasure of learning from her vast pool of knowledge. Thanks, Carol, for all that you've done for us!

I would also like to give a shout out to all of the current and past instructors for NAMSS who have donated and continue to donate many hours of their time providing a much-needed service to members of our profession. Like Carol, they have been great mentors for me, particularly retired instructor Sue King, CPMSM, CPHQ, CPCS, who encouraged me to step out of my comfort zone and pursue the option of serving as an instructor for NAMSS.

Finally, I'd like to acknowledge medical services professionals all over the world. Many of you work long hours and with little or no recognition for your important contribution to patient safety. You are making a difference!

—Kathy Matzka

As the rookie author of this amazing reference, I echo my coauthor's acknowledgment of Carol Cairns and the impact she has had on this healthcare world in which many of us live. Her contributions to the industry, her personal mentoring of many of us, and her longevity as a MSP has modeled and shaped credentialing in ways I don't think even she realizes.

From pre-Data Bank to criminal background checks, the world of credentialing is ever changing. We are fortunate to have resources, such as this, to guide us along the way. References and colleagues validate what we think we already know. To stay on top of these changes is not easily done alone. Our colleagues guide us. The references support us, and the teams with which we belong help us grow.

To be a part of this trio is very humbling and energizing at the same time. I am grateful to be a part of this team and to work in an industry that challenges me every day. My mentors are too numerous to mention, and the leaders that have paved the way for me remind me that there are more behind us following. With every new day and every new regulation, we move forward as executive MSPs, supporting each other, encouraging each other, and reminding each other—we are the patient advocates. Without us, where would they be?

—Stephanie Russell

Introduction

The Centers for Medicare & Medicaid Services' (CMS) *Conditions of Participation (CoP)* contain minimum requirements that all hospitals wishing to provide services to Medicare or Medicaid patients must meet. This governmental organization is a division of the U.S. Department of Health and Human Services. CMS does not directly survey healthcare organizations; instead, it surveys them through state governmental agencies, typically the state's health department.

There are also accrediting bodies whose minimum "standards" a healthcare organization must meet if it is to be voluntarily accredited by that body. These accrediting bodies must submit their standards to CMS, which then reviews the standards for compliance with CMS' *CoP*s. If the standards meet or exceed the CMS regulations, then the accreditation program is given "deemed" status, which means that healthcare organizations can participate in this voluntary accreditation in lieu of the state agency survey.

In many cases, accreditors have more stringent standards than those required by CMS regulations. As you read through the requirements of the various accreditors, you will notice areas in which the accreditation standards reflect only the minimum requirements of the *CoP*s; in other cases, you will see where additional requirements are included.

The Importance of Credentialing

One of the highest-risk procedures performed in a healthcare organization is not performed in an operating room, delivery room, GI laboratory, or emergency room. Nor is it performed by a surgeon, pediatrician, or family practitioner.

The procedure is credentialing, an activity that is performed in medical staff services departments, provider relations departments, medical clinics, ambulatory facilities, health plan credentialing offices, and credentials verification organizations (CVO) throughout the country. Regardless of the size or type of the organization, credentials specialists, medical services professionals, healthcare facilities and physician leadership, health plan executives, and governing bodies share the medical and legal responsibilities of and accountability for conducting a thorough, comprehensive, and timely credentialing process. The process includes verification, documentation, and approval of a practitioner's credentials to practice in a healthcare facility/participate in a managed care plan.

Brief Descriptions of Each Organization

Centers for Medicare & Medicaid Services (CMS): This governmental organization is a division of the U.S. Department of Health and Human Services. CMS does not directly survey healthcare

organizations; rather, it surveys them through state organizations, such as the Department of Health. CMS develops the *CoP*s that healthcare organizations must meet to begin and continue participating in the Medicare and Medicaid programs.

The Joint Commission (TJC): This organization offers accreditation programs for a variety of healthcare entities, including hospitals, freestanding ambulatory care facilities, office-based surgery practices, behavioral healthcare facilities, critical access hospitals, long-term care organizations, homecare organizations, and laboratory and point-of-care testing facilities.

National Committee for Quality Assurance (NCQA): This organization has established credentialing standards that are applicable to health plans, managed behavioral healthcare organizations, new health plans, credentials verification organizations, physician organizations, and hospitals.

DNV GL Healthcare USA (DNV GL): This organization was granted deeming status by CMS in 2008. Hospitals must comply with its National Integrated Accreditation for Healthcare Organizations (NIAHO®) standards to receive accreditation. What sets DNV apart from other accrediting organizations is that its standards integrate compliance with the International Organization for Standardization (ISO) 9001 quality management system.

Healthcare Facilities Accreditation Program (HFAP): This organization accredits hospitals, ambulatory care/surgical facilities, mental health facilities, physical rehabilitation facilities, clinical laboratories, critical access hospitals, and stroke centers. The Accreditation Association, a provider of hospital and health system accreditation, owns and manages this program through its subsidiary, The Accreditation Association for Hospitals and Health Systems.

Accreditation Association for Ambulatory Health Care (AAAHC): This organization primarily accredits freestanding ambulatory care centers such as surgery centers, birthing centers, lithotripsy centers, and pain management centers. It also accredits group practices, managed care organizations, and independent physician organizations.

What This Book Includes

This book is divided into three sections:

1. Credentialing and privileging standards for acute and managed care
2. Credentialing and privileging standards for ambulatory care
3. Medical staff standards that reference areas other than credentialing and privileging for hospitals (acute care)

In its table format, *Verify and Comply* is an efficient guide to the regulators' and accreditors' medical staff and credentialing standards.

Keeping Up to Date and Informed

Although information in this book is current at the time of publication, keep in mind that Hospital *CoP*s and accreditation standards are subject to change. It is important for readers to stay up to date with the latest accreditation standards and survey information. We encourage readers to access HCPro's Credentialing Resource Center website (*www.credentialingresourcecenter.com*) to obtain the latest credentialing-related information and to share information and ideas with each other.

Author's note: CMS CoPs use the definition of "physician" from the Social Security Act. This definition is carried through to the accreditation standards. "The term 'physician,' when used in connection with the performance of any function or action, means (1) an MD or DO legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) A doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) A doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) A doctor of optometry, but only for purposes of subsection (p)(1) with respect to the provision of items or services described in subsection(s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) A chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished."

We hope that you find this book and related tools valuable additions to your library. Please feel free to contact us with comments, suggestions, or questions related to this book or other HCPro products and services.

SECTION 1

Acute Care and Managed Care: Credentialing Standards

Author's Note

Within each column, the verification source and methodology are outlined in bold text. Verification from the listed sources is considered acceptable in meeting that regulator's/accreditor's standards. The desire to provide the highest-quality healthcare possible coupled with the need to reduce medical risks to patients and legal risks to the organization have prompted many healthcare organizations to develop and maintain a credentialing process that far exceeds The Joint Commission, NCQA, CMS, DNV, HFAP, or AAAHC standards. For this reason, this section not only includes minimum standards but also designates credentialing "best practices"—that is, practices that meet or exceed the accreditors' standards. These best practices are marked with a star icon and are in boldface text.

Italicized text is the author's opinion or an interpretation of a standard.

CHAPTER 1

Acute Care and Managed Care: Initial Appointment, Clinical Privileges, and Credentialing

PRACTITIONERS COVERED				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The governing body determines, in accordance with state law and scope of practice laws, which categories of practitioners are eligible for appointment to the medical staff. Medical staff at a minimum must be composed of physicians, defined as MDs or DOs. Other practitioners may be included as defined in the Social Security Act, such as the following: • Dentists (DDS/DMD) • Podiatrists (DPM) • Chiropractors (DC) • Optometrists (OD) The governing body may also determine, in accordance with state law, other types of practitioners that may be eligible for appointment to the medical staff/granted clinical privileges, such as nurse practitioners, PAs, certified registered nurse anesthetists, certified nurse midwives, clinical nurse specialists, clinical social workers, clinical psychologists, registered dietitians nutrition professionals, and anesthesiologist assistants. Practitioners do not need to be members of the medical staff in order to be granted privileges, as long as privileges were granted according to state law, recommended by the medical staff, and approved by the governing body. Oversight and ongoing review of competency must also be performed for such practitioners in the same manner that they are for medical staff members. › *Continued on next page*	**Licensed independent practitioners (LIP):** All LIPs must be credentialed and privileged through the organized medical staff structure. LIP status is defined as "any individual permitted by law and by the organization to provide care, treatment, and services without direction or supervision" within the scope of the individual's license and consistent with individually granted privileges. Individuals are considered LIPs if this definition applies to how they function within the organization, regardless of whether they are medical staff members and regardless of their employment or contractual relationship(s) with the organization. **Advanced practice nurses (APRN) or physician assistants (PA):** If an APRN or PA functions as an LIP, this individual must be credentialed and privileged through the organized medical staff. If the APRN or PA does not function independently but rather under some level of direction/supervision*, then the individual may be credentialed and privileged through the medical staff structure or an equivalent process and criteria.** This equivalent process must be approved by the governing body and must include communication with and input from the medical staff executive committee regarding privileges requested. › *Continued on next page*	The governing body determines, in accordance with state law (including scope of practice laws) which categories of practitioners are eligible for appointment to the medical staff. Medical staff, at a minimum, must be composed of physicians, defined as MDs or DOs. Other nonphysician practitioners may be included, in accordance with scope of practice laws, such as dentists, podiatrists, psychologists, physician assistants, advance practice registered nurses, nurse anesthetists, nurse midwives, psychologists, or other professionals legally authorized by the state and approved by the medical staff and governing body. Any individual who is permitted by the organization and by law to provide patient care services independently must have delineated clinical privileges. All patients must be under the care of a member of the medical staff or under the care of a practitioner who is directly under the supervision of a member of the medical staff. All practitioners providing patient care orders must meet the medical staff criteria and procedures for privileges that were granted according to the governing body. › *Continued on next page*	The governing body determines, in accordance with state law, which categories of practitioners are eligible for appointment to the medical staff. At a minimum, the medical staff must consist of doctors of medicine or osteopathy and, in accordance with state law (including scope of practice laws), may also include other types of healthcare professionals included in the definition of "physician" as stated in the Social Security Act of 1861(r): • Doctor of medicine or osteopathy • Doctor of dental surgery or dental medicine • Doctor of podiatric medicine • Doctor of optometry • Chiropractor These individuals must be legally authorized to practice within the state and provide services with their authorized scopes of practice. The governing body may also appoint nonphysician providers* to the medical staff in accordance with state law, regulations, and scope of practice. These practitioners are outlined and as defined by the Social Security Act, Section 1842, and include the following: › *Continued on next page*	HPs and MBHOs must have documented credentialing policies and procedures that apply to all LIPs who provide care to the organization's members (a person insured or provided coverage by a health plan). At a minimum, all LIPs certified or registered by the state to practice independently (without direction or supervision) and provide care to members are within the scope of the credentialing standards. HPs: The files of the following practitioners will be reviewed: • Physicians (MD, DO) • Oral surgeons (DDS/DMD) • Podiatrists (DPM) • Chiropractors (DC) • Nurse practitioners (APRN) who are licensed, registered or certified by the state to practice independently • Nonphysician practitioners with an independent relationship with the organization who provide care under medical benefits. Examples of this category of practitioner would be a nurse practitioner, nurse midwife, optometrist, physical or occupational therapist, and speech and language therapist. › *Continued on next page*

PRACTITIONERS COVERED				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Nonphysicians: The CMS Surgical Services standards also address the privileging of non-physicians "performing surgical tasks." The standards delineate practitioners such as dentists, oral surgeons, podiatrists, RN first assistants, nurse practitioners, surgical PAs, surgical technicians, etc. "Surgical tasks" are specifically defined within the standards. See the Interpretive Guidelines, §482.51, What constitutes "surgery"? *Note: If a hospital uses RNFAs, surgical PAs, or any non-MD/DO surgical assistants, the hospital must have criteria, qualifications, and a credentialing process to grant specific privileges to a practitioner based upon compliance with those criteria, and according to state and federal laws and regulations. This statement also applies to surgical tasks performed by practitioners under MD/DO supervision.* Tasks such as holding retractors, cutting or tying knots, and handling instruments are not considered performing surgery. However, cutting, burning, vaporizing, freezing, suturing, or manipulating tissue is considered surgery and thus requires privileging. › *Continued on next page*	**Direction/supervision of the APRN may be through a collaborative or supervisory agreement. A vast majority of PAs, according to their licenses and appropriate state law, are required to have a supervisory agreement with a physician.* If organizations choose to credential and privilege APRNs or PAs under the equivalent process, the "Human Resources" chapter of the Comprehensive Accreditation Manual for Hospitals (CAMH) should be consulted for the methodology.** These standards require that the governing body approve an equivalent process (to the medical staff process) for the credentialing and privileging/reprivileging of PAs and APRNs. ***The equivalent process is not an option for hospitals that use Joint Commission accreditation for deemed status.* At a minimum, the equivalent process does the following: • Evaluates the credentials of the applicant*** • Evaluates the current competence of the applicant*** • Includes documented peer recommendations › *Continued on next page*	DNV GL standards do not specifically address credentialing processes related to RN first assistants, surgical assistants, or physician employees who round with the physician. However, DNV GL provided an interpretation that these individuals' credentialing process and provision of care in the hospital must be governed by hospital policy. Further, DNV GL policy does not permit a physician employee who rounds with the physician to act as a scribe to the physician and make entries on the hospital medical record for physician signature.	• Physician assistant • Nurse practitioner • Clinical nurse specialist • Certified registered nurse anesthetist • Certified nurse midwife • Clinical social worker • Clinical psychologist • Registered dietitian or nutrition professional • Anesthesiologist assistant The governing body may grant physicians and nonphysicians medical staff privileges to practice at the hospital without being appointed to the medical staff. Nonphysician providers* may be granted privilege delineation rights and responsibilities without being given membership status or rights. Other types of licensed healthcare professionals (e.g., physical therapists, occupational therapists, speech language therapists, licensed pharmacists) are generally not eligible for medical staff privileges unless the scope of practice permitted in their state makes them more comparable to these (above) types of non-physician practitioners who in some states are permitted to provide patient care services, including monitoring and assessing of patients and ordering medications and laboratory tests. › *Continued on next page*	It is necessary to credential the following: • Practitioners with an independent relationship with the organization. An independent relationship is defined as when the organization selects and directs its members to a specific individual or group. This would include those practitioners that members can select as primary care practitioners. • Practitioners who see patients outside of hospital inpatient or freestanding ambulatory facilities. • Hospital-based practitioners who see members as part of their independent relationship. • All practitioners providing care under medical benefits (including oral surgeons). • Nonphysicians providing care under medical benefits with an independent relationship. • Rental network practitioners who are used as part of the primary network, whose members reside in the rental network area. • Rental network practitioners specifically identified for out-of-area care. › *Continued on next page*

PRACTITIONERS COVERED				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
CMS also requires a clear delineation of what surgical procedures must be conducted under supervision and that the degree of that supervision (to include whether the supervising practitioner is physically present in the same OR, in line of sight of the practitioner being supervised) be delineated in that practitioner's surgical privileges.	• Ensures communication with and input from appropriate individuals and committees, including the medical staff executive committee, so that informed decisions may be made regarding the applicant's request for privileges ****The evaluation process is documented*		Non-physician disciplines are determined by the governing body in consultation with the medical staff. All practitioners that provide medical care or conduct surgical procedures either directly or under supervision—regardless of employment by the hospital, a physician, other entity, or a contracted provider—must be individually credentialed and privileged based on their individual qualifications, and function under the bylaws, regulations and rules of the hospital's medical staff. Practitioners granted privileges must be consistent with state and scope of practice laws. All practitioners who require privileges to provide patient care must be evaluated according to the medical staff privileging process before the governing body may grant them privileges. **The term "Allied Health Practitioners" was removed from the HFAP manual, and such practitioners are now referred to as non-physician providers.*	• Rental network practitioners for out-of-area care whose members are incentivized to see. • Telemedicine. It is not necessary to credential practitioners who practice exclusively in the inpatient setting/freestanding facilities and provide care resulting from the member being directed to a hospital or other inpatient or ambulatory care setting. Examples include pathologists, radiologists, anesthesiologists, neonatologists, emergency room physicians, hospitalists, and telemedicine consultants, as well as practitioners at mammography centers, urgent care centers, surgicenters, ambulatory behavioral health facilities, and clinics for psychiatric and addiction disorders. It is also not necessary to credential the following: • Covering practitioners (i.e., locum tenens) who do not have an independent relationship with the organization • Pharmacists who work for a pharmacy benefits management organization that performs utilization management functions › *Continued on next page*

PRACTITIONERS COVERED				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				• Practitioners who do not care for members in a treatment setting (e.g., board-certified consultants) • Rental practitioners that provide out-of-area care specifically; members are not obligated or incentivized to seek care from these practitioners and may see any out-of-area practitioner MBHOs: For behavioral health professionals, the following files are reviewed: • Psychiatrists and other physicians (MD, DO) • Addiction medicine specialists • Licensed or certified psychologists (MA, PhD) • Licensed or certified clinical social workers (MSW) • Licensed clinical nurse specialists (MSN) or licensed psychiatric nurse practitioner (NP) • Other behavioral health specialists licensed, certified, or registered by the state to practice independently The organization must have policies and procedures for credentialing additional practitioner disciplines not previously listed. › *Continued on next page*

PRACTITIONERS COVERED				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				The process for credentialing must be similar to those of practitioners listed previously. These policies and procedures are reviewed by NCQA, but the files reviewed are limited to those disciplines identified. CVOs: The contract with the HP or MBHO or health delivery organization (e.g., physician hospital organization or hospital) would specify the types of individuals to be credentialed.

MEDICAL EDUCATION				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The medical staff must have a mechanism to examine evidence of professional education. CMS does not specify acceptable sources for this evidence. *** Correspondence with medical school** **Documented phone call with medical school** **Verification from the following:** • **The AMA Physician Profile for all United States and Puerto Rico medical school education** • **The AOA Physician Database** • **ECFMG for foreign medical schools**	Requires verification from the medical/osteopathic school (also dental, podiatric, or advanced practice nursing education or PA degree). Accepted "designated equivalent sources" are as follows: • The AMA Physician Profile for all United States and Puerto Rico medical school education • The AOA Physician Database • The ECFMG for foreign medical schools • The American Academy of Physician Assistants Profile provided through the AMA Physician Profile Service *Note: When an organization cannot obtain verification from the primary source, The Joint Commission standards permit use of a "reliable secondary source." Such a source can be another hospital that has a documented primary source verification of the credential.* *** Correspondence with medical school** **Documented phone call with medical school** **Form from approved source as specified above**	Requires verification of education from the primary source. The AMA Physician Profile is also acceptable, as is the ECFMG (as applicable). Continuing education is related, at least in part, to the practitioner's clinical privileges. *** Correspondence with medical school** **Documented phone call with medical school** **AMA Physician Profile or ECFMG as applicable**	Requires primary source verification of education sufficient to grant privileges. Additional defined sources are as follows: • AMA Physician Profile • AOA Official Osteopathic Physician Profile • ECFMG, as applicable *** Correspondence with medical school** **Documented phone call with medical school** **Form from approved source as specified above**	HP/CVO: The highest of the three levels of education and training attained must be verified. The three levels are defined as follows: 1. Graduation from medical or professional school 2. Residency, as appropriate 3. Board certification, if appropriate Therefore, if a physician is currently board-certified, verification of board certification suffices. See "Board Certification" for verification details. If the practitioner's board certification has expired, then verification of completion of the residency training program is required. If the physician is not board certified, verification of completion of residency suffices. Completion of residency training can be verified through any of the following: • The residency training program. • AMA Physician Profile. • AOA Official Osteopathic Physician Profile Report or AOA Physician Masterfile.* • An association of schools of the health profession, if the association obtains its verification from the primary source. Annually, the organization must obtain written confirmation that the association performs primary source verification. • The state licensing agency, as long as it conducts primary source verification. There must be written evidence on file, updated annually, that the state licensing agency performs primary source verification.** › *Continued on next page*

MEDICAL EDUCATION				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				• FCVS for closed residency programs. NCQA only recognizes residency programs accredited by the following: • Accreditation Council for Graduate Medical Education (ACGME) • American Osteopathic Association (AOA) • College of Family Physicians of Canada (CFPC) • Royal College of Physicians and Surgeons of Canada • Note: If education and training were completed via the AMA Fifth Pathway Program, this must be verified from the AMA as primary source. *Note: NCQA does not require verification of fellowship training. Further, verification of fellowship training does not meet the requirement for verification of residency training.* *Verification of fellowship is a best practice from a quality and risk management perspective.* If the physician did not complete a residency program, verification is required from one of the following sources: • The medical school. • AMA Physician Profile. • AOA Official Osteopathic Physician Profile Report or AOA Physician Masterfile.* • The ECFMG for international graduates licensed after 1986. › *Continued on next page*

MEDICAL EDUCATION				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				• An association of schools of the health professions, if the association obtains its verification from the primary source. Annually, the organization must obtain written confirmation that the association performs primary source verification. • The state licensing agency, as long as it conducts primary source verification. There must be written evidence on file, updated annually, that the state licensing agency performs primary source verification.** A dated printout of the licensing agency's website is also acceptable if the site states that education and training are verified with the primary sources and the information is current. Sealed transcripts are acceptable if the organization can confirm that it inspected the transcript and verified the practitioner graduated from the program. *Note: NCQA requirements vary for podiatrists, chiropractors, oral surgeons, and other healthcare professionals. See the NCQA credentialing standards for specific information.* MBHO/CVO: Verification for physicians is the same as those described above for HPs. For nonphysician behavioral healthcare professionals, MBHOs/CVOs must verify completion of education and training with one of the following: • The professional school. › *Continued on next page*

MEDICAL EDUCATION				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				• The state licensing agency or specialty board or registry, if the organization provides recent evidence that the agency conducts primary source verification of professional school education and training. There should be written evidence on file, updated at least annually, confirming that the agency performs primary source verification.** Verification time limit: None *According to the AOA, the documents it offers through the American Osteopathic Information Association (AOIA) is the "Official Osteopathic Physician Profile Report." This report is pulled directly from the AOA Physician Database. **Annual written confirmation is not necessary if a state statute requires the licensing board to obtain verification of education and training directly from the institution. In this instance, a copy of the relevant state statute should be retained in the document library. * **Verification of board certification (see "Board Certification" section for acceptable sources) or verification of completion of residency (acceptable sources stated in this section)** **Verification of medical education (acceptable sources stated in this section)**

POSTGRADUATE TRAINING: INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The medical staff must have a mechanism to examine evidence of training and documented experience. CMS does not specify acceptable sources for this evidence. *** Criteria-based evaluation form completed by postgraduate training program documenting clinical competence** **Documented phone call with postgraduate training program** **Verification from the following:** **•The AMA Physician Profile for all United States and Puerto Rico postgraduate training programs** **•The AOA Physician Database**	Requires verification from the primary source(s). This requirement encompasses internship, residency, and fellowship programs, as well as other relevant experience (e.g., military training). Accepted "designated equivalent sources" for United States and Puerto Rico postgraduate training are the AMA Physician Profile and the AOA Physician Database. *** Criteria-based evaluation form, addressing the six core competencies as defined by ACGME and ABMS completed by postgraduate training program documenting clinical competence** **Documented phone call with postgraduate training program** **Form from approved source as specified above**	Requires primary source verification of specific training. The AMA Physician Profile is also acceptable as a verification source. *** Criteria-based evaluation form completed by postgraduate training program documenting clinical competence** **Documented phone call with postgraduate training program** **AMA Physician Profile**	Requires primary source verification of education sufficient to grant privileges. Additional defined sources are as follows: • AMA Physician Profile • AOA Official Osteopathic Physician Profile *** Criteria-based evaluation form completed by postgraduate training program documenting clinical competence** **Documented phone call with postgraduate training program** **Form from approved source as specified above**	HP/CVO: The highest of the three levels of education and training attained must be verified. The three levels are defined as follows: 1. Graduation from medical or professional school 2. Residency, as appropriate 3. Board certification, if appropriate Therefore, if a physician is currently board-certified, verification of board certification suffices. See "Board Certification" for verification details. If the practitioner's board certification has expired, then verification of completion of the residency training program is required. If the physician is not board certified, then verification of completion of residency suffices. Completion of residency training can be verified through any of the following: • The residency training program. • AMA Physician Profile. • AOA Official Osteopathic Physician Profile Report or AOA Physician Masterfile.* • An association of schools of the health profession, if the association obtains its verification from the primary source. Annually, the organization must obtain written confirmation that the association performs primary source verification. › *Continued on next page*

POSTGRADUATE TRAINING: INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				• The state licensing agency, as long as it conducts primary source verification. There must be written evidence on file, updated annually, that the state licensing agency performs primary source verification.** • FCVS for closed residency programs. NCQA only recognizes residency programs accredited by the following: • Accreditation Council for Graduate Medical Education (ACGME) • American Osteopathic Association (AOA) • College of Family Physicians of Canada (CFPC) • Royal College of Physicians and Surgeons of Canada *Note: If education and training were completed via the AMA and 5th Pathway program, this must be verified with the AMA as the primary source.* *Note: NCQA does not require verification of fellowship training. Further, verification of fellowship training does not meet the requirement for verification of residency training.* Verification of fellowship is a best practice from a quality and risk management perspective. If the physician did not complete a residency program, verification is required from one of the following sources: › *Continued on next page*

POSTGRADUATE TRAINING: INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				• The medical school. • AMA Physician Profile. • AOA Official Osteopathic Physician Profile Report or AOA Physician Masterfile.* • The ECFMG for international graduates licensed after 1986. • An association of schools of the health professions, if the association obtains its verification from the primary source. Annually, the organization must obtain written confirmation that the association performs primary source verification. • The state licensing agency, as long as it conducts primary source verification. There must be written evidence on file, updated annually, that the state licensing agency performs primary source verification.** • Sealed transcripts are acceptable if the organization can confirm that it inspected the transcript and verified that the practitioner graduated from the program. A dated printout of the licensing agency's website is also acceptable if the site states that education and training are verified with the primary sources and information is current. › *Continued on next page*

POSTGRADUATE TRAINING: INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				Note: NCQA requirements vary for podiatrists, chiropractors, oral surgeons and other healthcare professionals. See the NCQA credentialing standards for specific information. MBHO/CVO: Verification for physicians is the same as those described above for HPs. For nonphysician behavioral healthcare professionals, MBHOs/CVOs must verify completion of education and training with one of the following: • The professional school. • The state licensing agency or specialty board or registry, if the organization provides recent evidence that the agency conducts primary source verification of professional school education and training. There should be written evidence on file, updated at least annually, confirming that the agency performs primary source verification.** Verification time limit: None *According to the AOA, the documents it offers through the American Osteopathic Information Association is the "Official Osteopathic Physician Profile Report." This report is pulled directly from the AOA Physician Database. › *Continued on next page*

POSTGRADUATE TRAINING: INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				Annual written confirmation is not necessary if a state statute requires the licensing board to obtain verification of education and training directly from the institution. In this instance, a copy of the relevant state statute should be retained in the document library. * **Verification of board certification (see "Board Certification" section for acceptable sources) or verification of completion of residency (acceptable sources stated in this section) **Verification of medical education (acceptable sources stated in this section)**

COMMENTS/TIPS:

1. In certain instances, foreign institutions will not or cannot verify training. In such cases, efforts to obtain primary source verification should be documented. The organization may be able to verify training and experience with individuals who trained with the applicant and who are now practicing in the United States.
2. When an organization cannot obtain verification from the primary source, The Joint Commission standards permit use of a "reliable secondary source." Such a source can be another hospital that has a documented primary source verification of the credential. An organization must document the attempts it made to obtain verification from the primary source before accepting the secondary source.
3. In the case of an applicant who has completed postgraduate training many years ago (e.g., 15–20 years), simple verification of completion of training may be sufficient (e.g., from training program, AMA, AOA).
4. The medical staff should establish policies defining the credentials verification process.

BOARD CERTIFICATION				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The Guidelines specifically state that the medical staff may not make its recommendation solely on the basis of the presence or absence of board certification but must consider evidence of current licensure, evidence of training and professional education, documented experience, and supporting references of competence. The Guidelines state that a medical staff is not prohibited from requiring board certification in its bylaws when considering a MD/DO for medical staff membership or privileges, only that such certification may not be the only factor that the medical staff considers. *** Secure electronic verification from specialty board** *** Correspondence or documented phone call with specialty board*** **The ABMS or services designated by ABMS as an Official Display Agent** **AMA Physician Profile** **AOIA Official Osteopathic Physician Profile Report (also known as AOA Physician Database)****	The Joint Commission standards do not require board certification. If the medical staff bylaws, policies, or rules and regulations require certification, however, The Joint Commission expects this credential to be verified. In the instance that board certification (or admissibility/eligibility) is to be verified in accordance with the organization's regulations, the verification may be obtained directly from the specialty board. The American Board of Medical Specialties (ABMS), the AOA, and the AMA Physician Profile also are considered equivalent sources. *** Secure electronic verification from specialty board** *** Correspondence or documented phone call with specialty board*** **The ABMS or services designated by ABMS as an Official Display Agent** **AOIA Official Osteopathic Physician Profile Report (also known as AOA Physician Database**)** **AMA Physician Profile** ***Note: The standards require board certification or comparable competence of a department chair if departments of the medical staff exist.***	There is no mention of board certification nor a requirement for verification in the qualifications for appointment section on medical staff. If bylaws or policies or criteria require certification, then DNV GL expects organizations to have verification of required certification. The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society. The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals who request privileges. *** Secure electronic verification from specialty board** *** Correspondence or documented phone call with specialty board*** **The ABMS or services designated by ABMS as an Official Display Agent** **AMA Physician Profile** **AOIA Official Osteopathic Physician Profile Report (also known as AOA Physician Database)****	There is a requirement to document specialty board certification status (as applicable). If the individual is certified by a member of the ABMS board, the ABMS is an appropriate source. If the individual is certified by an AOA board, verification should be obtained from the AOA Official Osteopathic Physician Profile. Standards also require that information be obtained from the specialty boards related to a history of sanctions, disciplinary actions, or investigations pending. HFAP states that a hospital is not prohibited from requiring board certification when considering a physician for medical staff membership. However, board certification should not be the sole criterion. In addition to board certification, the organization must also evaluate education, training, documented experience, competence, and current licensure. *** Secure electronic verification from specialty board** *** Correspondence or documented phone call with specialty board*** *** ABMS or services designated by ABMS as an Official Display Agent** **AOIA Official Osteopathic Physician Profile Report (also known as AOA Physician Database)****	HP/MBHO/CVO: NCQA does not require board certification. If the individual is board certified, verification must be obtained directly from the specialty board or through one of the following: • The American Board of Medical Specialties (ABMS) or a member board or services designated by ABMS as an Official Display Agent with a dated certificate of primary source authenticity available. • The AOA's Physician Masterfile, or Physician Profile Report. • The AMA's Physician Profile. • U.S. boards that are not members of the ABMS or AOA: The organization decides what specialty boards will be accepted. This information is contained in policy and procedures. The board provides a statement that the physician's education and training were verified with the primary source. This statement is updated at least annually. • State licensure, if the state licensing agency conducts primary source verification of board status and there is evidence on file—updated at least annually—that the state licensing agency performs primary source verification. › *Continued on next page*

BOARD CERTIFICATION				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				Note: The ABMS Certified Doctor Verification Program, available through the ABMS website, is for consumer reference only and is not an NCQA-recognized source for verification of board certification. *Note: Verification of board certification for nurse practitioners or other healthcare professionals is not required unless the health plan provides this information to its members.* The expiration date of the board certification is documented in the practitioner's credentials file. If the practitioner has a "lifetime" board certification, this status must be reflected in the practitioner's file. If the medical board does not provide an expiration date, then the organization must verify that the board certification is current and indicate its verification date. Verification time limit: • HP: 180 days • CVO: 120 days The 180-/120-day time limitation does apply to this element, regardless of whether the board certification expires. NCQA requirements vary for podiatrists, chiropractors, oral surgeons, and other healthcare professionals. See the NCQA credentialing standards for specific information. › *Continued on next page*

BOARD CERTIFICATION				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				MBHO/CVO: For non-physician behavioral healthcare professionals, MBHOs and CVOs must obtain confirmation from one of the following: • The specialty board. • The state licensing agency or registry, if the agency/registry conducts primary source verification of board certification. MBHOs and CVOs should receive written verification at least annually from the agency/registry that performs primary source verification. Verification time limit: • MBHO: 180 days • CVO: 120 days * **Secure electronic verification from specialty board** * **Correspondence or documented phone call with specialty board*** **ABMS or services designated by ABMS as an Official Display Agent** **AMA Physician Profile** **AOIA Official Osteopathic Physician Profile Report (also known as AOA Physician Database)**** **State licensing body with annual confirmation of primary source verification**

COMMENTS/TIPS:

***The AOA advises those verifying AOA board certification to contact the AOIA. Contacting the AOA specialty board results in a referral back to the AOIA directly (*www.doprofiles.org*) for response and thus delays verification.

****According to the AOA, the documents it offers through the American Osteopathic Information Association is the "Official Osteopathic Physician Profile Report." This report is pulled directly from the AOA Physician Database.

CURRENT LICENSURE				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The medical staff must have a mechanism to examine evidence of current licensure. CMS does not specify acceptable sources for this evidence, but the assumed requirement is that the applicable state license be primary-source-verified. CMS is also silent regarding verification of licensure at expiration. However, it can be assumed that such verification would be required. *** Licensing board verification through the state licensing board website, with appropriate documentation** **Correspondence or documented phone call with licensing board**	Primary source verification is required from the applicable* state licensing board at appointment and when granting clinical privileges (initially and also when considering requests for additional privileges). Verification of licensure is also required at expiration. **"Applicable" meaning the state where the practitioner is requesting and being granted privileges* *** Licensing board verification through the state licensing board website, with appropriate documentation** **Correspondence or documented phone call with licensing board** ***Note: Verification of all licenses (past and present) is considered best practice.***	Requires primary source verification from the state licensing body at the time of appointment. DNV requires current license of each staff member, so it is implied that licenses will be verified upon renewal to ensure that they remain current. The medical staff has a mechanism for consideration of automatic suspension of clinical privileges if a practitioner's professional license has been revoked or suspended for any reason. *** Licensing board verification through the state licensing board website, with appropriate documentation** **Correspondence or documented phone call with licensing board**	Standards require primary source verification from state licensing agencies of all current license(s), license sanctions, state(s) of current practice or intended practice, and all previous licenses held. Standards also require query of the National Practitioner Data Bank. State licensing bodies should be queried regarding previously successful/currently pending (if obtainable) challenges to any license and/or voluntary/involuntary relinquishment of licensure. In addition, the organization should seek information from FSMB's Disciplinary Action Databank or Fraud & Abuse Control Information Systems (FACIS). For care rendered via telemedicine: Standards state that when the practitioner and patient are located in different states, the practitioner providing the service must be licensed and meet other applicable standards that are required (state and local) both where the practitioner and patient are located. If telemedicine is utilized, review the process for validation of licensure and validate that it is being enforced. *** Certification through the state licensing board website(s), with appropriate documentation and NPDB query and FSMB or FACIS query** *** Correspondence or documented phone call with licensing boards**	HP/MBHO/CVO: The application requires a statement from the applicant regarding a history of loss of license. Primary source verification is required from the state licensing board. If a website is used for verification, then that website must be from the appropriate state licensing body. The license verification confirms that the practitioner possesses a valid current license or certification that is in effect and present in the file when the credentialing committee makes its decision. The organization verifies that the practitioner's license is in those states where the practitioner provides care for the organization's members. Verification time limit: • HP/MBHO: 180 days • CVO: 120 days *** Licensing board verification through the state licensing board website, with appropriate documentation** **Correspondence or documented phone call with licensing board**

CURRENT LICENSURE

COMMENTS/TIPS:

A best practice is documentation of verification of the status of all current state licensures and those no longer held, as well as whether any actions have been taken against the practitioner.

Verification sources include the state licensing boards (primary source), the FSMB (designated equivalent source), the AMA Physician Masterfile, and the AOA Physician Database.

Subscribing to the NPDB Continuous Query provides more timely information to the organization. The organization is notified by NPDB within 24 hours of the NPDB's receipt of all licensure actions, Medicare/Medicaid exclusions, medical malpractice payments, clinical privilege actions, and other adjudicated actions or findings concluded against a practitioner.

SANCTIONS AGAINST LICENSURE				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
CMS is silent regarding evaluation of licensure sanctions. However, the Interpretive Guidelines do reference privileging criteria that consider the individual's character, as well as compliance with medical staff bylaws, rules and regulations. Therefore, if verification of license sanctions is part of the medical staff rules, it must be done. *** Licensing board verification through website, with appropriate documentation** **Correspondence or documented phone call with the licensing board** **Correspondence with or form from the FSMB** **NPDB confirmation** **Application statement**	Before recommending privileges, the following is evaluated: • Information regarding challenges to any licensure or registration • Voluntary and involuntary relinquishment of any licensure or registration The standards are silent regarding the specific method of meeting this requirement. One way would be to request that the applicant provide the required information. This information also may be obtained or confirmed through the licensing boards, the FSMB, and/or the NPDB. *** Licensing board verification through website, with appropriate documentation** **Correspondence or documented phone call with the licensing board** **Correspondence with or form from the FSMB** **NPDB confirmation** **Application statement**	The requirements are silent regarding evaluation of licensure sanctions. There is a requirement to obtain database profiles from NPDB, OIG, and Medicare/Medicaid Exclusions. There is also a requirement within the governing body section to establish and apply criteria for medical staff appointment that considers the individual's character. *** Licensing board verification through website, with appropriate documentation** **Correspondence or documented phone call with the licensing board** **Correspondence with or form from the FSMB** **NPDB confirmation** **Application statement**	Requirements state that information regarding licensure sanctions must be sought for all current license(s), state(s) of current practice or intended practice, and all previous licenses held. Specifically: • NPDB is to be queried • Information is to be sought regarding previously successful/currently pending challenges to any license, and/or voluntary or involuntary relinquishment of licensure • Information is to be obtained from either the FSMB Disciplinary Action Databank or the Fraud and Abuse Control Information Systems (FACIS) *** Licensing body verification through website with appropriate documentation along with NPDB and FSMB or FACIS query**	HP/MBHO/CVO: Information on sanctions, restrictions on licensure, and limitations on scope of practice for the past five-year period must be obtained. If the individual was licensed in multiple states during the most recent five years, all states where the practitioner worked must be queried. For physicians, information must be obtained from one of the following: • State licensing board (or appropriate state agency) • FSMB • NPDB* For oral surgeons, information must be obtained from one of the following: • State licensing board • NPDB* For podiatrists, information must be obtained from one of the following: • State licensing board • Federation of Podiatric Medical Boards • NPDB* For chiropractors, information must be obtained from one of the following: • State licensing board • Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD) • NPDB* › *Continued on next page*

SANCTIONS AGAINST LICENSURE				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				For nonphysician healthcare practitioners, information must be obtained from the following: • State licensing or certification board • Appropriate state agency • NPDB* *NCQA accepts use of the NPDB Continuous Query. Verification time limit: • HP/MBHO: 180 days • CVO: 120 days *Note: If an organization uses a sanctions alert service, they must review the information provided with 30 days of receipt of the alert. Documentation of the entity's subscription is available for review during the time of the review.* * **Licensing board verification through website, with appropriate documentation** **Correspondence or documented phone call with the licensing board** **Correspondence with or form from the FSMB** **NPDB confirmation**

COMMENTS/TIPS:

The AMA Physician Profile and the AOA Physician Database contain information on multiple state licensures. If a sanction is present, the requester is referred back to the state licensing authority for additional information.

Subscribing to the NPDB Continuous Query provides more timely information to the organization. The organization is notified by NPDB within 24 hours of the NPDB's receipt of all licensure actions, as well as Medicare/Medicaid exclusions, medical malpractice payments, clinical privilege actions, and other adjudicated actions or findings concluded against a practitioner.

PROFESSIONAL LIABILITY/MALPRACTICE COVERAGE				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Primary source verification is not required. The requirement for professional liability coverage is common in healthcare organizations. Medical staff bylaws and rules and regulations routinely state the requirements of the organization. Therefore, verification of coverage ensures compliance. Verification of the coverage may come directly from the carrier or in the form of a copy of the applicant's professional liability certificate of insurance that shows the dates of coverage and amounts of coverage. *** Correspondence with the carrier showing endorsements, if available and as applicable** **Documented phone call with the carrier identifying endorsements, if available and as applicable** **Copy of the applicant's current professional liability certificate of insurance with endorsements noted (if applicable)**	Primary source verification is not required. However, if the medical staff bylaws, policies, or rules and regulations require professional liability coverage, The Joint Commission expects the organization to have a method of verifying such coverage. Verification of coverage may come directly from the carrier or in the form of a copy of the applicant's current professional liability certificate of insurance that shows dates of coverage and amount of coverage. *** Correspondence with the carrier showing endorsements, if available and as applicable** **Documented phone call with the carrier identifying endorsements, if available and as applicable** **Copy of the applicant's current professional liability certificate of insurance with endorsements noted (if applicable)**	Verification is not specifically required. However, the requirements do state that the medical staff bylaws provide a mechanism for consideration of an automatic suspension of clinical privileges if the practitioner fails to maintain the required amount of professional liability insurance. The requirement for professional liability coverage is common in healthcare organizations, which implies that verification of coverage should be done. Verification of coverage may come directly from the carrier or in the form of a copy of the applicant's certificate of insurance that shows the dates and amounts of coverage. *** Correspondence with the carrier showing endorsements, if available and as applicable** **Documented phone call with the carrier identifying endorsements, if available and as applicable** **Copy of the applicant's current professional liability certificate of insurance with endorsements noted (if applicable)**	Requires evidence of professional liability insurance, including current certificates showing coverage amounts (and dates of coverage). *** Correspondence with the carrier showing endorsements, if available and as applicable** **Documented phone call with the carrier identifying endorsements, if available and as applicable** **Copy of the applicant's current professional liability certificate of insurance with endorsements noted (if applicable)**	HP/MBHO/CVO: The applicant attests on the application (or addendum) to the dates and amount of professional liability insurance (even if the applicant is not covered for professional liability) or the entity may obtain evidence of coverage through a copy of the applicant's current professional liability certificate of insurance (insurance face sheet) that shows dates and amount of coverage. The copy may be obtained from either the carrier or the practitioner. Verification time limit: HP/MBHO: The credentials information must be valid, current, and no more than 365 calendar days old at the time of the credentialing committee's decision. CVO: The credentials elements must be valid, current, and verified (as applicable) within 305 calendar days prior to submission to each client.* *CVOs must complete their verification within the 120-day time frame so that the file may be released to the client in sufficient time for the client to meet the 180-day time frame (even if they have a current certificate on file) *Note: Language regarding MA Deemed status was removed from the standards.* *** Correspondence with the carrier showing endorsements, if available and as applicable** **Documented phone call with the carrier identifying endorsements, if available and as applicable** › *Continued on next page*

PROFESSIONAL LIABILITY/MALPRACTICE COVERAGE				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				Copy of the applicant's current professional liability certificate of insurance with endorsements noted (if applicable) **Applicant's attestation**

COMMENTS/TIPS:

If the organization requests that the applicant name the organization as a "certificate holder," then the professional liability carrier will automatically provide the named organization with renewal certificates, thus relieving the burden on the applicant. The carrier will also notify the organization if the policy is changed or canceled by either party.

Organizations should also seek information on inclusions, exclusions, and/or limitations to professional liability coverage—whether requested by the practitioner or imposed upon the practitioner. Carriers sometimes call this information an "endorsement" or "waiver," among other terms. An example of an inclusion in coverage would be bariatric surgery for a general surgeon. An example of an exclusion would be no coverage for spinal surgery for an orthopedic surgeon. An example of a limitation in coverage would be suture of lacerations except facial/cosmetic for emergency medicine physicians.

Research has revealed that the professional liability carriers vary widely in how this information is disclosed. Some carriers place the information clearly on the policy binder. Some carriers have a provision for this information to be disclosed on the policy binder but indicate via a code number—thus requiring additional investigation. Some endorsements or waivers are displayed in very simple language; conversely, some carriers explain the endorsement/waiver in great detail, covering 3–5 pages or more.

Because inclusions, exclusions, and limitations to professional liability coverage constitute important information, it is suggested organizations evaluate the feasibility of obtaining this information—either from the carrier or the practitioner or both. If the information is available, accessible, and understandable, the organization may want to expand its current verification processes. If the information is not easily obtainable or very complex (e.g., three pages of text) organizations may not wish to pursue this option.

MALPRACTICE HISTORY				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The CMS standards are silent regarding evaluation of malpractice history. However, CMS does require organizations be compliant with state and federal law, as well as medical staff bylaws, rules, and regulations. Thus, if malpractice insurance history is part of the medical staff rules, this must then be verified. Query of the NPDB is a federal requirement of all organizations granting privileges to a practitioner. The NPDB contains information regarding malpractice settlements and judgments. * **Application statement, NPDB confirmation, and correspondence with the carrier*** **Application statement and NPDB confirmation**	The organized medical staff evaluates any evidence of an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the applicant. The standards are silent regarding the specific method by which to accomplish this requirement. One way would be to request that the applicant provide information regarding involvement in professional liability action (as required by the medical staff bylaws, rules and regulations, or policies). At minimum, the applicant would be required to report final judgments or settlements. This information also may be obtained or confirmed through a query to the professional liability carrier and/or the NPDB. * **Application statement and correspondence with the carrier*** **Application statement and NPDB confirmation**	The bylaws must describe the qualifications to be met by a candidate. Among the qualifications is review of the applicant's involvement in any professional liability action. The requirement does not differentiate between final actions versus open claims. * **Application statement and correspondence with the carrier encompassing any actions—both final actions as well as open claims and NPDB query**	Requires evidence of malpractice litigation history from the professional liability carrier and a NPDB query regarding settlements or judgment within the past five years. * **Application statement and correspondence with the carrier encompassing any actions—both final actions as well as open claims**	HP/MBHO/CVO: The applicant must provide at least a five-year history of malpractice settlements on behalf of the practitioner. This information must be verified either through written confirmation from the malpractice carrier or through the NPDB.** ***NCQA accepts use of the Continuous Query service.* If the five-year history includes residency or fellowship, the organization does not need to obtain confirmation for those covered through the hospital insurance policy. Verification time limit: • HP/MBHO: 180 days • CVO: 120 days * **Application statement and confirmation of the information provided by the applicant from the carrier*** **Application statement and NPDB confirmation**

COMMENTS/TIPS:

*A best practice would be to query the carrier regarding not only final judgments or settlements but also on open claims.

Subscribing to the NPDB Continuous Query provides more timely information to the organization. The organization is notified by NPDB within 24 hours of the NPDB's receipt of all licensure actions, Medicare/Medicaid exclusions, medical malpractice payments, clinical privilege actions, and other adjudicated actions or findings concluded against a practitioner.

WORK HISTORY				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
CMS does not use the term "work history." However, the standards and guidelines do require examination of documented experience and supporting references of competence. A best practice would be to require that the applicant document a chronological history of education, training, and experience. * **Well-constructed application or complete curriculum vitae** * **Verification of information as applicable to requested privileges**	Although The Joint Commission does not use the term "work history," it does require evidence of current competence and expects organizations to obtain information regarding licensure (or registration), education, training, experience, and competence. The first step in the process would be to require that each applicant provide on the application a complete chronological history (mm/year–mm/year) of his or her education, training, and experience. * **Well-constructed application or complete curriculum vitae** * **Verification of information as applicable to requested privileges**	Although DNV GL does not use the term "work history," it does require evidence of current competence, experience, and judgment. A best practice would be to require the applicant to document a chronological history of education, training, and experience. * **Well-constructed application or complete curriculum vitae** * **Verification of information as applicable to requested privileges**	Standards require the applicant provide information regarding other facilities where the individual had healthcare-related employment/appointment/privileging history. This requirement includes verification of this information, including information regarding pending investigations of disciplinary actions, voluntary resignations, or relinquishments of membership, clinical privileges, and/or contracts. * **Well-constructed application or complete curriculum vitae along with verification of information from primary sources through completion of criteria-based questionnaires that provide an assessment or recommendation**	HP/MBHO/CVO: The applicant must provide a minimum of the most recent five-year relevant work history statement on either the application or curriculum vitae, which allows identification of gaps in work history. Relevant experience is defined as "work as a health professional." If the individual has practiced fewer than five years from the credentialing date, the work history begins at the time of initial licensing. Experience as a non-physician healthcare practitioner (e.g., registered nurse, nurse practitioner, clinical social worker, etc.) should be included if within the five-year period. Work history should include the beginning and ending month and year for each work experience. If the applicant has had continuous employment for five or more years (i.e., no gaps), designating the year is acceptable (e.g. 2008–2014). No verification of the work history is required. However, NCQA does require evidence of review of work history and identification of gaps. Documentation of this review is found in the applicant's credentials file. The reviewer's signature/initials are found on the application, curriculum vitae, checklist, or other appropriate location. (6th edition) Any work history gap of six months or more should be reviewed and clarified (verbally* or in writing). Further, the applicant is required to clarify in writing any gap that exceeds one year. *Verbal communication needs to be documented in the credentials file. › *Continued on next page*

WORK HISTORY				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				Verification time limit: HP/MBHO: The credentials information must be valid, current, and no more than 365 calendar days old at the time of the credentialing committee's decision.** CVO: The credentials elements must be valid, current, and verified (as applicable) within 305 calendar days prior to submission to each client.** **CVOs must complete their verification within the 120-day time frame so the file may be released to the client in sufficient time for the client to meet the 180-day time frame *Note: Deemed status language was removed from the standards.* * **Well-constructed application or complete curriculum vitae**

COMMENTS/TIPS:

1. Acute care organizations should establish a policy defining a "gap" (i.e., what is the minimum time period that does not require an explanation). In some organizations, this permitted "gap" is no more than 30 days. Other organizations may permit it to be as long as six months. Although NCQA has defined a gap from a standards perspective, health plans and acute care facilities may establish a stricter interpretation and policy.

2. Over the past two decades, there have been increasing numbers of physicians with contracts and/or employment status with healthcare organizations. These physicians may or may not have simultaneous membership/privileges. Examples are physicians who are exclusively office-based (perhaps a family practitioner, a pediatrician, or an internal medicine specialist) or a physician practicing in an urgent care center. Therefore, obtaining and evaluating "work status" has increasing importance.

CURRENT COMPETENCE				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The medical staff must have a mechanism to examine evidence of professional education, training, documented experience, and supporting references of competence. Criteria must be established for determining privileges and considers: • Individual character • Individual competence • Individual training • Individual experience • Individual judgment * **Primary sources/ peers complete criteria-based questionnaires that provide an assessment or recommendation. The peers (industry standard is generally three) may be identified by the applicant as well as targeted peers through a medical staff policy (e.g., previous department chairs, section chiefs, program directors, medical staff officers, etc.).** **Correspondence or documented phone call with primary sources/peers.**	Requires verification of each applicant's professional and clinical performance through contact with appropriate teaching facilities, hospitals, and/or other relevant organizations. Primary source documentation must contain informed opinions of the applicant's professional performance. (See "Peer recommendation" section.) The Joint Commission requires organizations to establish criteria that determine a practitioner's ability to provide patient care within the requested privileges. Included in the criteria are licensure/certification, relevant training, physical ability to perform requested privileges, peer recommendation, and data from professional practice review by an organization that currently privileges the applicant (if available). The Joint Commission suggests parameters for evaluation of proficiency may include the six areas of "General Competencies" adapted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative. *Note: The "General Competencies" are listed in the "Comments/Tips" section.* › *Continued on next page*	The medical staff section outlines qualifications to be met by the applicant that include current competence (primary source verified). The requirements also specify that, if available, individual performance data should be reviewed for variation from criteria determined by the medical staff. Identified variations are to be evaluated through a peer review process to determine validity. The governing body section also references the governing body's responsibility to establish and apply criteria for medical staff appointment that considers the individual's competence and judgment. * **Verification of competence from primary sources. Peers complete criteria-based questionnaires that provide an assessment or recommendation. The peers (at least two) may be identified by the applicant as well as targeted peers by a medical staff policy (e.g., previous department chairs, section chiefs, program directors, medical staff officers, etc.).** **Correspondence or documented phone call with primary sources/peers.**	Membership selection criteria include evaluation of current competence along with licensure, training/education, health status, experience, character, and judgment. The medical staff seeks information regarding the practitioner's clinical activity. The applicant provides documentation regarding clinical activity, either from his or her residency/ fellowship or from facilities where the applicant has been practicing. Applicant provides documentation of clinical activity and competency for consideration of requested privileges. Procedure logs should be obtained with outcomes to support requested privileges for a procedure not attested to by references from postgraduate program. * **Verification of current competence from primary sources. Peers complete criteria-based questionnaires that provide an assessment or recommendation. The peers (generally three... industry standard) may be identified by the applicant as well as targeted peers by a medical staff policy (e.g., previous department chairs, section chiefs, program directors, medical staff officers, etc.).** › *Continued on next page*	Terminology is not used.

CURRENT COMPETENCE				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
	* **Verification of competence to perform privileges requested from primary sources. Peers complete criteria-based questionnaires that provide an assessment or recommendation by someone who can attest to the applicant's professional performance. The peers (generally three…industry standard) may be identified by the applicant as well as targeted peers through a medical staff policy (e.g., previous department chairs, section chiefs, program directors, medical staff officers, etc.).** **Correspondence (i.e., evaluation form with specific areas of evaluation) or documented phone call with primary sources/peers.**		* **Procedure/patient logs as appropriate to clinical privileges requested** **Correspondence or documented phone call with primary sources/peers.**	

COMMENTS/TIPS:

The six General Competencies, adapted from the ACGME and the ABMS joint initiative, as stated in the 2014 CAMH, are as follows:

1. Patient care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
2. Medical/clinical knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences and to apply their knowledge to patient care and the education of others.
3. Practice-based learning and improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
4. Interpersonal and communication skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, their families, and other members of the healthcare teams.
5. Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity,* and a responsible attitude toward patients, their profession, and society.

   *Note: Diversity is defined as race, culture, gender, religion, ethnic background, sexual preference, language, mental capacity, and physical disability.
6. Systems-based practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided and the ability to apply this knowledge to improve and optimize healthcare.

When evaluating requests for privileges, procedure logs with outcomes are obtained to support requested privileges not encompassed in references from postgraduate experience.

As the time interval from completion of postgraduate training and the applicant's request for privileges increases, so does the importance of documenting the applicant's specific clinical activity relative to the privileges requested. This information is needed to evaluate the applicant's demonstrated current clinical competence.

MEDICARE/MEDICAID SANCTIONS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
CMS is silent regarding evaluation of Medicare/Medicaid sanctions. However, the Interpretive Guidelines do reference privileging criteria that considers the individual's character. In addition, all practitioners must follow medical staff bylaws, rules, and regulations. Therefore, if medical staff rules require review of sanctions, this must be done. *** The List of Excluded Individuals and Entities, maintained by the Office of Inspector General (OIG) (available via the Internet)** *** NPDB** *** FSMB**	Not specifically addressed in the Joint Commission standards. However, the Joint Commission standards specifically require query of the NPDB. Medicare/Medicaid sanctions information is available through that query. *Note: The Joint Commission requires hospitals to comply with laws and regulations (i.e., query of NPDB, OIG exclusions, etc.)* *** The List of Excluded Individuals and Entities, maintained by the Office of Inspector General (OIG) (available via the Internet)** *** NPDB** *** FSMB**	The standards require receipt of information on OIG Medicare/Medicaid Exclusions for initial appointment as well as prior to granting temporary privileges. It is also required that the medical staff bylaws provide a mechanism for immediate and automatic suspension of privileges in the event of termination or revocation of the practitioner's Medicare or Medicaid status. *** The List of Excluded Individuals and Entities, maintained by the Office of Inspector General (OIG) (available via the Internet)** *** NPDB**	The application requests information regarding disciplinary actions taken or investigations pending by Medicare/Medicaid. This information is also verified through an NPDB query and FSMB Disciplinary Action Databank or FACIS query. (Query of these agencies is also required in the licensure section of the standards.) *** Query of the NPDB and the FSMB or the FACIS** *** The List of Excluded Individuals and Entities, maintained by the Office of Inspector General (OIG) (available via the Internet)**	HP/MBHO/CVO: Review of information on Medicare and Medicaid sanctions for the most recent five years must be done by querying one of the following: • NPDB • FSMB • The List of Excluded Individuals and Entities, maintained by the Office of Inspector General (OIG) (available via the Internet) • The Medicare Exclusion Database • The Federal Employees Health Benefits Plan Program department record published by the Office of Personnel Management, OIG • The state Medicaid agency or intermediary and the Medicare intermediary Verification time limit: • HP/MBHO: 180 days • CVO: 120 days *** NPDB report or Continuous Query service** *** FSMB** *** The List of Excluded Individuals and Entities, maintained by the Office of Inspector General (OIG) (available via the Internet)** *** The Medicare Exclusion Database** › *Continued on next page*

MEDICARE/MEDICAID SANCTIONS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				The Federal Employees Health Benefits Plan Program department record published by the Office of Personnel Management, OIG **The state Medicaid agency or intermediary and the Medicare intermediary**

COMMENTS/TIPS:

The OIG requires that healthcare organizations check the OIG List of Excluded Individuals/Entities (LEIE) at *http://oig.hhs.gov/exclusions* before hiring, contracting, or privileging healthcare practitioners.

The General Services Administration (GSA) System for Award Management (SAM) is a comprehensive database that federal agencies can use to determine the eligibility of individuals or entities to participate in their programs. In July 2012, GSA migrated its Excluded Parties List System (EPLS) and other systems to the new SAM. SAM includes OIG's exclusions but also includes debarment actions taken by federal agencies. The LEIE lists only exclusion actions taken by OIG.

The LEIE is the primary source of information about OIG exclusions because the LEIE is maintained by OIG, is updated monthly, and provides more details about persons excluded by OIG than GSA's SAM, such as the statutory basis for the exclusion action, the person's occupation at the time of exclusion, the person's date of birth, and address information. Also, because the LEIE is maintained directly by OIG, OIG's exclusions staff can respond to questions and verify information regarding persons identified on LEIE. The effect of OIG exclusion is to preclude payment by federal healthcare programs for items or services furnished, ordered, or prescribed by the excluded party. OIG exclusion does not affect a person's ability to participate in other government procurement or non-procurement transactions. Moreover, OIG has no authority to impose civil money penalties (CMP) on the basis of employment of (or contracting with) a debarred person. Additional information regarding SAM and debarment is available at *www.sam.gov*.

Subscribing to the NPDB Continuous Query provides more timely information to the organization. The organization is notified within 24 hours of the NPDB's receipt of all licensure actions, Medicare/Medicaid exclusions, medical malpractice payments, clinical privilege actions, and other adjudicated actions or findings concluded against a practitioner.

ONGOING MONITORING OF SANCTIONS, COMPLAINTS, AND QUALITY ISSUES				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The CMS standards do not address this element. However, ongoing monitoring of sanctions is a best practice. * **Verification of sanction status is stated in each element (e.g., Medicare/Medicaid sanctions, licensure sanctions, etc.**)	This element is not specifically addressed in this manner in the Joint Commission standards. However, ongoing monitoring of sanctions is a best practice. *Note: The Joint Commission requires a summary of ongoing data collection (usually a part of the peer review or quality process) to be considered when assessing a practitioner's behavior and clinical competence. This information is considered at the time of reappointment and privileging.* * **Verification of methodology sanction status should be stated for each element (e.g., Medicare/Medicaid sanctions, licensure sanctions, etc.) in an organizational policy**	Although DNV GL does not specifically require ongoing monitoring of sanctions, it does require the medical staff bylaws provide a mechanism for immediate and automatic suspension of privileges in the event of termination or revocation of the practitioner's Medicare or Medicaid status as well as revocation or restriction of licensure or registration (DEA). * **Verification of sanction status is stated in each element (e.g., Medicare/Medicaid sanctions, licensure or registration [DEA] sanctions, etc.). DNV also requires review of performance to include national data (i.e., sanctions and complaints).**	The application must request information regarding disciplinary actions taken or investigations pending by hospitals/healthcare facilities, specialty boards, Medicare/Medicaid, DEA, or state CDS certificate and actions in NPDB. * **Verification of sanction status is stated in each element (e.g., Medicare/Medicaid sanctions, licensure sanctions or registration sanctions [DEA], etc.)**	HP/MBHO: There are policies and procedures for the ongoing monitoring of Medicare and Medicaid sanctions, and sanctions or limitations on licensure or limitations on scope of practice. Documentation is regularly obtained and reviewed. Sources for monitoring Medicare/Medicaid sanctions and sanctions or limitations on licensure are found in the individual verification element (i.e., "Medicare/Medicaid sanctions" or "Sanctions against licensure or registration"). NCQA accepts use of an "alert service" for ongoing monitoring as long as the information is from a NCQA–approved source. Monitoring efforts occur as information is published or released. The organization is responsible for reviewing the information within 30 days of publication. If information is not released on a routine schedule, then the organization must request the desired information at least every six months and document that the reporting entity does not routinely provide this information. If the reporting entity does not release sanction reports, the organization must query on affected practitioners 12-18 months after the last credentialing cycle. › *Continued on next page*

ONGOING MONITORING OF SANCTIONS, COMPLAINTS, AND QUALITY ISSUES				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				If an organization subscribes to a sanctions alert service, then the organization must show evidence of review of information within 30 days of a new release. The organization also routinely monitors (at least every six months) and evaluates the following: • Practitioner complaints from members* • Information from identified adverse events (i.e., patient injury)** *A mechanism is in place to investigate all practitioner-specific complaints from members as received. Evaluation includes the specific complaint along with the practitioner's history of issues. At least every six months, there is evidence of review of all practitioners' complaint histories. **Adverse events (an injury to a member) are also monitored on an ongoing basis. At a minimum, this information is reviewed every six months. The organization may choose to limit the ongoing monitoring of adverse events to primary care practitioners and high-volume behavioral health practitioners. The organization acts on important quality and safety issues as they are identified and as appropriate. › *Continued on next page*

ONGOING MONITORING OF SANCTIONS, COMPLAINTS, AND QUALITY ISSUES				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				The organization has and follows its policies and procedures when sanction information, complaints, and/or adverse events suggest poor quality that could affect the health and safety of its members. CVO: There are policies and procedures that define the types of disciplinary information to be reported along with the process for discovering and reporting the information. There are also policies and procedures for the ongoing monitoring of practitioner sanctions (Medicare and Medicaid sanctions, state sanctions, and licensure sanctions) and reporting obligations. The CVO regularly obtains and reviews documentation on sanctions and licensing limitations and discloses to relevant clients information about any and all disciplinary actions taken against its practitioners. Monitoring efforts occur as information is published or released. The organization is responsible for reviewing the information within 30 days of publication. If information is not released on a routine schedule, the organization must request the desired information at least every six months and document that the reporting entity does not routinely provide this information. › *Continued on next page*

ONGOING MONITORING OF SANCTIONS, COMPLAINTS, AND QUALITY ISSUES				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
				If the reporting entity does not release sanction reports, the organization must query on affected practitioners 12-18 months after the last credentialing cycle. If the CVO subscribes to an NCQA–approved alert service, the CVO must review the data within 30 days of a new alert. Upon discovery or notification,*** the CVO must notify appropriate client organizations of the following: • Loss or limitation of license • State sanctions, limitations, or restrictions in scope of practice of practitioner as defined by the state licensing agent • Medicare or Medicaid sanctions ***Exception: If a CVO does not provide this service, this requirement is not applicable. However, the CVO will not be eligible to seek certification for this element. * **Verification of sanction status as stated in each element (e.g., Medicare/Medicaid sanctions, licensure sanctions, etc.)** * **Methodologies collect and review information regarding practitioner complaints and adverse events** * **Internal policies and procedures should define the sources and the methodology of documenting, reviewing, and taking action**

FEDERAL DRUG ENFORCEMENT AGENCY (DEA) CERTIFICATE OR STATE CONTROLLED DANGEROUS SUBSTANCES (CDS) CERTIFICATE				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The CMS regulations do not address this element. However, verification of DEA and state CDS certificates would be appropriate. Verification sources could be as follows: • Applicant response to questions regarding any challenges to registration (state, district, or federal) and whether there had ever been a voluntary or involuntary relinquishment of such registration • Viewing a copy of current DEA/CDS certificates or contact with the issuing body or verification agency with equivalent information, such as the NPDB, National Technical Information Service, AMA Physician Profile, or AOIA Official Osteopathic Physician Profile Report * **Verification from primary source or designated equivalent** **Copy of certificates**	The organized medical staff evaluates any challenges to any registration, as well as the voluntary and involuntary relinquishment of any registration. The standards are silent regarding the specific methodology to use in complying with this requirement. One source for this information may be through the applicant response to questions regarding any challenges to registration (state, district, or federal) or the voluntary and involuntary relinquishment of such registration. This information also may be obtained or verified through viewing a copy of current DEA and CDS certificates or through contact with the issuing body or a recognized verification agency with equivalent information, such as the NPDB, National Technical Information Service (NTIS), AMA Physician Profile, or AOIA Official Osteopathic Physician Profile Report. * **Verification from primary source or designated equivalent** **Copy of certificates** **DEA Diversion website**	The medical staff section outlines qualifications to be met by the applicant to include a current Federal Narcotics Registration Certificate (DEA) number, if required. The requirements do not specify how this registration is to be verified. Verification sources could be as follows: • Applicant response to questions regarding any challenges to registration (state, district, or federal) and if there had ever been a voluntary or involuntary relinquishment of such registration • Viewing a copy of current DEA/CDS certificates or contact with the issuing body or verification agency with equivalent information, such as the National Practitioner Data Bank, National Technical Information Service, American Medical Association Masterfile, or American Osteopathic Information Association Official Osteopathic Physician Profile Report * **Verification from primary source or designated equivalent** **Copy of certificates**	The application requests information regarding actions against the federal DEA certificate or state CDS certificate. DEA sanctions are reported through query of the NPDB (also a required verification). * **NPDB** **AND** * **Verification from primary source**	HP/MBHO/CVO: The organization verifies a DEA or CDS certificate in each state where the practitioner is authorized to prescribe medications and provides care to its members. Verification must be obtained through one of the following: • The applicant provides a copy or copies of current DEA or CDS certificate(s) • The original certificate(s) are visualized with appropriate documentation • Confirmation through DEA or CDS agency • Confirmation through the National Technical Information Service (NTIS) database • AMA Physician Profile (DEA only) • Confirmation through the state pharmaceutical licensing agency, where applicable • AOA Official Osteopathic Physician Profile Report (also known as AOA Physician Masterfile) DEA and CDS certificates are not applicable to chiropractors, and CDS certificates are not applicable to oral surgeons. The DEA or CDS certificate must be current at the time of action by the credentialing committee or transmittal by the CVO. *Note: The organization may credential a practitioner with a pending DEA certificate if the organization has a documented policy for permitting a practitioner to work without a DEA license. A practitioner with a valid DEA may write prescriptions on behalf of the applicant within the guidelines of the policy, until the applicant obtains his or her DEA.* * **Verification from primary source or designated equivalent** **Copy of certificates**

PHYSICAL ABILITY TO PERFORM CLINICAL PRIVILEGES REQUESTED/ESSENTIAL FUNCTIONS OF POSITION				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The current version of the Medical Staff section of the *CoP*s does not include this language. In versions prior to October 2008, the Composition of the Medical Staff section did reference "health status" as a qualification that needed to be evaluated at appointment. This requirement has been removed. However, in a separate section of the *CoP*s, "Surgical Services," the survey procedures still require a written assessment of "health status" as one parameter of evaluation. Evaluation of every applicant's ability to perform the privileges requested is a best practice. *** Documented confirmation of the applicant's statement**	The organized medical staff evaluates documentation regarding the applicant's physical ability to perform the requested privilege. The applicant is asked to provide information regarding any health problems that might affect his or her exercise of clinical privileges. An evaluation of the applicant's ability to practice the requested privileges is achieved through confirmation by the director of a post-graduate training program, by a chief of service at another hospital at which the applicant holds privileges, or by a currently licensed physician approved by the organized medical staff's process. In instances of doubt regarding the applicant's ability to perform the requested privileges, an evaluation by an external/internal source may be required. Such a request would come from the organized medical staff. *** Documented confirmation of the applicant's statement**	The medical staff section is silent on evaluation of the physical ability to perform the privileges requested (health status). However, in the Surgical Services section, there is a comment in the Surveyor Guidance section that indicates that the health status of the practitioner with surgical privileges needs to be verified. In addition, the surgical services section states that privileges will be granted according to medical staff policy. Therefore, if medical staff policy requires an evaluation of a practitioner's health status, then this needs to be done. *** Documented confirmation of the applicant's statement**	Membership selection criteria include evaluation of health status. Standards also require that the verification process include evaluation by at least one professional reference (peer with the same professional credential as the applicant*) that includes a statement regarding the applicant's physical and mental health in relation to privileges requested. **Note: If someone with the same professional credential is not available, then a person from the same practice area may be used, who can speak to the applicant's (or reapplicant's) professional competence and ethical standards. A statement pertaining to the physician's physical and mental health must be included and related to privileges requested.* *** Documented confirmation of the applicant's statement**	HP/MBHO/CVO: At a minimum, the applicant must provide a current, signed attestation statement regarding the reasons for any inability to perform the essential functions of his or her position and attesting to the lack of present illegal drug use. NCQA standards provide guidance that queries regarding illegal drug use and ability to perform essential functions may extend beyond the NCQA- required minimum, depending on the organization's interpretation of applicable legal requirements (e.g., Americans with Disabilities Act). Verification time limit: HP/MBHO: The credentials information must be valid, current, and no more than 365 calendar days old at the time of the credentialing committee's decision. CVO: The credentials elements must be valid, current, and verified (as applicable) within 305 calendar days prior to submission to each client. *** Documented confirmation of the applicant's statement** **Signed application statement**

PHYSICAL ABILITY TO PERFORM CLINICAL PRIVILEGES REQUESTED/ESSENTIAL FUNCTIONS OF POSITION

COMMENTS/TIPS:

Application: Assessing the applicant's physical ability to perform the privileges requested or the essential functions of the position starts with the application. The following is an acceptable question that applicants may be required to answer: "Do you have a physical, mental, or emotional condition or substance abuse problem that could affect your ability to exercise the clinical privileges requested or that would require a reasonable accommodation for you to exercise those privileges safely and competently?"

Assessment: At a minimum, a good practice would be to include reference to the applicant's answer to the question above regarding the applicant's ability to perform the requested privileges. A best practice would be to require all initial applicants for privileges to undergo a meaningful physical with appropriate laboratory testing (including chemical and substance abuse testing) and recommended applicable immunizations. However, this lofty goal is not a common practice across the United States. Various federal and state laws address immunizations, TB testing, drug testing, physicals, etc. A variety of medical staff and facility policies also individually address health assessment of practitioners.

Human resource requirements for employed practitioners generally exceed what is required of non-employed practitioners through medical staff requirements. Organizations should evaluate current human resource and medical staff policies and resolve any existing or potential conflicts.

Many facilities include physical and cognitive assessments for continued practice of providers after reaching a defined age, within compliance with the ADA.

MEDICAL STAFF MEMBERSHIP				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
CMS does not specifically require evaluation of an individual's previous membership and/or clinical privileges on a medical staff. Asking the applicant to report past and current information related to membership/privileges on any medical staff and subsequently verifying this information is a best practice. * **Previous* healthcare organization(s) completes criteria-based questionnaire that provides an assessment or recommendation** * **NPDB query and response** **Correspondence or documented phone call with previous* healthcare organization(s)** **Application statement** **** See comment 3***	The organized medical staff evaluates information regarding the applicant's history of voluntary or involuntary termination of medical staff membership and the voluntary or involuntary limitation, reduction, or loss of clinical privileges. Although the standards are silent on how organizations can comply with this requirement, one method would be to query the applicant (i.e., the application would request information regarding the voluntary or involuntary termination of medical staff membership, and the voluntary or involuntary limitation, reduction, or loss of clinical privileges). Because membership/clinical privileges are not limited to hospitals (acute care environment), the query should be broad enough to encompass other types of healthcare facilities, such as birthing centers, ambulatory surgery centers, urgent care centers, primary care sites, etc. This information could also be obtained/confirmed through querying facilities where the applicant holds or has held membership/privileges. This query, if adequately worded, also could serve as a verification of the applicant's current competence if completed by a peer who is knowledgeable about the practitioner's professional performance. › *Continued on next page*	DNV GL does not specifically require evaluation of an individual's previous membership/clinical privileges on a medical staff. Asking the applicant to report past and current information related to membership/privileges on any medical staff and subsequently verifying this information is a best practice. * **Previous* healthcare organization(s) completes criteria-based questionnaire that provides an assessment or recommendation** * **NPDB query and response** **Correspondence or documented phone call with previous* healthcare organization(s)** **Application statement** **** See comment 3***	Standards require the applicant to provide information regarding other facilities where the individual had healthcare-related employment/appointment or clinical privilege history. This requirement includes verification of this information, including information regarding pending investigations of disciplinary actions, voluntary resignations, or relinquishments of membership, clinical privileges, and/or contracts. * **Well-constructed application or complete curriculum vitae along with verification of information from primary sources through completion of criteria-based questionnaires that provide an assessment or recommendation** * **NPDB query and response**	HP/MBHO/CVO: The application includes a current, signed, and dated attestation statement from the applicant regarding his or her history (since initial licensure) of all past and present circumstances regarding limitation or loss of clinical privileges or other disciplinary activity at all facilities where the individual has held or holds privileges. NCQA does not require practitioners to have medical staff membership or clinical privileges at an acute care organization. Verification time limit: HP/MBHO: The credentials information must be valid, current, and no more than 365 calendar days old at the time of the credentialing committee's decision.* CVO: The credentials elements must be valid, current, and verified (as applicable) within 305 calendar days prior to submission to each client.* *CVOs must complete their verification within the 120-day time frame so the file may be released to the client in sufficient time for the client to meet the 180-day time frame. *Note: Deemed status language has been removed from the standards.* * **Correspondence with previous healthcare organization(s) or organization completes criteria-based questionnaire that provides an assessment or recommendation** **Documented phone call with previous healthcare organization(s)** › *Continued on next page*

MEDICAL STAFF MEMBERSHIP				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
	*** Previous* healthcare organization(s) completes criteria-based questionnaire that provides an assessment or recommendation** **Correspondence or documented phone call with previous* healthcare organization(s)** **Application statement** **** See comment 3***			**Signed application statement**

COMMENTS/TIPS:

1. The credentialing industry makes a distinction between medical staff membership and clinical privileges. Legal opinions and the regulators and accreditors' standards support this distinction. Medical staff membership defines the individual's relationship (rights, roles, and responsibilities) within the medical staff. Clinical privileges define the individual's clinical role within the organization.
2. An increasing number of practitioners have employment or contractual relationships with healthcare facilities. A common provision within these agreements is that if employment and/or the contract cease, the practitioner will automatically withdraw or resign membership and/or privileges. Given this nuance, it is also recommended that applications and reference questionnaires include language querying and verifying these relationships (i.e., employment verifications).
3. In the past few decades, a standard best practice has been to contact all previous healthcare organizations where the practitioner had membership/privileges. The increasing number of employed/contracted practitioner positions has created opportunities for practitioners to change practice locations more easily. Further, technological advances such as telemetry have changed the way medicine has been traditionally delivered (e.g., telemedicine). Thus, some practitioners may have provided care in 20, 30, 40, or even potentially hundreds of healthcare organizations without ever having a physical presence in the facility. (This issue is discussed in depth in the Appendix, "Verification of Medical Staff Membership and/or Privileges.") It is therefore recommended that individual medical staffs evaluate the issue of verification of affiliation/competence at multiple organizations. Medical staff leaders and MSPs should create a policy addressing the verification necessary. For example, in the instance of a teleradiologist who is employed by a telemedicine service and has privileges at 25–50 healthcare entities, the credentialing verification policy might outline the following: "Verification of a teleradiologist's affiliation history and current competence will be done by (1) asking the applicant to identify 3–5 facilities that he or she is currently providing significant interpretation services (2) verifying the current competence* of the applicant with these facilities (3) requesting the telemedicine services to verify the applicant's affiliation history with the remaining facilities and provide an overall assessment of competence* of the applicant.

*Utilizing a criteria-based questionnaire that provides an assessment and recommendation by a peer.

CLINICAL PRIVILEGES HISTORY				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
CMS does not specifically require evaluation of an individual's previous membership/clinical privileges on a medical staff. Asking the applicant to report information related to past and current membership/privileges on any medical staff and subsequently verifying this information is a best practice. *** Previous* healthcare organization(s) completes criteria-based questionnaire that provides an assessment or recommendation** *** NPDB query and response** **Correspondence or documented phone call with previous* healthcare organization(s)** **Application statement** **** See comment 3 under medical staff membership section.***	The organized medical staff evaluates information regarding the applicant's history of voluntary or involuntary termination of medical staff membership and the voluntary or involuntary limitation, reduction, or loss of clinical privileges. Although the standards are silent on how organizations can comply with this requirement, one method would be to query the applicant (i.e., the application would request information regarding the voluntary/involuntary termination of medical staff membership and the voluntary/involuntary limitation, reduction, or loss of clinical privileges). Because membership/clinical privileges are not limited to hospitals (acute care environment), the query should be broad enough to encompass other types of healthcare facilities, such as birthing centers, ambulatory surgery centers, urgent care facilities, primary care sites, etc. This information also could be obtained or confirmed through querying facilities where the applicant holds or has held membership/privileges. This query, if adequately worded, also could serve as a verification of the applicant's current competence if completed by a peer knowledgeable about the practitioner's professional performance. *** Previous* healthcare organization(s) completes criteria-based questionnaire that provides an assessment or recommendation** **Correspondence or documented phone call with previous* healthcare organization(s)** **Application statement** **** See comment 3 under medical staff membership section.***	DNV GL does not specifically require evaluation of an individual's previous membership/clinical privileges on a medical staff. Asking the applicant to report information related to past and current membership/privileges on any medical staff and subsequently verifying this information is a best practice. *** Previous* healthcare organization(s) completes criteria-based questionnaire that provides an assessment or recommendation** *** NPDB query and response** **Correspondence or documented phone call with previous* healthcare organization(s)** **Application statement** **** See comment 3 under medical staff membership section.***	Standards require the applicant provide information regarding other facilities where the individual had healthcare-related employment/appointment or clinical privilege history. This requirement includes verification of this information, including information regarding pending investigations of disciplinary actions, voluntary resignations, or relinquishments of membership, clinical privileges, and/or contracts. *** Well-constructed application or complete curriculum vitae along with verification of information from primary sources through completion of criteria-based questionnaires that provide an assessment or recommendation** *** NPDB query and response**	HP/MBHO/CVO: The application includes a current signed and dated attestation statement from the applicant regarding his or her history (since initial licensure) of limitation or loss of clinical privileges or other disciplinary activity at all facilities where the individual has held or holds privileges. NCQA does not require practitioners to have medical staff membership or clinical privileges at an acute care organization. Verification time limit: HP/MBHO: The credentials information must be valid, current, and no more than 365 calendar days old at the time of the credentialing committee's decision. CVO: The credentials elements must be valid, current, and verified (as applicable) within 305 calendar days prior to submission to each client. *Note: Deemed status language has been removed from the standards.* *** Correspondence with previous healthcare organization(s)** *** NPDB query and response** **Documented phone call with previous healthcare organization(s)** **Signed application statement**

CLINICAL PRIVILEGING SYSTEM/INITIAL GRANTING OF CLINICAL PRIVILEGES				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The governing body ensures that the medical staff bylaws describe the privileging process. The process articulated in the bylaws or rules/regulations includes the criteria for determining privileges that may be granted to the individual practitioner and the procedure for applying the criteria to the individual practitioner. Specific criteria that must be considered are as follows: • Individual character • Individual competence • Individual training • Individual experience • Individual judgment Specific privileges (privileging system) must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. The medical staff has a system to ensure that there is a mechanism for practitioners to request expanded/additional privileges. This request is considered by the medical staff and board the same as initial requests for privileges. Privileges are not granted for tasks/procedures/activities that are not conducted within the hospital—regardless of the practitioner's ability to perform them. › *Continued on next page*	The organized medical staff is responsible for planning and implementing a privileging process. The hospital has a process to determine whether there is adequate information regarding clinical activity to determine whether privileges should be granted, limited, or denied. This process includes the following: • Developing and approving a procedures list • Processing the application • Evaluating applicant-specific information • Submitting recommendations to the governing body for applicant-specific delineated privileges • Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision • Monitoring the use of privileges and quality of care issues Decisions to grant or deny a privilege(s) are objective, evidence-based processes. Criteria are established and consistently evaluated that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. › *Continued on next page*	The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges. The Interpretive Guidelines in the Surgical Services section also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined. The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society. DNV GL also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted. The Medical Staff section is silent on how this latter regulation is accomplished. However, the Surgical Services section states that a current roster listing each practitioner's specific surgical privileges must be available in the surgical suite and area/location where the scheduling of surgical procedures is done. A current list of surgeons suspended from surgical privileges or whose surgical privileges have been restricted must also be retained in these areas/locations. * **Prescribed privilege delineation forms and associated criteria**	The medical staff bylaws define the process for granting privileges and will include all practitioner categories (not just physicians or medical staff members). The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges. The bylaws also define the mechanisms that the clinical departments, if applicable, or the medical staff as a whole, establish criteria for specific privilege delineation. It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges. Privileges must be granted within the capabilities of the facility. (Thus, privileges cannot be granted to a practitioner for tasks/activities/procedures the hospital cannot support—regardless of the practitioner's ability to perform them.) Specific to non-physician providers, HFAP requires the privileges, responsibilities, and duties be consistent with federal and state regulations (and limitations) for the discipline and do not exceed the scope allowed. Non-physician provider privileges and scope of practice may be in narrative or checklist format and must define and describe the scope of services of the discipline. Non-physician providers will be privileged through the medical staff process. › *Continued on next page*	NCQA standards do not require health plans to have a privileging system.

CLINICAL PRIVILEGING SYSTEM/INITIAL GRANTING OF CLINICAL PRIVILEGES				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task/activity/privilege that is specified for that practitioner (specialty) and can automatically be granted the full range of privileges. The individual practitioner's ability to perform each task/activity/privilege must be individually assessed. It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges, and a process to inform hospital departments of these privileges. A current roster listing each practitioner's specific surgical privileges must be available in the surgical suite and area/location where the scheduling of surgical procedures is done. A current list of surgeons suspended from surgical privileges or whose surgical privileges have been restricted must also be retained in these areas/locations, as the surgery department must know at all times who has surgical privileges. * **Prescribed privilege delineation forms and associated criteria**	At the time of initial application, the practitioner must request specific clinical privileges based upon his or her licensure/certification (as appropriate), education, relevant training, experience, current competence, and physical ability to perform the requested privileges. Each of these elements is individually and separately defined in this chapter. The Joint Commission also requires the surgical service maintain a listing (paper or electronic) of each practitioner's surgical privileges. Peer/faculty recommendations are obtained along with data from professional practice review by an organization(s) that currently privileges the applicant (if available). The organization then considers the request(s) in accordance with its predefined criteria and process and determines to what extent the practitioner's request for clinical privileges will be recommended/granted. The Joint Commission requires the organization to consider the resources necessary to support the requested privilege prior to granting the privilege. Resources are defined by The Joint Commission as sufficient space, equipment, staffing, and financial resources to support the requested privilege. The needed resources are to be currently available or available within a specified time frame. › *Continued on next page*		The privileging form(s) must identify those privileges requiring physician supervision—direct or indirect—to include co-signature requirements. Non-physician provider files must contain applicable laws, codes, or regulations that govern the scope of practice for the non-physician provider or the hospital may establish a central file (in human resources or medical staff office) for this purpose. Supervision of non-physician providers must be consistent with state law and stated in a policy (i.e., ratio of physician to non-physician providers). All non-physician providers authorized to provide care must have an annual competence/skill assessment. * **Prescribed privilege delineation forms and associated criteria**	

CLINICAL PRIVILEGING SYSTEM/INITIAL GRANTING OF CLINICAL PRIVILEGES				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
	Further, the organization consistently determines the resources needed for each requested privilege (i.e., not all procedures, treatments, and services can or should be performed or provided in all facilities/settings.) This requirement can be accomplished through a facility plan outlining the types of care that can be rendered in various healthcare settings (e.g., operating room, ambulatory surgery center, intensive care unit, hospital-owned physician office). This information also may be delineated in the privileging system and related to the individual practitioner. Privileges are initially granted for a time not to exceed two years. * **Prescribed privilege delineation forms and associated criteria**			
COMMENTS/TIPS: The credentialing industry makes a distinction between clinical privileges and medical staff membership. Legal opinions and regulators' and accreditors' standards support this distinction. Clinical privileges define the individual's clinical role within the facility. Medical staff membership defines the individual's relationship (roles, rights, and responsibilities) within the medical staff. These requirements pertain to the initial request for privileges and also to a practitioner who already has been granted privileges and is seeking additional privileges.				

NATIONAL PRACTITIONER DATA BANK (NPDB)				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Query of the NPDB is not addressed in the *CoP*s. However, CMS does require that organizations be compliant with state and federal law as well as the medical staff bylaws and rules and regulations. Federal law requires all organizations granting clinical privileges to query the NPDB. The Interpretive Guidelines do require that whenever a practitioner's privileges are limited, revoked, or in any way constrained, the hospital must, in accordance with state/federal laws or regulation, report these constraints to the appropriate state and federal authorities, registries, and/or databases, such as the NPDB. * **NPDB query and response**	Query of the NPDB is required for initial granting of privileges. Query also is required if a practitioner desires additional or expanded privileges. Thereafter, the organization is expected to query at the time of renewal of privileges. This requirement applies to all physicians, dentists, and other healthcare practitioners granted privileges through the medical staff process. * **NPDB query and response** **** Continuous Query with NPDB meets this requirement and is best practice.***	Query and receipt of the database profiles of the NPDB is required for initial appointment and in the granting of temporary privileges. * **NPDB query and response**	Requires query of the NPDB at initial application. NPDB is also identified as a source for malpractice litigation history, licensure sanction information, as well as disciplinary actions taken by healthcare facilities, specialty boards, and federal or state agencies. * **NPDB query and response**	HP/MBHO/CVO: NCQA does not require a separate query of the NPDB. However, query of the NPDB satisfies some NCQA verification requirements for physicians and dentists (i.e., sanctions or limitations on licensure, Medicare and Medicaid sanctions, and/or malpractice history). Use of the NPDB Continuous Query service is acceptable. A practitioner self-query may not be used to satisfy these elements. *Note: NCQA accepts documentation of query of the NPDB and receipt of response. The actual NPDB results do not have to be viewed by the NCQA surveyors.* * **NPDB query and response**

COMMENTS/TIPS:

The Health Care Quality Improvement Act of 1986 established the NPDB, requiring appropriate agencies to report information related to medical malpractice payments, licensure disciplinary actions, adverse clinical privilege actions taken by a healthcare entity (such as hospitals, health maintenance organizations, and group practices), and adverse actions affecting professional society membership of physicians and dentists. The Act allows for organizations to report adverse professional actions taken against healthcare practitioners other than physicians and dentists, such as psychologists, APRNs, PAs, etc.

The Act also requires hospitals and certain other authorized healthcare entities to query the NPDB at initial appointment, when granting clinical privileges, and at least every two years thereafter.

Subscribing to the NPDB Continuous Query provides more timely information to the organization. The organization is notified within 24 hours of the NPDB's receipt of all licensure actions, Medicare/Medicaid exclusions, medical malpractice payments, clinical privilege actions, and other adjudicated actions or findings concluded against a practitioner.

HISTORY OF FELONY CONVICTIONS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
CMS does not mention evaluation or verification of history of felony convictions. *Note: Some states do require a criminal background check for members of medical staffs or individuals privileged through the medical staff. (CMS requires organizations to comply with all applicable state and federal regulations and requirements—i.e., licensure requirements, law, rules, and regulations.)* *Organizations are voluntarily exercising this credentialing option, even if their states do not require them to do so. The majority of medical staffs now routinely include this verification as part of their credentialing processes. An even higher percentage is found in organizations that are required by the state to conduct criminal background checks on employees.* *CMS requires compliance with medical staff bylaws, rules, and regulations. Therefore, if the medical staff requires a criminal background check, it must be done.* *** Verification through appropriate law enforcement agencies and the criminal justice system** *** Verification through state, federal, or private agencies that collect and report criminal activity information** **Application statement**	The medical staff standards are silent regarding verification of an applicant's history of felony convictions. However, The Joint Commission human resource standards do require information to be obtained on the individual's criminal background as required by law, regulation, or hospital policy. Therefore, if the applicant is to be an employee of the organization, the organization must conduct criminal background checks as required or as defined by hospital policy. *Note: Some states do require a criminal background check for members of medical staffs or individuals privileged through the medical staff. (The Joint Commission requires organizations to comply with all applicable state and federal regulations and requirements—i.e., licensure requirements, law, rules, and regulations.)* *Organizations are voluntarily exercising this credentialing option, even if their states do not require them to do so. The majority of medical staffs now routinely include this verification as part of their credentialing processes. An even higher percentage is found in organizations that are required by the state to conduct criminal background checks on employees.* *** Verification through appropriate law enforcement agencies and the criminal justice system** *** Verification through state, federal, or private agencies that collect and report criminal activity information** **Application statement**	DNV GL does not mention evaluation or verification of history of felony convictions. *Note: Some states do require a criminal background check for members of medical staffs or individuals privileged through the medical staff. (DNV GL requires organizations to comply with all applicable state and federal regulations and requirements—i.e., licensure requirements, law, rules, and regulations.)* *Organizations are voluntarily exercising this credentialing option, even if their states do not require it. The majority of medical staffs now routinely include this verification as part of their credentialing processes. An even higher percentage is found in organizations that are required by the state to conduct criminal background checks on employees.* *** Verification through state, federal, or private agencies that collect and report criminal activity information** **Application statement**	Requires review of information for each applicant related to criminal history (i.e., felony convictions/ criminal history) for past 7–10 years. The application requests information regarding any criminal history. This information is verified as required by federal or state regulations and/or based upon information provided in the application. *** Verification through appropriate law enforcement agencies and the criminal justice system** *** Verification of the applicant's statement through appropriate law enforcement agencies and the criminal justice system** *** Verification of the applicant's statement through state, federal, or private agencies that collect and report criminal activity information**	HP/MBHO/CVO: The application requires a statement from the applicant regarding his or her history of felony convictions since initial licensure. Verification time limit: HP/MBHO: The credentials information must be valid, current, and no more than 365 calendar days old at the time of the credentialing committee's decision.* CVO: The credentials elements must be valid, current, and verified (as applicable) within 305 calendar days prior to submission to each client.* **Note: Some states do require a criminal background check for those who provide medical care. NCQA requires health plans to comply, as referenced above.* *Organizations are voluntarily exercising this credentialing option, even if their states do not require them to do so. The majority of medical staffs now routinely include this verification as part of their credentialing processes. An even higher percentage is found in organizations that are required by the state to conduct criminal background checks on employees.* *** Verification through appropriate law enforcement agencies and the criminal justice system** *** Verification through state, federal, or private agencies that collect and report criminal activity information** **Signed application statement**

HISTORY OF FELONY CONVICTIONS

COMMENTS/TIPS:

Criminal background checks are becoming more common employment practice in many businesses and industries and have become a standard verification practice in most medical staff initial credentialing methodologies.

Organizations should give serious consideration to including this step in their credentialing process.

IDENTITY				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Terminology not used.	The credentialing process includes a mechanism to ensure that the applicant is the same person as the one identified in the credentialing documents by viewing one of the following: • A current picture hospital ID card • A valid picture ID issued by a state or federal agency (e.g., a driver's license or passport) *Note: A process to accomplish this requirement would be an agent of the organization to view the document and the person. (Optional: A copy of the document.) The agent would attest to the process and identification by signing/initialing and dating the copied document or a document outlining the verification.*	Terminology not used.	Terminology not used.	Terminology not used.
COMMENTS/TIPS: The Joint Commission requirement is as stated above. However, the methodology outlined ensures only that the individual pictured is the one in the hospital ID, driver's license, or passport. This process does not ensure that the practitioner is the individual who completed the education, completed the postgraduate training, is the subject of the peer references, etc. Therefore, a best practice would be to affix or scan in a passport-style photograph of the applicant to professional reference questionnaires and request that the respondent confirm that the pictured applicant is the individual about whom the reference is written.				

ATTESTATION STATEMENT				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Terminology not used.	Terminology not used.	Terminology not used.	Bylaws include language regarding high ethical conduct and physician adheres to code of ethics as prescribed by their specific profession (e.g., AMA, AOA, ADA, or AMPA).	HP/MBHO/CVO: The applicant must provide a current, signed attestation statement regarding the correctness and completeness of his or her application. *Note: Faxed, digital, electronic, scanned and photocopied signatures are acceptable.* Verification time limit: HP/MBHO: The credentials information must be valid, current, and no more than 365 calendar days old at the time of the credentialing committee's decision. CVO: The credentials elements must be valid, current, and verified (as applicable) within 305 calendar days prior to submission to each client. * **Signed application statement**

AGREEMENTS/CONSENTS/RELEASES				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Terminology not used.	Terminology not used. *Note: Before January 2004, The Joint Commission required that the applicant do the following:* • *Agree to be bound by the medical staff bylaws* • *Consent to inspection of records and documents pertaining to licensing, specific training, experience, current competence, and ability to perform privileges requested* • *Agree to be interviewed (if requested)* • *Pledge to provide continuous patient care* • *Acknowledge bylaws provisions for release and immunity from civil liability* • *Agree to submit any reasonable evidence of current ability to perform requested privileges* *The current Medical Staff standards no longer specifically require these agreements/consents/releases.* *However, the previous standards' language established a good practice that carries forth as a best practice.* *In addition, current standards state medical staff leaders should strive to ensure that medical staff members understand the significance, content, purpose, and importance of the medical staff bylaws.* * **A well-constructed, comprehensive, legally binding document signed by the applicant**	Terminology not used.	Terminology not used.	Terminology not used.

AGREEMENTS/CONSENTS/RELEASES

COMMENTS/TIPS:

The industry standard for acute and managed care organizations is to have a well-constructed, comprehensive, legally binding document signed by the applicant. In this document, the applicant agrees to adhere to established policies and regulations of the organization, authorizes the organization to perform the credentialing and privileging verification processes, and releases the organization and respondents to verifications queries of civil liability if the processes are performed in good faith.

PEER RECOMMENDATION				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The medical staff must have a mechanism to examine supporting references of competence for initial applicants. The standards do not define the qualifications of the references. * **A peer completes a criteria-based questionnaire that provides an assessment or recommendation** * **Correspondence or documented phone call with a peer**	There must be peer recommendations for each applicant for initial granting of clinical privileges. A peer is defined as an individual in the same professional discipline with personal knowledge of the practitioner's clinical practice, ability to work as part of a team, and ethical behavior. The Joint Commission also considers documented peer evaluations of practitioner-specific data collected from various sources to evaluate current competence as acceptable evidence of compliance. The peer recommendation addresses (as appropriate) the following for each individual, at present: • Medical/clinical knowledge • Technical and clinical skills • Clinical judgment • Interpersonal skills • Communication skills • Professionalism Sources identified for peer recommendations are as follows: • An organization performance improvement committee, the majority of whose members are the applicant's peers • A reference letter(s), written documentation, or documented telephone conversation(s) about the applicant from a peer(s) who is knowledgeable about the applicant's professional performance and competence › *Continued on next page*	The medical staff section outlines qualifications to be met by the applicant that include two peer recommendations. The requirements do not define the qualifications of the peer. * **A peer completes a criteria-based questionnaire that provides an assessment or recommendation** * **Correspondence or documented phone call with a peer**	Standards require "professional references" as a source of information regarding current competence, peer recommendations/references, and ability to perform privileges requested (health status). At least one reference must be from a peer—defined as an individual with the same professional credential as the applicant. If no "peer" is available, then a practitioner in the same practice area who can address the applicant's professional competence and ethical standards may be used. This reference must also include a statement regarding the practitioner's physical and mental health related to the privileges requested. * **A peer completes a criteria-based questionnaire that provides an assessment or recommendation** * **Correspondence or documented phone call with a peer**	HP/MBHO: A credentialing committee (using a peer-review process) is designated to make recommendations regarding credentialing decisions. The credentialing committee has representation from a range of participating practitioners. The credentialing committee may be a multidisciplinary committee representing various types of practitioners/specialties or may designate separate review bodies for various disciplines (e.g., physicians, oral surgeons, psychologists). For further information on the approval process and the medical director's role, see section "Approval Process/Expedited Approval Process." CVO: Not applicable *Note: If the organization is part of a regional or national organization, their credentials committee may meet this criterion and serve as the peer review organization for a local organization.* * **Credentialing committee minutes that reflect thoughtful review and discussion** * **A peer completes a criteria-based questionnaire that provides an assessment or recommendation**

PEER RECOMMENDATION				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
	• A department or major clinical service chair who is a peer • The medical staff executive committee * **Peer completes a criteria-based questionnaire that provides an assessment or recommendation, which includes elements listed above** * **A written peer evaluation of practitioner-specific data collected from various sources to validate current competence, which includes elements listed above** **Documented phone call with a peer**			

COMMENTS/TIPS:

As organizations review and update their peer evaluation forms, it is suggested that criteria in the Joint Commission column, along with the six "General Competencies," also be evaluated for inclusion, as appropriate. See "Current Competence," earlier in this chapter.

SITE VISIT				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Terminology not used.	Terminology not used; concept is not addressed. *Note: Although site visits are not a component of the initial appointment process, the Joint Commission survey may encompass practitioner office sites and clinics that are owned by the hospital. Therefore, practitioners (LIPs, APRNs, and PAs) at these sites must be privileged to provide care, treatment, and services at these sites through the organized medical staff.* * **Evidence of privileging process as appropriate and applicable**	Terminology not used.	Terminology not used.	CVO: The NCQA CVO standards do not include requirements for site visits except as they relate to delegation agreements. *Note: Site visit language was removed from the NCQA standards in 2016.*

TEMPORARY PRIVILEGES/PROVISIONAL CREDENTIALING				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Terminology not used; concept is not addressed. *Note: CMS' interpretation is that there is no abbreviation for the privileging process. Thus, if a medical act is to be performed (by a practitioner), the CMS standards related to privileging apply. At a minimum, CMS would expect that the process and requirements for granting temporary privileges be outlined in the medical staff bylaws.* *CMS does not recognize a shortened process for privileging except for "emergency" situations, such as a national disaster.* *Temporary privileging or expedited privileging is not acceptable if the process is not in compliance with the CMS standards related to privileging. At a minimum, CMS will review medical staff bylaws related to granting temporary privileges and evaluate the organization's compliance with the interpretation outlined above.* * **Regardless of circumstances of application, evidence in the applicant's file of an individual who would meet all criteria for approval through a complete and fully verified application without identified issues/concerns** › *Continued on next page*	Temporary clinical privileges may be granted for a limited period of time for only two circumstances: • To fulfill an important patient care, treatment, or service need • When an applicant for new privileges* with a complete application who raises no concerns is awaiting a recommendation from the medical executive committee and approval by the governing body Under the first circumstance (fulfilling an important patient care, treatment, and/or service need), at a minimum, the organization must verify current licensure and current competence.** The temporary privileges for patient care need are time-limited as specified by the medical staff bylaws, policies/procedures, or regulations. ***Note: The Joint Commission standards do not require an NPDB query prior to granting temporary privileges for patient care need. However, the NPDB regulations interpret the granting of any form of privileges (to include temporary privileges or locum tenens privileges) as requiring NPDB query before granting these privileges.* Under the second circumstance (an applicant for new privileges* without identified concerns awaiting a recommendation from the MEC and approval of the governing body), there must be evidence of verification of the following: › *Continued on next page*	**Applicants:** Temporary privileges may be granted for no longer than 120 days for urgent patient care need or when a completed application without any negative or adverse information is awaiting action by the medical staff or governing body. The CEO (or designee) may grant temporary privileges upon the recommendation of a member of the medical executive committee, president of the medical staff, or medical director (defined by the medical staff) after evaluating the following: • Primary verification of education (AMA/AOA profile acceptable) • Evidence of current competence • Primary verification of state professional licenses • Receipt of professional references (including current competence) • Receipt of database profiles from the AMA or AOA (as applicable), NPDB, OIG Medicare/Medicaid Exclusions **Locum tenens:** The organization provides medical staff services through use of locum tenens or similar temporary medical services that may be used for no longer than six months. The medical staff defines in the bylaws the process for approval of practitioners providing such services along with the required credentialing and privileging processes. › *Continued on next page*	Temporary privileges can be granted under the following circumstances: • When a completed application is awaiting MEC and governing body approval • For care of a specific patient(s) • For locum tenens practitioners • In an emergency/disaster situation The CEO (or designee), upon recommendation of the chair of department/service, may grant time limited temporary privileges when it is determined prudent to do so. (State law must be followed.) Prior to granting temporary privileges, the following information has been obtained: • Primary source verification of licensure to include NPDB query • Copy of a DEA certificate • Verification of professional liability coverage • At least one recent reference from a previous hospital chief or department chair The standard does not specify a maximum length of time for temporary privileges but limits these privileges to the specific patients identified. A best practice would be for these parameters to be defined in the medical staff bylaws and/or credentials manual. › *Continued on next page*	HP/MBHO: Provisional credentialing is permitted for those practitioners who are applying to the organization for the first time. A practitioner may be provisionally credentialed only one time. This applies, provided that the following are true: • Current licensure is primary source verified within the past 180 days • A five-year history of malpractice claims or settlements is obtained from the carrier, or the NPDB* query results are obtained within the past 180 days • There is a current, signed application, with attestation within the past 365 days • The credentialing committee or medical director considers the preceding information as it provisionally credentials the applicant utilizing the same process that applies to non-provisional practitioners • The provisional period is granted for no longer than 60 days CVO: Not applicable *Note: Provisional credentialing may not be granted for practitioners credentialed by a delegate on behalf of the organization.* › *Continued on next page*

TEMPORARY PRIVILEGES/PROVISIONAL CREDENTIALING				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
* **Form, with appropriate signatures, that documents the provisional credentialing process, in accordance with the established medical staff process, defined in the bylaws, rules and regulations, or policies.** **Appropriate documentation in applicant's file**	• Current licensure • Relevant training or experience • Current competence • Ability to perform privileges requested • Other criteria outlined within the medical staff bylaws • NPDB query and evaluation of outcome • A complete application • No current or previously successful challenges to licensure/registration • No history of involuntary termination of medical staff membership at other institutions • No history of involuntary limitation, reduction, denial, or loss of clinical privileges *Applicant for new privileges is defined as a first-time applicant, an already privileged practitioner requesting an additional privilege(s), or a reapplicant requesting an additional privilege(s). Under the second circumstance (pendency of an application), temporary privileges for new applicants may not exceed 120 days. In both instances cited above, all temporary privileges are granted by the CEO or authorized designee upon the recommendation of medical staff president or authorized designee. › *Continued on next page*	* **Regardless of circumstances of application, evidence in the applicant's file of an individual who would meet all criteria for membership or privileges through a complete and fully verified application without identified issues/concerns** **AND** * **DNV requires supporting documentation (i.e., form, with appropriate signatures) that documents the granting of temporary privileges, when a practitioner is granted temporary privileges to confirm process was followed.**	In the instance of a locum tenens practitioner, HFAP standards allow the granting of temporary privileges for specific periods of time that are not typically sequential. (This allowance is made to bypass the need for repeated applications.) * **Regardless of circumstances of application, evidence in the applicant's file of an individual who would meet all criteria for membership or privileges through a complete and fully verified application without identified issues/concerns** **AND** * **Form, with appropriate signatures, that documents the granting of temporary privileges** **Appropriate documentation in applicant's file** **Bylaws or credentials manual identifies the mechanisms for granting all temporary privileges.**	* **Regardless of circumstances of application, evidence in the applicant's file of an individual who would meet all criteria for approval through a complete and fully verified application without identified issues/concerns** * **Form, with appropriate signatures, that documents the provisional credentialing process** **Appropriate documentation in applicant's file**

TEMPORARY PRIVILEGES/PROVISIONAL CREDENTIALING				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
	* Regardless of circumstances of application, evidence in the applicant's file of an individual who would meet all criteria for membership/privileges through a complete and fully verified application without identified issues/concerns * Form, with appropriate signatures, that documents the granting of temporary privileges Appropriate documentation in applicant's file			

APPROVAL PROCESS/EXPEDITED APPROVAL PROCESS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The governing body determines whether to grant, deny, revise, or limit specified privileges, including medical staff membership, after considering the medical staff's recommendation. Only the governing body has the authority to grant a practitioner privileges to provide care in the hospital. The CMS standards do not provide for an expedited process. There is no requirement for medical staff departments, a credentials committee, or an executive committee. If there is an executive committee, the majority of its members must be doctors of medicine or osteopathy. * **Approval process is defined in medical staff bylaws**	**Approval process:** The governing body or delegated governing body committee has final authority to grant, renew, or deny privileges. Privileges are granted for up to two years. The governing body bases decisions regarding membership and privileges for the individual practitioner on recommendations from the medical executive committee. Credentialing processes are outlined in the medical staff bylaws, rules and regulations, and medical staff and hospital policies. Medical staff bylaws also specify the time frame on which completed applications are acted upon. When medical departments exist, the department chair recommends clinical privileges for each member of the department. When there are no medical staff clinical departments, privileges are recommended through designated medical staff mechanisms, as described in bylaws, rules, and regulations. If the medical staff is departmentalized, at a minimum, the medical staff executive committee considers the department chair's recommendations and forwards resultant recommendations regarding membership and clinical privileges to the governing body for action. › *Continued on next page*	The governing body appoints members of the medical staff and approves clinical privileges after evaluating the recommendations of the medical staff. The medical staff is accountable to the governing body for the quality of care provided to patients. The governing body may elect to render decisions regarding initial appointment, reappointment, and renewal or modification of clinical privileges to a committee of the governing body. Executive committee: The medical staff shall meet at regular intervals, and minutes shall be maintained. If the medical staff has an executive committee, then a majority of the members of the committee shall be doctors of medicine or osteopathy. * **Approval process is defined in bylaws or related documents**	The governing body appoints members of the medical staff after considering recommendations of the medical staff. The medical staff bylaws define the application and privilege delineation process. The application, including all verified information, is reviewed, evaluated, and summarized by credentialing professionals. The summary is a clear report of the review of the information received. Discrepancies and unusual or problematic issues are reviewed and discussed by appropriate committee members and medical staff leaders. Medical staff leaders, committees, and the governing body review the summary. *Note: A typical process in a departmentalized medical staff would include a recommendation from the department chair* to the credentials committee** to the medical executive committee to the governing body.* **Departmentalization is not required by HFAP.* ***HFAP standards define the role of a credentials committee or medical staff credentials "function."* * **Approval process is defined in bylaws or related documents**	HP/MBHO: The organization designates a credentialing committee to make recommendations regarding credentialing decisions. Credentialing committee meetings may also be in real-time virtual meetings such as through video conferences or audio web conferences. NCQA does not accept meetings conducted only through email. The organization also may develop policies and procedures and establish criteria to designate "clean files," allowing review and approval by the medical director (or equally qualified physician). The medical director's review and approval (handwritten signature, initials, or unique electronic identifier*) is documented and is considered the credentialing decision date. Therefore, only credentials files of practitioners who do not meet the organization's established criteria need to be reviewed by the credentialing committee. *If the medical director uses an electronic signature, the organization must be able to demonstrate that only the medical director is able to enter his or her electronic signature. › *Continued on next page*

APPROVAL PROCESS/EXPEDITED APPROVAL PROCESS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
	Expedited process: The Joint Commission also allows the governing body to delegate authority to a committee of the governing body (consisting of at least two voting members of the governing body) to decide upon initial appointment, granting of clinical privileges, reappointment, and renewal or modifying privileges. The organized medical staff must first develop criteria for an expedited process. To be eligible for the expedited process, the applicant must meet certain established criteria and be recommended by the medical staff executive committee. An applicant will not be eligible for the expedited process if any of the following exist: • An incomplete application • A recommendation from the medical staff executive committee that is adverse to the candidate or contains limitations on the appointment/privileges In addition, the candidate is generally not eligible for an expedited process if any of the following exist (see note): • A current challenge or previously successful challenge to licensure or registration • An involuntary termination of medical staff membership at another organization • An involuntary limitation, reduction, denial, or loss of clinical privileges › *Continued on next page*			The practitioner may not provide care to members prior to the decision of the credentialing committee. Exception: See section "Temporary privileges/Provisional credentialing." Some organizations may require a subsequent review of the credentialing committee's decision (or medical director's review and approval) by another review board or governing body. In these instances, NCQA considers the date of the credentialing committee action or the medical director's approval to be the decision date. Therefore, the timeliness of credentialing processes is determined using the credentialing committee date or the date of the medical director's approval. CVO: Not applicable * **Approval process is defined in credentialing committee policies and procedures**

APPROVAL PROCESS/EXPEDITED APPROVAL PROCESS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
	• An unusual pattern or excessive number of professional liability actions resulting in final judgment against the applicant *Note: The Joint Commission states that such cases must be evaluated on a case-by-case basis.* * **Approval process is defined in medical staff bylaws. At a minimum, the bylaws contain the basic steps of the process. "Associated details" that further define the process may be outlined in the medical staff bylaws, rules and regulations, or policies.**			

COMMENTS/TIPS:

Although CMS, The Joint Commission, DNV GL, and HFAP standards do not require a credentials committee, many medical staffs have appointed one to focus on credentialing and privileging and related issues. In this instance, recommendations would flow through the credentials committee to the medical executive committee.

In smaller organizations, an officer or MEC member may be assigned responsibility for the credentialing function, reporting on findings, and making recommendations. This process depends upon the medical staff organization as defined in the medical staff bylaws.

DECISION NOTIFICATION				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
CMS requires that the medical staff bylaws describe the privileging process. Thus, practitioner notification would be contained within the described process. CMS also requires that hospital departments be notified of a practitioner's privileges. * **Process is outlined in medical staff bylaws**	The practitioner is informed of the decision to grant, limit, or deny an initially requested privilege within the time frame indicated in the medical staff bylaws. If a privilege is limited or denied, the practitioner is notified of the reason and the applicable rights of due process or of a hearing and appeal process, when applicable. The decision to grant, deny, revise, and/or revoke privileges are distributed and made available to all appropriate entities (both internal and external) according to hospital policy and applicable laws. The process is approved by the medical staff. * **Approval process is defined in medical staff bylaws. At a minimum, the bylaws contain the basic steps of the process. "Associated details" that define the process in greater detail may be outlined in the medical staff bylaws, or rules and regulations, or policies**	Standards are silent on this issue. DNV GL requires that the medical staff bylaws include the privileging criteria along with the procedure for applying the criteria to those individuals that request privileges. Thus, practitioner notification would be contained within the described process. * **Process is outlined in medical staff bylaws**	Standards require that the practitioner be informed of the privileges granted as well as any revisions/revocations. Further, HFAP requires the medical staff bylaws define the application and privilege delineation process. The practitioner notification process would be included within the described process. * **Process is outlined in medical staff bylaws**	HP/MBHO: The organization has policies and procedures outlining the process to ensure that practitioners are notified of the initial credentialing decision within 60 calendar days. CVO: Not applicable * **Process is outlined in policies and procedures**

HEARING/APPEAL PROCESS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Standards are silent on the provision of hearing and/or appeal. CMS requires that the medical staff bylaws describe the privileging process. Thus, practitioner rights to a hearing and/or appeal would be contained within the described process. The national standard is to provide two levels of redress: a hearing before the medical staff and an appeal to the governing body. *CMS requires that all practitioners who hold privileges be afforded the protection and due process rights outlined in the medical staff bylaws, rules, and regulations. In addition, medical staffs must comply with state and federal laws and therefore compliance with the Health Care Quality Improvement Act (HCQIA), which identifies the hearing and appellate review process that must be adhered to. Bylaws should define this process as well.* *** Process as outlined in medical staff bylaws.**	The medical staff bylaws outline fair hearing and appellate review mechanisms for medical staff members and other individuals holding clinical privileges. The bylaws will include the processes for scheduling and conducting hearings and appeals. At a minimum, the hearing and appeal process is designed to be a fair process for a review of decisions regarding reappointment, denial, reduction, suspension, or revocation of privileges that involve quality of care, treatment, and services. The fair hearing and appeal process, which may be different for members and nonmembers of the medical staff, provides for a mechanism to schedule a requested hearing, outlines the hearing procedures, stipulates that the hearing committee should be composed of impartial peers, and outlines a process to appeal adverse decisions to the governing body. The Joint Commission standards do not require that the hearing and appellate review mechanisms for initial applicants be the same as those for existing staff members and practitioners with clinical privileges. Nor does The Joint Commission require that the same rights be afforded to those applying for staff membership versus those applying for clinical privileges. › *Continued on next page*	The medical staff bylaws shall contain fair hearing and appeal provisions for any adverse actions related to initial appointment, suspension, reduction, or revocation of privileges of any individual who has applied for or has been granted clinical privileges. Further, the Interpretive Guidelines state that once the hearing and appeal process is complete, the medical staff will document the findings and resolutions in writing. *Medical staffs must comply with state and federal laws and therefore be in compliance with the Health Care Quality Improvement Act (HCQIA), which identifies the hearing and appellate review process must be adhered to and bylaws should define this process.* *** Process as outlined in medical staff bylaws.**	The fair hearing and appeal process may be different for members of the medical staff versus nonmembers (non-physician providers). At a minimum, the fair hearing plan provides for a fair hearing and appeal process for the following: • Denial • Modification or changes in appointment category • Initial granting or re-granting of privileges with final review/action by the governing body The standards require that individuals involved in the process (peer review) be impartial peers who do not have an economic interest or conflict of interest with the subject of the peer review activity. An impartial peer would exclude a practitioner with a blood relationship, employer/employee relationship, or other potential conflicts that might prevent an impartial assessment or give the appearance of potential bias. *** Process as outlined in medical staff bylaws.**	HP/MBHO: The practitioner is to be notified of his or her right to review the information submitted to support the credentialing application and information obtained from outside sources such as malpractice carriers, state licensing bodies, etc. References or other peer review protected information are not included in the practitioner's right to review. Further, the applicant is to be notified if information is received that significantly differs from that provided by the practitioner. Policies and procedures outline the practitioner's right to correct any information that is erroneous and the method for doing so, including time frames to make corrections. The policy needs to include how and where to submit corrections. Documentation of corrections should be included in the credentials file. The applicant has a right to be informed of the application status (upon request) and of the initial credentialing decision within 60 days of the decision. The organization defines an appeal process in the event that the organization takes action against a practitioner based on not meeting quality of care and service standards. (See "Hearing/Appeal process" in Chapter 2 for more details on the appeal process.) › *Continued on next page*

HEARING/APPEAL PROCESS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
	Note: The Joint Commission requirement relates to decisions involving quality of patient care, treatment, and services. Therefore, it is not necessary to allow the rights of a full hearing and appeal process to individuals for reasons such as a reduction in medical staff status, termination of a leave of absence due to non-return, or situations prompting automatic suspensions, such as a loss of license, professional liability coverage, etc. * **Approval process is defined in the medical staff bylaws. At a minimum, the bylaws contain the basic steps of the process. "Associated details" that further define the process may be outlined in the medical staff bylaws, or rules and regulations, or policies.**			Policies and procedures also describe the procedures for reporting to authorities (e.g., state licensing agencies, NPDB). See "Notification of Authorities" in Chapter 3 for more details. CVO: Not applicable. * **Process as outlined in policies and procedures**
COMMENTS/TIPS: The Health Care Quality Improvement Act of 1986 (HCQIA) and the NPDB reporting mechanisms have been cited by The Joint Commission and NCQA as benchmarks for policy and procedure development. In addition, in general, healthcare attorneys advocate compliance with the multiple aspects of the Act.				

LENGTH OF INITIAL APPOINTMENT/CREDENTIALING/CLINICAL PRIVILEGES				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
The CMS requirements do not specify a length of initial appointment and/or privileges. However, there are requirements that each individual be periodically appraised for continued medical staff membership or privileges. In the absence of a state law that establishes a time frame for periodic reappraisal, a hospital medical staff must conduct a periodic appraisal of each practitioner. CMS recommends that an appraisal be conducted at least every 24 months for each practitioner. * **In the absence of a state law allowing for a longer initial appointment (up to 36 months), all appointments may not exceed two years.**	Initial appointments may not exceed two years.	Initial appointments and the granting or revision of clinical privileges shall be for a period defined by state law or, if permitted by state law,* not to exceed three years. **Note: DNV GL requires that organizations follow the state law. Thus, if the state requirements specifically indicate that appointments/reappointments or the granting/renewal/revision of privileges are to be for less than three years (e.g., two years or 24 months), then the state law is to be followed. However, if the state law permits longer appointments/reappointments or granting/renewal/revision of clinical privileges or if the state law is silent on the time allowed, then the DNV GL standards apply (i.e., appointments/reappointments and the granting/renewal/revision of clinical privileges may "not exceed three years.")* * **Initial appointments and the granting or revision of clinical privileges shall be for a period defined by state law or, if permitted by state law, not to exceed three years.**	The HFAP requirements state that each individual be periodically appraised for continued medical staff membership or privileges but does not define a specific time frame. The time frame for periodic appraisal should conform to state law. In the absence of a state-specific time frame, HFAP standards cite the CMS recommendations of at least every 24 months. * **In the absence of a state law allowing a longer initial appointment (up to 36 months), all appointments may not exceed 24 months**	HP/MBHO/CVO: The initial credentialing period may be for up to 36 months. NCQA counts the 36-month cycle from the date of the initial credentialing decision to the month and not to the day. Exception: If the practitioner has been on active military assignment, maternity leave, or a sabbatical and there is a contract in place between the organization and the practitioner, the organization may recredential the practitioner upon return. The practitioner's file must contain documentation of the reason for the delay, and the recredentialing process must be completed within 60 days of the practitioner's resumption of practice. In these instances, the organization must verify licensure before the practitioner renders care. This exception does not apply to terminated contracts or breaks in service of more than 30 calendar days. If a termination or break in service occurs, the organization must initially credential the practitioner before he or she begins to practice again, if the time exceeds 30 days. *Note: Organizations also must observe state requirements, as applicable, to initial and recredentialing time frames.* * **Initial credentialing may be for up to 36 months if in accordance with state law**

CONTINUING MEDICAL EDUCATION (CME)				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
Not addressed related to initial appointment/privileges. However, CMS does require the hospital to ensure that personnel are licensed or meet other state or local requirements. Included in the standards identified is continuing education. Thus, this requirement would apply, at a minimum, to all privileged practitioners with licenses. *Note: Many states require that practitioners attest to or document CME activities for continued licensure.* **Evidence of CME as required by medical staff (e.g., bylaws, policies, rules, and regulations) to establish competence for privileges requested:** • * **Copies of certificates of attendance** • **Documentation by the applicant** • **Computer listing of CMEs at organization**	Initial appointment/privileging standards do not specifically identify CME as a component. However, consideration of CME may be relevant to establishing the applicant's education/training/current competence for clinical privileges requested. In addition, The Joint Commission states that all LIPs and other practitioners privileged through the medical staff participate in continuing education. *Note: Many states require that practitioners attest to or document CME activities for continued licensure.* **Evidence of CME as required by medical staff (e.g., bylaws, policies, rules, and regulations) to establish competence for privileges requested:** • * **Copies of certificates of attendance** • **Documentation by the applicant** • **Computer listing of CMEs at organization**	All practitioners with clinical privileges are expected to participate in continuing education. At least a part of the CME activity is to be related to the privileges they are requesting. Action on the applicant's initial appointment/initial privileges is withheld until information on the practitioner's participation in CME is obtained and verified. *Note: Many states require that practitioners attest to or document CME activities for continued licensure.* **Evidence of CME as required by medical staff (e.g., bylaws, policies, rules, and regulations) to establish competence for privileges requested:** • * **Copies of certificates of attendance** • **Documentation by the applicant** • **Computer listing of CMEs at organization**	Initial appointment/privileging standards do not specifically identify CME as a component. However, consideration of CME may be relevant to establishing the applicant's education/training/current competence for clinical privileges requested. *Note: Many states require that practitioners attest to or document CME activities for continued licensure.* **Evidence of CME as required by medical staff (e.g., bylaws, policies, rules, and regulations) to establish competence for privileges requested:** • * **Copies of certificates of attendance** • **Documentation by the applicant** • **Computer listing of CMEs at organization**	HP/MBHO/CVO: Terminology not used.

TIME FRAME FOR COMPLETION OF VERIFICATION/APPROVAL PROCESS				
CMS	**The Joint Commission**	**DNV GL**	**HFAP**	**NCQA**
CMS requires that the medical staff bylaws describe the privileging process. Thus, any time frames for completion of the application, verification process, or consideration by the medical staff and the governing body would be as outlined within the bylaws or related medical staff documents. * **Process as outlined in medical staff bylaws**	The medical staff bylaws must include a description of the credentialing and privileging processes and appointment to membership on the medical staff. Completed applications must be acted upon within the period of time specified in the medical staff bylaws. The organization completes the credentialing and privileging decision process in a timely manner. * **Approval process is defined in medical staff bylaws. At a minimum, the bylaws contain the basic steps of the process. "Associated details" that define the process in greater detail may be outlined in the medical staff bylaws, or rules and regulations, or policies.**	DNV GL requires that the completed application be acted upon within a reasonable time frame as specified in the medical staff bylaws. * **Process as outlined in medical staff bylaws**	The medical staff bylaws define the application and privilege delineation process to include the time frames for acting on each application. The credentials committee/credentials function section states that a recommendation is to be made to the medical executive committee within 60 days of receipt of a completed application. The recommendation should be based upon the requesting practitioner's qualifications and current competency. * **Process as outlined in medical staff bylaws**	HP/MBHO: The credentials information must be valid, current, and no more than 180 calendar days old at the time of the credentialing committee's decision, unless otherwise noted in the individual element in this chapter. CVO: The credentials elements must be verified within 120 calendar days prior to submission to each client, as applicable, unless otherwise noted in the individual element in this chapter. All applicable elements (e.g., licensure, DEA/CDS, malpractice coverage) must be valid and be current. NCQA counts backwards from the date of the decision to the date on which the verification was obtained to verify compliance with their time frame requirement. * **Process as outlined in policies and procedures**

DISASTER PRIVILEGES		
CMS	**The Joint Commission (Ambulatory)**	**Accreditation Association for Ambulatory Health Care (AAAHC)**
§416.41(c)(1) Disaster Preparedness Plan (1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff, and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. (2) The ASC coordinates the plan with state and local authorities, as appropriate. (3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan.	**EM.02.01.01—Emergency Management Plan** The organization has a written Emergency Management Plan. **EM.02.02.13 Volunteer LIPs** When the emergency management plan has been activated and the organization is unable to handle the immediate patient needs, disaster privileges may be granted to volunteer LIPs. The organization identifies the individual(s) responsible to do so. Appropriate policies and procedures define a mechanism for overseeing the professional performance of the LIP with disaster privileges, along with a mechanism for identifying the volunteer LIP easily. Disaster privileges may be granted to LIPs upon presentation of a valid government-issued photo ID, such as a driver's license or passport, and at least one of the following: • Current healthcare organization picture ID card that identifies the LIP's professional discipline • Current license to practice* • Primary source verification of the license • Identification indicating the practitioner is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal group • Identification indicating the practitioner has been given the authority by a government entity to provide clinical care during a disaster • Affirmation by an LIP currently privileged by the organization or by a staff member with personal knowledge of the individual's ability to act as an LIP during a disaster Primary source verification of licensures begins as soon as the immediate situation is under control or within 72 hours** of the practitioner presenting to the organization › *Continued on next page*	**Infection Prevention and Control and Safety** **7.II.E -** There is a written emergency and disaster preparedness plan addressing internal and external emergencies, including participating in community health emergency or disaster preparedness, when applicable. The plan includes a provision for the safe evacuation of individuals during an emergency, particularly individuals who are at greater risk. The following standards are additionally required for an ASC participating in the Medicare deemed status survey. **Governing Body—General Requirements** **I.G -** The governing body has oversight and accountability for developing and maintaining a disaster preparedness plan. **Infection Prevention and Control and Safety** **7. I.L -** The ambulatory surgery center (ASC) must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff, and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. The ASC does the following: • Coordinates this plan with state and local authorities, as appropriate • Conducts drills, at least annually, to test the plan's effectiveness • Completes a written evaluation of each drill and promptly implements any corrections to the plan

DISASTER PRIVILEGES		
CMS	**The Joint Commission (Ambulatory)**	**Accreditation Association for Ambulatory Health Care (AAAHC)**
	The organization determines within 72 hours of the practitioner's approval whether privileges will be allowed to continue based on oversight of the practitioner's professional performance. *License verification is not necessary if the LIP is/has not provided care, treatment, or services requiring LIP licensure. **If extraordinary circumstances prevail (e.g., no electronic communication, lack of resources) and primary source verification is delayed beyond 72 hours, there is documentation of the reasons for delay, evidence of the LIP's ability to provide care, and evidence of the organization's attempted effort to complete the primary source verification as soon as possible. **EM.02.02.15: Non-LIP Volunteers** Emergency management standards also outline a process to allow non-LIPs who are licensed, certified, or registered to provide care. Essentially, their standards mirror those stated for the volunteer LIP.	
COMMENTS/TIPS: When considering a policy covering natural or man-made disaster, contact with the state licensing body is important to evaluate the statutes relative to the acceptability of allowing out-of-state licensees to provide patient care in a disaster circumstance.		

VERBAL/PHONE VERIFICATION		
CMS	**The Joint Commission (Ambulatory)**	**Accreditation Association for Ambulatory Health Care (AAAHC)**
This element is not specifically addressed.	The Joint Commission standards permit documented telephone verifications.	Primary source verifications can be electronic or via mail, fax, or telephone, provided that the means by which it is obtained are documented and measures are taken to demonstrate that there was no interference in the communication by an outside party.

COMMENTS/TIPS:

If verification is obtained via phone or verbally, it is an accepted practice to document the following:

- The information verified
- The name and title of the person supplying the information
- The date of verification
- The name or initials of the person obtaining the information

FAX VERIFICATION		
CMS	**The Joint Commission (Ambulatory)**	**Accreditation Association for Ambulatory Health Care (AAAHC)**
This element is not specifically addressed.	Electronic verifications, including facsimile, are acceptable. The Joint Commission standards do not outline requirements for facsimile (fax) verification. However, fax copies are acceptable.	Primary source verifications can be electronic or via mail, fax, or telephone, provided that the means by which it is obtained are documented and measures are taken to demonstrate that there was no interference in the communication by an outside party.

INTERNET/ELECTRONIC VERIFICATION		
CMS	**The Joint Commission (Ambulatory)**	**Accreditation Association for Ambulatory Health Care (AAAHC)**
This element is not specifically addressed.	Credentials verification can be accomplished through the primary source or designated equivalent source via a secure electronic communication.	Primary source verifications can be electronic or via mail, fax, or telephone, provided that the means by which it is obtained are documented and measures are taken to demonstrate that there was no interference in the communication by an outside party.
COMMENTS/TIPS:		
It is important that the electronic verification is dated (either by the source or manually). If the verification does not automatically contain the date when printed, manually include the date and initial.		

USE OF A CREDENTIALS VERIFICATION ORGANIZATION (CVO)		
CMS	**The Joint Commission (Ambulatory)**	**Accreditation Association for Ambulatory Health Care (AAAHC)**
This element is not specifically addressed.	**Glossary—CVO** Organizations may use a CVO to verify information. If this is done, the organization should be confident in the completeness, accuracy, and timeliness of that information. The Joint Commission outlines principles to initially and periodically evaluate such an agency, including that the agency discloses the following: • What data and information are available • How data are collected, how information is developed, and what verification processes are used • Information on database functions, to include the limitations on the information available (e.g., practitioners who are not in the database), turnaround time for reporting, and a summary of quality control processes, to include transmission accuracy, data integrity, security, technical specifications, etc. • How the information is to be transmitted • What information is from the primary source versus what information is obtained from an equivalent or secondary source • Whether time-sensitive data are collected and verified (e.g., licensure) and whether information is also provided regarding expiration dates and the date on which the information was last updated • A certification that the information transmitted to the user is reflective of the information obtained • Whether the information obtained is complete or whether there is additional information available (and, if so, where to obtain it) • The mechanisms available through the quality control system to resolve issues regarding transmission errors, inconsistencies, or other data concerns • The user should have a formal agreement with the CVO for communication regarding changes in credentialing information.	**Governance—Subchapter II—Credentialing and Privileging** **2.II.B.4 -** Credentials verification is completed in accordance with the organization's bylaws, policies, and/or rules and regulations. The organization outlines procedures to obtain required information from primary or secondary source verifications. The organization is then responsible to obtain the information. AAAHC standards permit the use of CVOs after assessing the CVO's capabilities and quality. The CVO may demonstrate capability and quality if accredited or certified by a nationally recognized accreditation organization. If a CVO is utilized, then the CVO must obtain verifications from primary sources unless such sources do not exist or are not possible to verify.
COMMENTS/TIPS: When an organization contracts with a CVO to perform verifications, it is important that a mutually agreed upon formal agreement outline each organization's responsibilities, the specific activities, and the process for evaluation of the CVO's performance.		

ORIENTATION OF LICENSED INDEPENDENT PRACTITIONERS		
CMS	**The Joint Commission (Ambulatory)**	**Accreditation Association for Ambulatory Health Care (AAAHC)**
This element is not specifically addressed.	**HR.02.02.01 LIP Orientation** Orientation is provided to LIPs and is documented. The orientation includes key safety issues as identified by the organization including relevant policies and procedures, infection control, assessing and managing pain, and sensitivity to cultural diversity. **EC.03.01.01 LIP Roles and Responsibilities** LIPs should be able to describe what actions to take in the event of an environment of care incident. The orientation is completed and documented prior to providing care, treatment, or services.	**Infection Prevention and Control and Safety** **7.1.E (Non-Deemed) 7.1.D (Medicare Deeming) -** Medical staff members and AHPs are provided education and training on infection prevention. Individuals comply with requirements. **7.II.C -** Medical staff members and AHPs are provided education and training regarding the safety program. Individuals comply with requirements. **Surgical and Related Services** **7.II.C -** The organization has written policies and procedures to enable trained and experienced allied healthcare personnel to conduct duties necessary to assist in the provision of lithotripsy, including providing staff education such as orientation to equipment.

FIGURE 8.1: SAMPLE POLICY AND PROCEDURE FOR VERIFICATION OF IDENTITY

Policy:

It is the policy of _____ Hospital to verify the identity of all licensed independent practitioners (LIP) who apply for medical staff appointment and privileges prior to the practitioner providing any patient care, treatment, or services. This is done to determine that these practitioners are the same practitioners identified in the credentialing documents.

Verification of identity can be accomplished by viewing any of the following:

Military ID, State ID, Customs Passport, State Driver's License

Procedure:

Verification can be conducted during any of the following processes:

- During provider orientation
- During the process of obtaining hospital picture ID
- Any time that the practitioner presents in person

After presentation of a valid Military ID, state driver's license/ID, or customs passport that includes a picture, the person verifying completes the Verification of Identity Documentation Form (Attachment A). The completed form is forwarded to the Medical Staff Office for inclusion in the practitioner's credentials file.

Attachment A: Verification of identity documentation form

Practitioner Name: _____

I have reviewed the following identification for the above-named practitioner:

_ Military ID

_ Passport

_ State driver's license or ID _____

[List issuing state]

Signature of person verifying
_____

Date
_____

Printed name of person verifying

_____

7TH EDITION

VERIFY & COMPLY

Credentialing, Medical Staff, and Ambulatory Care Standards

- Kathy Matzka, CPMSM, CPCS
- Stephanie Russell, CPMSM, CPCS
- Carol S. Cairns, CPMSM, CPCS

Celebrated by medical staff and credentialing professionals for over 15 years, *Verify and Comply* is back, bigger, and better. ***Verify and Comply, Seventh Edition,*** is the latest version of one of HCPro's most popular credentialing and accreditation resources. Credentialing and medical staff standards and regulations are covered in one easy-to-navigate side-by-side crosswalk, giving MSPs one book that answers all their accreditation questions.

This expanded guide includes ambulatory care, acute care, and managed care standards for the most popular regulators and accreditors: CMS, The Joint Commission, NCQA, DNV, HFAP, and AAAHC. This book allows you to compare what each accreditor states about initial appointment, reappointment, and other medical staff functions, and provides tips and best practices to help you meet the most challenging standards. Use this resource to keep up to date with regulators' and accreditors' credentialing and medical staff standards.

This book will help you:

- Streamline and structure your medical staff and its responsibilities
- Implement best practices in your medical staff services department that ensure compliance with your accreditor's standards
- Determine which verifications are necessary to obtain in the credentialing process
- Understand the differences between the appointment, reappointment, and ongoing assessment stages of the credentialing process
- Determine the appropriate areas in medical staff governance documentation to include specific items required by accreditation standards and regulations
- Adopt best practices for complying with telemedicine and ambulatory accreditation standards

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