Companion to best-selling *Verify & Comply*

Medical Staff Standards Crosswalk

A Quick Reference Guide to The Joint Commission, CMS, HFAP, and DNV Standards

Kathy Matzka, CPMSM, CPCS

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HCPro

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About the Author

Kathy Matzka, CPMSM, CPCS

Kathy Matzka, CPMSM, CPCS, is a consultant and speaker with almost 25 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.

Matzka has authored a number of books related to medical staff services, including the HCPro, Inc., publications *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), and *The Medical Staff Meeting Companion: Tools and Techniques for Effective Presentations*. She 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' library team, developing and editing educational materials related to the field, including CPCS and CPMSM certification exam preparatory courses, CPMSM and CPCS professional development workshops, and NAMSS core curriculum. She also serves as an instructor for NAMSS.

Matzka shares her expertise by serving on the editorial advisory boards for two HCPro, Inc., publications—*Credentialing Resource Center Journal* and *Credentialing and Peer Review Legal Insider.*

Matzka is a highly regarded industry speaker, and in this role has developed and presented numerous 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.

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

Acknowledgments

It's difficult to author a book that is a companion to "*Verify and Comply*" without acknowledging Carol Cairns, CPMSM, CPCS, the author of the original *Verify and Comply: A Quick Reference Guide to Credentialing Standards*, published by HCPro, Inc., in Danvers, MA. Carol has been a mentor to me and countless other medical services professionals who have had the pleasure of learning from her vast pool of knowledge. Thanks, Carol, for all you do!

Building on the success of Carol's book, this publication contains standards related to the medical staff that are not tied directly to credentialing and privileging and are therefore not included in the original "Verify and Comply."

I would also like to give a "shout out" to all of the current and past instructors for NAMSS who 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!

Continuing Education Information

National Association Medical Staff Services (NAMSS)

This program has been approved by the National Association Medical Staff Services for 5 continuing education credits. Accreditation of this educational program in no way implies endorsement or sponsorship by NAMSS.

Continuing Education Instructions

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2. Complete the continuing education exam by visiting the link provided below. You must receive a score of at least 80% to pass.
3. Provide your contact information, including e-mail address, at the end of the exam.
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This book and associated exam are intended for individual use only. If you want to provide this continuing education exam to other members of your staff, contact HCPro's customer service department at 877/727-1728 to place your order. The exam fee schedule is as follows:

Exam Quantity	Fee
1	$0
2–25	$15 per person
26–50	$12 per person
51–100	$8 per person
101+	$5 per person

Learning objectives

Chapter 1

After reading this chapter, you will be able to:

- Discuss the importance of having an organized medical staff
- Define the structure of your medical staff and its responsibilities
- Explain your medical staff's involvement in organizational leadership functions
- Determine the appropriate area in medical staff governance document to include specific documentation required by accredidation standards and regulatory requirements

Chapter 2

After reading this chapter, you will be able to:

- Identify the levels of oversight necessary for different types of practitioners
- Explain the guidelines for performing history and physical exams on patients
- Discuss the medical staff's responsibility for oversight of patient care, treatment, and services
- Implement the new CMS regulations regarding telemedicine

Chapter 3

After reading this chapter, you will be able to:

- Discuss regulatory requirements for completion of medical records
- Identify accreditation standards and regulatory requirements regarding admission of patients to the hospital
- Develop a list of hospital policies and procedures that require medical staff involvement or approval

Introduction

The Centers for Medicare & Medicaid Services' (CMS) *Conditions of Participation (CoP)* contain minimum requirements that all hospitals that wish 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; rather, it surveys them through state governmental agencies, typically the state's health department.

There are also voluntary accrediting bodies with minimum "standards" that must be met in order for a healthcare organization to be accredited by that body. These accrediting organizations must submit their standards to CMS, which then reviews the standards for compliance with CMS' *CoP.* If the standards meet or exceed the CMS regulations, the accreditation program is given "deemed" status. This means that the healthcare organization 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*, and in other cases you will see where additional requirements are included.

Brief Description of Each Program

The following is a brief description of the hospital accrediting bodies with hospital accreditation programs granted deeming authority by CMS:

- The Joint Commission's Hospital Accreditation Program: Founded in 1951, The Joint Commission is the oldest and largest hospital accrediting body.
- American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP): If the hospital is accredited by HFAP, it is deemed to meet all Medicare requirements for hospitals, except the requirements for utilization review, which fall under the jurisdiction of state agencies, and the special conditions for psychiatric hospitals. The American Osteopathic Information Association oversees this accreditation program.
- Det Norske Veritas Healthcare, Inc.'s (DNV) National Integrated Accreditation for Healthcare Organizations (NIAHOSM): DNV Healthcare's hospital accreditation program integrates the ISO 9001 standards (international quality standards that define minimum requirements for a quality management system) and the Medicare hospital *CoP*. CMS granted this organization deeming status in 2008.

Using this book

This publication contains standards related to the medical staff that are not related to credentialing and privileging and are therefore not included in *Verify and Comply: A Quick Reference Guide to Credentialing Standards*, fifth edition written by Carol Cairns, CPMSM, CPCS, and published by HCPro, Inc. This book also references standards that are not included in the medical staff section of the standards. In days past, all standards related to the medical staff were contained in the medical staff chapter, but now they are interspersed throughout the standards.

In its book format, *Verify and Comply: A Quick Reference Guide to the Medical Staff Standards* is a simple, efficient guide to compare the hospital accreditation requirements related to the medical staff as contained in the standards of The Joint Commission, DNV's NIAHO, and HFAP. Each section begins with the CMS *CoP* related to the issue addressed, followed by the standards of the accreditors. Using this grid, you can identify the areas in which the standards include more stringent requirements.

Keeping up to date and informed

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 website *(www.hcpro.com)* to obtain the latest credentialing-related information and to share information and ideas with each other.

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.

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CHAPTER 1

Medical Staff Structure, Medical Staff Bylaws, and Medical Staff Involvement in Organizational Leadership Functions and Required Committees

CHAPTER 1

Medical Staff Structure, Medical Staff Bylaws, and Medical Staff Involvement in Organizational Leadership Functions and Required Committees

The medical staff must be well organized to effectively participate in important organizational functions, including providing patient care, evaluating the quality of patient care, and maintaining the medical staff organization. To accomplish this goal, the medical staff develops and adopts bylaws, rules, regulations, and other policies, and defines its organizational structure in a way that allows it to accomplish its responsibilities.

The "organized" medical staff organization began in 1919, with the publication of "Minimum Standards" by the American College of Surgeons. These standards, which eventually evolved into the first set of Joint Commission standards, required physicians and surgeons practicing within a hospital to organize and adopt rules and regulations governing the professional work done in the facility.

Although some components of the modern medical staff organization are required by federal and state regulations, as well as by the accreditation standards, the medical staff can define its formal structure and specific operational mechanisms. For this reason, a hospital's medical staff's structure typically reflects the size of the medical staff and the patient care services provided by the organization.

Traditional medical staffs either elect or appoint officers and organize themselves into departments that reflect physician specialties or subspecialties. Each of these departments in turn elects or appoints officers. In most cases, physician department directors assume administrative responsibilities in addition to their patient care responsibilities.

Medical staff committees, such as the credential committee, carry out many of the medical staff's required functions and make recommendations to the medical staff executive committee (MEC). These committees perform many functions required by accreditation standards and regulatory bodies on behalf of the medical staff. They also evaluate and make recommendations regarding clinical processes and organizational functions.

Medical staff meetings are great tools for brainstorming about important issues, and they strengthen the medical staff team's commitment to the outcome. Further, the organized medical staff is more likely to accept the decisions of the committee that worked together to reach a decision or recommendation.

The medical staff bylaws must document the functions and responsibilities of each medical staff department and committee.

MEDICAL STAFF STRUCTURE AND ACCOUNTABILITY

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
§482.12(a)(5) [The governing body must:] Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. **Interpretive Guidelines §482.12(a)(5)** The governing body must ensure that the medical staff as a group is accountable to the governing body for the quality of care provided to patients. The governing body is responsible for the conduct of the hospital and this conduct includes the quality of care provided to patients. All hospital patients must be under the care of a practitioner who meets the criteria of 42 CFR 482.12(c)(1) and who has been granted medical staff privileges, or under the care of a practitioner who is directly under the supervision of a member of the medical staff. All patient care is provided by or in accordance with the orders of a practitioner who has been granted privileges in accordance with the criteria established by the governing body, and who is working within the scope of those granted privileges.	**LD.01.05.01: Medical Staff Structure** The hospital must have an organized medical staff. The medical staff is accountable to the governing body. **MS.01.01.01: Medical Staff Structure** Medical staff bylaws include the definition of the medical staff's structure. If there are clinical departments, these are documented in the bylaws and include the qualifications, roles and responsibilities of the department chair. In most cases, there should be a single medical staff for the hospital. In the following case, there may be more than one medical staff: If the hospital is organized under a single governing body, but has multiple inpatient care sites serving geographically different patient populations, there may be separate medical staffs organized at each site. In this case, the patient population must consist of individuals who chose the hospital as their primary	**03.00.00 Medical Staff** The medical staff operates under bylaws approved by the governing body. The organized medical staff is responsible for the quality of medical care provided to patients by the hospital. **03.01.05 Bylaws-Organization of the Medical Staff** The organization of the medical staff must be described in the bylaws. **03.00.01 Governing Body Responsibility and Medical Staff Membership and 03.00.02 Restrictions of Medical Staff Membership** The governing body determines, per State law, which categories of practitioners are eligible for medical staff appointment. The medical staff must be composed of MDs and DOs and, if allowed by State law, may include other practitioners appointed by the governing body. The medical staff may include doctors of dental surgery or dental medicine if allowed by State law.	**MS.1 Organized Medical Staff** There must be an organized medical staff composed of fully licensed MDs and/or DOs. Other practitioners may be appointed to the medical staff if allowed by State law. **MS.2 Eligibility** In accordance with State law, the board determines which categories of practitioners are eligible for appointment to the medical staff. **MS.3 Accountability** The medical staff is accountable to the board and is responsible for oversight of the quality of the medical care provided to patients. The medical staff must be organized in a manner that is approved by the board.

MEDICAL STAFF STRUCTURE AND ACCOUNTABILITY (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
§482.22(a) Standard: Composition of the Medical Staff **§482.22** *Conditions of Participation:* Medical Staff The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital. **Interpretive Guidelines §482.22** The hospital may have only one medical staff for the entire hospital (including all campuses, provider-based locations, satellites, remote locations, etc.). The medical staff must be organized and integrated as one body that operates under one set of bylaws approved by the governing body. These medical staff bylaws must apply equally to all practitioners within each category of practitioners at all locations of the hospital and to the care provided at all locations of the hospital. The single medical staff is responsible for the quality of medical care provided to patients by the hospital.	source of inpatient care. The hospital must design and deliver patient care services consistent with its mission.	**03.00.07 Medical Staff Responsibilities to the Governing Body** The medical staff must be well organized in a manner approved by the governing body and is accountable to the governing body for the quality of the medical care provided to patients. There must be only one organized medical staff within the hospital. **03.01.26 Bylaws-Medical Staff Structure** Bylaws describe the medical staff structure (departments, services, committees). **03.01.27 Bylaws-Clinical Department Structure** 03.17.01 Department Structure Requirements–Family Practice 03.18.01 Department Structure Requirements–Internal Medicine Services 03.19.00 Department: OB/GYN Services 03.20.00 Department: Surgical Services	

MEDICAL STAFF STRUCTURE AND ACCOUNTABILITY (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
§482.22(a) Standard: Composition of the Medical Staff The medical staff must be composed of doctors of medicine or osteopathy and, in accordance with State law, may also be composed of other practitioners appointed by the governing body. **§482.22(c)(3)** [The bylaws must:] Describe the organization of the medical staff. **Interpretive Guidelines §482.22(c)(3)** The medical staff bylaws must describe the organizational structure of the medical staff, and lay out the rules and regulations of the medical staff to make clear what are acceptable standards of patient care for all diagnostic, medical, surgical, and rehabilitative services. **§482.12(a) Standard: Medical Staff** The governing body must: (1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.		The following reflects requirements for all departments noted above: If departments exist, bylaws include the following organizational requirements: • Structure—officers and meeting frequency • That no fewer than three active staff physicians can organize a separate department or service • Criteria for membership • Duties and obligations of department or service • Selecting a chair and other officers • The duties and responsibilities of the chair • That the department is accountable to the MEC and medical staff **03.01.24 Quality of Care Accountability** The medical staff is accountable to the governing body for the quality of patient care. In this role, it must act on the reports of services, departments, and committees; report regarding medical staff appointments, reappointments, and privileges; report on suspension, corrective	

MEDICAL STAFF STRUCTURE AND ACCOUNTABILITY (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
Interpretive Guidelines §482.12(a)(1) The medical staff must, at a minimum, be composed of physicians who are doctors of medicine or doctors of osteopathy. In addition, the medical staff may include other *types of healthcare professionals* included in the definition *of a physician* in Section 1861(r) of the Social Security Act: • Doctor of medicine or osteopathy • Doctor of dental surgery or of dental medicine • Doctor of podiatric medicine • Doctor of optometry • Chiropractor In all cases, the healthcare professionals included in the definition of a physician must be legally authorized to practice within the State where the hospital is located and providing services within their authorized scope of practice. In addition, in certain instances the Social Security Act and regulations attach further limitations as to the type of hospital services for which a healthcare professional may be considered to be a "physician."		action, and fair hearing of medical staff members; submit medical staff organizational issues, including revisions in bylaws, rules and regulations, and medical staff officers; report findings from ongoing evaluation of the medical staff; and collaborate with hospital administration and the governing body in regards to institutional budgets, planning, and resource utilization.	

MEDICAL STAFF STRUCTURE AND ACCOUNTABILITY (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
The governing body has the flexibility to determine whether healthcare professionals included in the definition of a physician other than a doctor of medicine or osteopathy are eligible for appointment to the medical staff. Furthermore, the governing body has the authority, in accordance with State law, to appoint some types of non physician practitioners to the medical staff. Practitioners are defined in Section 1842(b)(18)(C) of the Act as a: • Physician assistant • Nurse practitioner • Clinical nurse specialist (Section 1861(aa)(5) of the Act) • Certified registered nurse anesthetist (Section 1861(bb)(2) of the Act) • Certified nurse-midwife (Section 1861(gg)(2) of the Act) • Clinical social worker (Section 1861(hh)(1) of the Act) • Clinical psychologist (42 CFR 410.71 for purposes of Section 1861(ii) of the Act) • Registered dietician or nutrition professional			

MEDICAL STAFF STRUCTURE AND ACCOUNTABILITY (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
Other types of licensed health-care professionals have a more limited scope of practice and are generally not eligible for hospital medical staff privileges, unless their permitted scope of practice in their state makes them comparable to the above types of practitioners. Physicians and non-physicians may be granted medical staff privileges to practice at the hospital by the governing body for practice activities authorized within their state scope of practice without being appointed a member of the medical staff.			

COMMENTS/TIPS

Example of a traditional single organized medical staff:

Memorial Community Hospital (MCH) is 280-bed facility with two off-site outpatient urgent care clinics and one off-site ambulatory surgical center that function under a single provider number. MCH's medical staff and board bylaws both define a single organized medical staff for all facilities.

Example of a hospital organization with two medical staffs:

St. Thomas Hospital and St. Agnes Hospital, community hospitals with a full range of inpatient services, are owned by the same not-for-profit entity. The hospitals are 50 miles apart in neighboring towns, and each facility serves a geographically distinct patient population. To conserve administrative and governance resources, the hospitals' parent organization combined the hospitals into one entity under a single governing body. Due to the geographic distance between the two hospitals and the fact that there were very few providers who were on both medical staffs, the organization continued to have two separate medical staffs. The state licensure division and CMS approved the parent organization's decision to combine the hospitals under a single provider number.

MEDICAL STAFF LEADERSHIP

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
§482.12(a)(5) [the governing body must] Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. **§482.22(b) Standard: Medical Staff Organization and Accountability** The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy. (3) The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by State law of the state in which the hospital is located, a doctor of dental surgery or dental medicine.	**LD.01.05.01: Organized Medical Staff Structure** The medical staff must oversee the quality of the care provided by those who have been granted privileges. An MD or DO (or a DDS if allowed by state regulations) is responsible for the medical staff's organization and conduct. The governing body must afford the medical staff the opportunity for participation in governance. The medical staff has the right to be represented at governing body meetings. This must be accomplished by giving the medical staff's representative the right to speak at and attend governing body meetings. Medical staff members are eligible for membership on the board unless this is prohibited by law. **LD.01.07.01: Leadership Competencies and Training** The governing body, senior managers, and medical staff identify the skills required of individual leaders. Medical staff leaders are oriented to the hospital's: • Mission and vision • Safety and quality goals	**03.01.02 Medical Staff Leadership Qualifications** The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by State law of the state in which the hospital is located, a doctor of dental surgery or dental medicine. **03.03.01 Medical Executive Committee** Bylaws require a medical executive committee (MEC) function or process. The medical staff as "committee of the whole" can accomplish this function. Meeting frequency and attendance requirements for the MEC is the responsibility of the hospital. **03.03.02 Medical Executive Committee Scope** The MEC must be empowered to act on behalf of the medical staff when the medical staff cannot meet or in intervals between regular meetings of the medical staff.	**MS.4 Responsibility** The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by State law of the state in which the hospital is located, a doctor of dental surgery or dental medicine.

MEDICAL STAFF LEADERSHIP (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
	• Structure and the decision-making process • Development of the budget and interpretation of financial statements • Population served and any issues related to that population • Individual and interdependent responsibilities and accountabilities of each leadership component as they relate to supporting the mission of the hospital and to providing safe, high-quality care • Applicable laws and regulations **MS.01.01.01: Organized Medical Staff Structure, Accountability** Medical staff bylaws must include the medical staff's structure. This includes defining the officers and clinical leaders of the medical staff.		

COMMENTS/TIPS

The Joint Commission defines a leader as "an individual who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization's governance, management, clinical, and support functions and processes." Included in this definition are medical staff leaders, such as medical staff officers, and clinical leaders, such as department chairs.

REQUIRED COMMITTEES

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
§482.22(b)(2) Standard: Medical Staff Organization and Accountability If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy. CMS requires a utilization review committee but does not require that it be a medical staff committee. Small hospitals can delegate the utilization review function to an outside group if it is impractical to have a staff committee. **§482.30(b) Standard: Composition of Utilization Review Committee** A utilization committee consisting of two or more practitioners must carry out the utilization review function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in §482.12(c)(1).	**MS.02.01.01: MEC** The medical staff must have an executive committee. The medical staff, as a committee of the whole, may serve as the medical executive committee (MEC). Standards require that a MEC be formed. The individual EPs describe the functions, composition, and responsibilities of the MEC and what needs to be documented in medical staff bylaws. The Joint Commission does not attempt to dictate the makeup of the MEC, but it does require that all medical staff members and the hospital CEO are allowed to participate. The medical staff is free to define the structure. It may be composed of elected or appointed department directors, or it may be a body of elected members. Standards assign the following duties to the MEC, which should be included in the medical staff bylaws: • In intervals between medical staff meetings, the MEC acts on behalf of the medical staff. • The MEC has a mechanism for recommending terminations of medical staff membership.	**03.02.05 Required Committees** Required committees are: • Medical executive committee (medical staff as a whole may accomplish this function) • Utilization review committee • Utilization of osteopathic methods and concepts committee (required only if the hospital has 10 or more DOs who admit patients and provide direct patient care)	**MS.5 Executive Committee** If there is a medical staff executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy. The hospital chief executive officer and the nurse executive or their designee(s) attend MEC meetings on an ex-officio basis, either with or without vote.

REQUIRED COMMITTEES (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
	• When there is a question about the ability to perform the privileges granted for a practitioner privileged through the medical staff process, the MEC must request an evaluation of that practitioner. The MEC should evaluate the results of the medical staff performance improvement activities. If these activities identify a problem provider or a provider who is functioning below the acceptable level of care, the MEC must take action. This action should be documented in the minutes of the MEC meeting or in an attached addendum to those minutes. • Makes recommendations to the governing body regarding the structure of the medical staff. • Makes recommendations to the governing body regarding the process for reviewing credentials and delineating privileges.		

COMMENTS/TIPS

Evaluate the structure of your medical staff committees. If you find that there are many hospital staff members and few medical staff members on these committees, consider making this a hospital committee with medical staff representation if the committee is not required by accreditation standards.

MEDICAL STAFF BYLAWS

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
§482.12(a)(3) [The governing body must:] Assure that the medical staff has bylaws. **Interpretive Guidelines §482.12(a)(3)** The governing body must assure that the medical staff has bylaws and that those bylaws comply with State and Federal law and the requirements of the Medicare hospital *Conditions of Participation.* **§482.12(a)(4)** [The governing body must:] Approve medical staff bylaws and other medical staff rules and regulations. **Interpretive Guidelines §482.12(a)(4)** The governing body decides whether or not to approve medical staff bylaws submitted by the medical staff. The medical staff bylaws and any revisions must be approved by the governing body before they are considered effective. **§482.12(a)(6)** [The governing body must:] Ensure the criteria for selection are individual character, competence, training, experience, and judgment.	**MS.01.01.01: Organized Medical Staff Structure, Accountability, and Bylaws** The organized medical staff develops, adopts, and amends bylaws. The process for adoption and amendment cannot be delegated. Proposed changes in bylaws must be submitted to the governing body for action and are not effective until approved. Medical staff bylaws, rules and regulations, and policies can be proposed directly to the governing body. If the medical staff chooses to do this, it should first convey the proposed change to the MEC. The medical staff may choose to delegate authority to make proposals for changes in rules, regulations, or policies to the MEC. When the MEC recommends a change or amendment to rules, regulations, policies, or procedures, the proposed changes must be communicated to the medical staff. (This applies only if the organized medical staff has delegated this authority to the MEC and the governing body has approved the delegation.)	**03.00.00 Medical Staff Organization and Structure** The medical staff operates under bylaws approved by the governing body. **03.01.03 Medical Staff Bylaws** Bylaws must be adopted and enforced by the medical staff in order to carry out its responsibilities. The governing body must approve the bylaws. The bylaws must include the following: **03.01.01 Medical Executive Committee Membership** – The MEC must include medical staff officers and include a hospital administrator, or designee, as an ex-officio participant. **03.01.02 Medical Staff Leadership Qualifications** – Duties are listed for each officer, as well as the process for removal from office in the event of non-performance of the office, and/or malfeasance. **03.01.04 Categories** – The bylaws must describe medical staff categories and the duties and privileges of each category of medical staff (e.g., active,	**MS.7 Medical Staff Bylaws** The medical staff must operate under bylaws and rules and regulations adopted and enforced by the medical staff. Changes to the medical staff bylaws and rules and regulations must be approved by the medical staff and governing body. Bylaws must describe the medical staff organization. They must include a statement of the duties and privileges of each category of medical staff so that acceptable standards are met for providing patient care for all diagnostic, medical, surgical, and rehabilitative services. Medical staff bylaws must include • Mechanisms for corrective action and indications • Qualifications to be met in order for the medical staff to recommend that the governing body appoint the applicant • Time frame for acting on completed applications • Criteria for determining the privileges to be

MEDICAL STAFF BYLAWS (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
Interpretive Guidelines §482.12(a)(6) The governing body must ensure that the medical staff bylaws describe the privileging process to be used by the hospital. The process articulated in the medical staff bylaws, rules, or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to practitioners that considers individual: • Character • Competence • Training • Experience • Judgment The governing body must ensure that the hospital's bylaws governing medical staff membership and granting of privileges applies equally to all practitioners in each professional category of practitioners. **§482.22 *Conditions of Participation:* Medical Staff** The hospital must have an organized medical staff	The medical staff must have a process to manage any conflicts that may happen between the medical staff and the MEC regarding recommendations to adopt or change rules, regulations, or policies and other issues that may occur. Using a mechanism determined by the governing body, medical staff members may communicate to the governing body regarding a rule, regulation, or policy adopted by the MEC or by the organized medical staff. There may be an incident in which a critical change to rules and regulations may be necessary to comply with a law or regulation. In such cases, the MEC can provisionally adopt and the board can provisionally approve these amendments without notifying the medical staff. This authority must be delegated by the voting members of the organized medical staff. If this urgent amendment is required, the MEC must immediately notify the medical staff of the change, and the medical staff must be given the opportunity for retrospective review and comment. If the medical staff and	courtesy, etc.). LIPs and allied health professionals granted medical staff membership must be included in a staff category. All practitioners who provide a medical level of care—such as physicians, dentists, RN first assistants, surgical assistants, anesthesia assistants, CRNAs, midwives, and any other practitioner required to be privileged—must be included in a staff category. **03.01.05 Organization of the Medical Staff** – The organization of the medical staff must be described in the bylaws. **03.01.07 Process for Application and Reapplication and Criteria for Membership** – Bylaws fully describe the criteria and qualifications for privileging physicians, other members of the medical staff, and allied health practitioners; and must include the procedure for applying the criteria. (Can also be included in a credentials procedures manual that is appended to the bylaws.) **03.01.08 History and Physical Requirement** – The medical staff shall adopt and enforce bylaws to carry out its responsibilities.	granted and a procedure for applying the criteria • Mechanism to ensure that those with clinical privileges provide services only within the approved scope of privileges • Mechanism for consideration of automatic suspension of clinical privileges on revocation/restriction of professional license; revocation/suspension/probation of DEA certificate; failure to maintain the required professional liability insurance; and noncompliance with written medical records requirements • Mechanism for immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner's Medicare or Medicaid eligibility • Fair hearing and appeal provisions for adverse actions regarding the appointment, reappointment, suspension, reduction, or revocation of privileges of any individual who has applied for

MEDICAL STAFF BYLAWS (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital. **482.22(c)(5)** [The bylaws must:] Include a requirement that: (i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy. **482.22(c)(5)** [The bylaws must:] Include a requirement that: (ii) An updated examination of the patient, including any changes	MEC are in agreement, the amendment stands. If there is a disagreement, the conflict resolution process must be implemented. The medical staff must comply with and enforce, and the governing body must uphold, the bylaws, polices, and procedures. In some cases, the medical staff may recommend specific action to the governing body. Further, the medical staff may have authority to take action itself in some circumstances. Medical staff bylaws, rules and regulations, and policies must not conflict with the governing body bylaws. In some cases, there may be related details or fine points that, depending on what the medical staff decides, may be contained in the medical staff bylaws or in rules, regulations, or policies. Although authority for adoption of associated details contained in bylaws can't be delegated, the medical staff can delegate the adoption of changes to details contained in rules, regulations, or policies. At a minimum, the	The HFAP standards require that the language from Medicare *Conditions of Participation* §482.22(c)(5)(i), (ii) be included in the bylaws. **03.01.09 Granting of Privileges** – Bylaws must include the criteria used to determine privileges granted and the procedure used for applying the criteria. **03.01.11 Periodic Review** – Bylaws include a mechanism for review at least every two years. **03.01.18 Temporary Privileges** – Bylaws include a provision for granting temporary privileges for applicants with a complete application waiting to be presented to the MEC and the board, for care of specific patient(s), locum tenens, and in emergency and/or disaster. **03.01.23 Definition of a Clinical Emergency** – The medical staff defines what constitutes an emergency. **03.01.19 Code of Ethics** – There must be a code of ethics in the medical staff bylaws that provides for corrective action,	or has been granted clinical privileges • Mechanism for management of corrective or rehabilitative action for medical staff • Requirement for the preparation and maintenance of complete and accurate medical records and policies and procedures for dealing with medical record delinquencies • Requirement that the medical staff have periodic meetings at regular intervals to review and analyze medical records of the patients for adequacy and quality of care • Requirement that a medical history and physical examination (H&P) for each patient shall be done no more than 30 days before or 24 hours after an admission or registration, but prior to surgery or other procedure requiring anesthesia services, and placed in the patient's medical record within 24 hours after admission • Circumstances and criteria under which consultation or management by a

MEDICAL STAFF BYLAWS (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.	following must be delineated in bylaws: • Medical staff structure. • Qualifications for medical staff appointment. • The duties and privileges for each medical staff category (e.g., active, courtesy, etc.). The Joint Commission interprets this to mean "the duties and prerogatives of each category" and not clinical privileges, which are typically delineated on a privilege form. • Requirements for completing and documenting histories and physicals (H&Ps). The patient must receive the H&P no more than 30 days prior to or within 24 hours after registration or inpatient admission, and prior to surgery or a procedure requiring anesthesia. For an H&P that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is required to be completed within 24 hours after registration or inpatient admission, and prior to	a fair hearing mechanism, and physician adherence to the code of ethics prescribed by his or her profession. **03.01.25 Meeting Frequency and Attendance** – Bylaws outline the requirements for meeting frequency, attendance, and quorum requirements. Active staff should attend meetings. Meeting attendance is evaluated on reappointment. **03.01.26 Medical Staff Structure, and 03.01.27 Clinical Department Structure** – Bylaws describe the medical staff structure (departments, services, committees). See the section "Medical Staff Structure and Accountability," earlier in this chapter, for additional requirements. **03.02.05 Required Committees** Required committees are: • Medical executive committee (medical staff as a whole may accomplish this function) • Utilization review committee • Utilization of osteopathic methods and concepts committee (required only	physician or other qualified LIP is required

MEDICAL STAFF BYLAWS (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
	surgery or a procedure requiring anesthesia. • Description of medical staff members eligible to vote. • Medical staff officer positions. • Function, size, and composition of the MEC. If authority is delegated to the MEC to act on behalf of the medical staff, such authority is documented, as is the mechanism for delegation or removal of this authority. • Documentation that the MEC includes physicians and that it may include others if established by the medical staff. • Documentation that the MEC has authority to act on the behalf of the medical staff between meetings. This must be included in the defined responsibilities of the MEC. • Indications for automatic suspension and summary suspension of medical staff membership or clinical privileges, and indications for recommending termination or suspension of medical staff membership and/or termination,	if the hospital has 10 or more DOs who admit patients and provide direct patient care)	

MEDICAL STAFF BYLAWS (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
	suspension, or reduction of clinical privileges. • Processes for credentialing/recredentialing and privileging/reprivileging licensed independent practitioners (LIPs) and other practitioners. • Medical staff appointment and reappointment. • Selecting, electing, and removing MEC members. • Adopting and amending the medical staff bylaws, rules and regulations, and policies. • Fair hearing and appeal of an adverse recommendation, including how hearings and appeals are scheduled and conducted and the composition of the hearing committee. • Selection, election, and removal of medical staff officers. • Automatic and summary suspension of medical staff membership or clinical privileges. • Recommending termination or suspension of medical staff membership and/or termination, suspension, or reduction of clinical privileges.		

MEDICAL STAFF BYLAWS (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
	• If the medical staff is departmentalized, the qualifications, roles, and responsibilities of the department chair must be included. (See the section "Medical Staff Leadership," earlier in this chapter, for a list of the roles and responsibilities of the department chair.) **MS.01.01.03: Bylaws Amendments** This standard prohibits both the medical staff and the hospital board from unilaterally changing the medical staff bylaws or rules and regulations; meaning neither body can make changes without the approval of the other. **MS.06.01.03: Credentialing** Bylaws contain the timeframe for acting on completed applications		

COMMENTS/TIPS

The bylaws, rules and regulations, and policies of the medical staff cannot conflict with the governing body bylaws. Both medical staff and board bylaws may address and agree on the same issues, for example, credentialing and privileging. At times, changes are made in one body's bylaws but not the other's. Review and compare medical staff and governing body bylaws to ensure there are no discrepancies.

See Figure 1.1 at the end of this chapter for a sample chart that can be used to document areas in which like material is addressed. This form is available in the downloadable materials accompanying this book.

MEDICAL STAFF INVOLVEMENT IN ORGANIZATIONAL LEADERSHIP FUNCTIONS

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
§482.12(d) Standard: Institutional Plan and Budget **§482.12(d)(6)** The plan must be reviewed and updated annually. **§482.12(d)(7)** The plan must be prepared: (i) Under the direction of the governing body (ii) By a committee consisting of representatives of the governing body, the administrative staff, and the medical staff of the institution	**LD.01.05.01: Organized Medical Staff Structure** The medical staff must oversee the quality of the care provided by those who have been granted privileges. An MD or DO (or a DDS if allowed by state regulations) is responsible for the medical staff's organization and conduct. **LD.02.04.01: Managing Conflict** Medical staff leaders work with senior managers and the board to develop a process for managing conflict that may occur among leadership groups.	**03.01.24 Quality of Care Accountability.** The medical staff must collaborate with hospital administration and the governing body in regard to institutional budgets, planning, and resource utilization.	**GB.1 Legal Responsibility** Together with the governing body and administrative officials, the medical staff is responsible and accountable for ensuring that: • The organization is in compliance with all applicable laws regarding the health and safety of patients • The organization is licensed by the appropriate state or local authority • The organization establishes criteria that includes aspects of individual character, competence, training, experience, and judgment for the selection of individuals working for the organization, directly or under contract, and/or appointed through the formal medical staff appointment process • Personnel working in the organization are properly licensed or otherwise meet all applicable Federal, State, and local laws

MEDICAL STAFF INVOLVEMENT IN ORGANIZATIONAL LEADERSHIP FUNCTIONS (CONT.)

CMS	THE JOINT COMMISSION	HFAP	DNV-NIAHO
			GB.2 Institutional Plan and Budget The organization must have a budget and plan prepared under the direction of the governing body and by a committee consisting of representatives of the governing body, administrative staff, and medical staff.

COMMENTS/TIPS

CMS regulations and all hospital accreditors require medical staff involvement in hospital budgeting and planning.

Editor's note: A sample form for documenting all required elements of CMS regulations and The Joint Commission standards is included in the appendix and in the downloadable materials accompanying this book. This form can be used to track where in your bylaws the CMS regulations and The Joint Commission standards are addressed, or where to potentially add elements to your bylaws.

FIGURE 1.1: SAMPLE CROSSWALK MEDICAL STAFF AND GOVERNING BOARD BYLAWS, RULES, REGULATIONS, POLICIES, AND PROCEDURES

[HOSPITAL NAME]		
MEDICAL STAFF DOCUMENT	**ISSUE ADDRESSED**	**BOARD DOCUMENT**
[Article V, Section 1.3]	[Medical staff representation on governing body]	[Article II, Section 2.3]

Medical Staff Standards Crosswalk

Kathy Matzka, CPMSM, CPCS

A Quick Reference Guide to The Joint Commission, CMS, HFAP, and DNV Standards

Medical Staff Standards Crosswalk: A Quick Reference Guide to The Joint Commission, CMS, HFAP, and DNV Standards compares medical staff–relevant standards across four accreditation and regulatory bodies: DNV, HFAP, TJC, and CMS. It includes sample tools, forms, and policies to help you meet the goals of the standards no matter which accreditation body you use.

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