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FIFTH EDITION

VERIFY and Comply

A Quick Reference Guide to Credentialing Standards

Carol S. Cairns, CPMSM, CPCS

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HCPro

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ABOUT THE AUTHOR

Carol S. Cairns, CPMSM, CPCS

Carol S. Cairns, CPMSM, CPCS, has participated in the development of the medical staff services profession for more than 40 years. She is the president of PRO-CON, an Illinois consulting firm specializing in credentialing, privileging, medical staff organization operations, and survey preparation. Cairns is a senior consultant and frequent presenter with The Greeley Company; she also serves as an information resource for HCPro, Inc. A recognized expert in the field, Cairns is a frequent presenter at healthcare entities as well as state and national seminars.

Cairns' career in medical staff services began in Joliet, IL, where she coordinated and directed medical staff services for Provena Saint Joseph Medical Center and Silver Cross Hospital.

In 1991, Cairns became clinical faculty for The Joint Commission by collaboratively developing an educational program entitled Credentialing and Privileging Medical Staff and Allied Health Professionals. She served as clinical faculty for this program from 1991 to 2000. For The Joint Commission, Cairns coauthored *The Medical Staff Handbook: A Guide to Joint Commission Standards,* which focuses on the medical staff credentialing and privileging standards, and authored *The LIP's Guide to Credentials Review and Privileging.*

In addition, Cairns has been a faculty member with the National Association Medical Staff Services (NAMSS) since 1990. She has presented at numerous state and national seminars on subjects such as basic and advanced credentialing and privileging, CMS' *Conditions of Participation,* The Joint Commission standards and survey preparation, National Committee on Quality Assurance (NCQA) standards, Healthcare Facilities Accreditation Program Standards, AHP credentialing, core privileging, and meeting management and documentation. In 1995, Cairns coauthored the NAMSS educational program for certification of provider credentialing specialists (CPCS), for which she also currently serves as faculty.

In 1996, NCQA appointed Cairns as a surveyor in its certification program for credentials verification organizations (CVO). She surveyed CVOs for the NCQA and was a clinical faculty member for the NCQA on credentialing and CVO certification until 2006. Cairns also serves as an advisor to healthcare attorneys, including providing expert witness testimony regarding credentialing and privileging processes.

In 2003, Cairns provided input to the American Osteopathic Association 2004 Healthcare Facilities Accreditation Program, relative to the medical staff and allied health professionals credentialing and privileging standards.

In 2005, the Illinois Association Medical Staff Services recognized Cairns by presenting her with the first Distinguished Member award.

HCPro, Inc., books that Cairns has authored include *The FPPE Toolbox: Field-Tested Documents for Credentialing, Competency, and Compliance;* and *Core Privileges for AHPs: A Practical Approach to Developing and Implementing Criteria-Based Privileges.*

ACKNOWLEDGMENTS

In 1968, when I entered the credentialing and privileging world, there were no medical staff offices, medical service professionals, managed care organizations, or provider credentialing specialists. Educational programs for medical staff leaders and credentialing specialists essentially did not exist, and written resources were limited to accreditation or regulatory standards. Verification of an applicant's credentials consisted of confirming his or her licensure, graduation from medical school, and postgraduate training and obtaining "three personal references." Often, the applicant hand-carried these documents into the institution and they were accepted without hesitation!

What has changed? Nearly everything! *Verify and Comply* attests to the importance and complexity of credentialing and privileging processes in today's world. Patients and plan members depend upon us to do credentialing and privileging well. Healthcare organizations (hospitals, managed care organizations, ambulatory care organizations) need for us to do credentialing and privileging well. Accreditors, regulators, and payers expect us to do credentialing and privileging well.

The evolution of the art and science of credentialing and privileging has many contributors across the country and over the decades. Many of us learned our craft from thoughtful leaders. My earliest mentors at (Provena) St. Joseph Medical Center in Joliet, IL, were Sister M. Theresa Ettelbrick, administrator, and Leon P. Gardner, MD, medical director. They were joined by countless dedicated medical staff leaders (officers, department chairs, committee chairs) and senior administrators who struggled to "do the right thing" for our patients, the organization, and the medical community.

Our quest was also a national quest. Fortunately, we sought and found assistance by networking with other medical staff leaders and medical service professionals across the country. Over the years and through the efforts of many visionaries, we have all created and promulgated industry standards and best practices that focus on protecting the patient. Ultimately, we all share the responsibility of safeguarding and improving the patient care we deliver and receive.

It has been an honor and a privilege to learn from, work alongside, and collaborate with some of the healthcare industry's brightest stars. I will be forever grateful for the professional and personal experiences and relationships that have evolved over time and that will last far beyond the life of this edition of *Verify and Comply*.

INTRODUCTION

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 does a surgeon, pediatrician, or family practitioner perform this high-risk procedure.

The procedure is credentialing, an activity that is performed in medical staff offices, provider relations departments, and credentials verification organizations (CVO) across the country. Regardless of the size or type of the organization, credentials specialists, healthcare facilities and physician leadership, managed care organization executives, and governing bodies share the medical and legal responsibilities and accountability to conduct 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 and/or to participate in a managed care plan.

Credentialing regulations

There are federal regulations requiring healthcare organizations to credential and privilege practitioners. The most cited federal regulations in this regard are the Centers for Medicare & Medicaid Services' (CMS) *Conditions of Participation (CoP).* State licensing agencies also have requirements regarding the credentialing process.

Also, there are accrediting bodies who have established nationally recognized standards. The latter category includes The Joint Commission, the National Committee for Quality Assurance (NCQA), the Healthcare Facilities Accreditation Program (HFAP), and Det Norske Veritas (DNV). Additionally, there are a handful of other accrediting organizations, but the vast majority of healthcare organizations and healthcare plans in the United States are regulated and/or accredited by CMS, The Joint Commission, NCQA, HFAP, and/or DNV.

Brief descriptions of each organization

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

- **NCQA:** This organization has established credentialing standards that are applicable to health plans (HP), managed behavioral healthcare organizations (MBHO), new health plans, CVOs, and physician organizations (PO), as well as hospitals.

- **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. Additionally, and more commonly, healthcare organizations are surveyed by accrediting organizations which have been granted deemed status by CMS. The accrediting organizations' standards must comply with CMS' *CoP*s in order to obtain deeming status, and often exceed them.

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

- **HFAP:** This organization accredits hospitals, ambulatory care/surgical facilities, mental health facilities, physical rehabilitation facilities, clinical laboratories, critical access hospitals, and stroke centers. New HFAP standards were published in 2009. This represents the first rewrite of the standards since 2005. The American Osteopathic Association transferred oversight of this accreditation program to the American Osteopathic Information Association.

What this book includes

In the book format, *Verify and Comply: A Quick Reference Guide to Credentialing Standards* is a simple, efficient guide to The Joint Commission, NCQA, CMS, DNV, and HFAP credentialing standards. The guide contains six chapters, divided into two sections:

"Unit 1: Acute Care & Managed Care" contains three chapters and compares and contrasts specific credentialing and privileging elements for three organizations (CMS, The Joint Commission, and NCQA):

- Chapter 1: Initial Appointment/Clinical Privileges/Credentialing
- Chapter 2: Reappointment/Renewal/Reappraisal of Clinical Privileges/Recredentialing (Note: The Joint Commission, CMS, DNV, and HFAP use the term reappointment; The Joint Commission uses the term renewal; CMS, DNV, and HFAP use the term reappraisal; and NCQA uses the term recredentialing)
- Chapter 3: Other Credentialing Aspects (aspects that cover both initial appointment and credentialing and renewal/reappraisal of privileges/reappointment/recredentialing)

"Unit 2: Ambulatory Care" contains three chapters:

- Chapter 4: Initial Appointment/Clinical Privileges
- Chapter 5: Reappointment/Renewal of Clinical Privileges
- Chapter 6: Other Credentialing Aspects (aspects that cover both initial appointment and reappointment/renewal of privileges)

The acute care and managed care chapters (Unit 1) cover the Joint Commission hospital standards for credentialing, contained in the Medical Staff, Leadership, and Human Resources chapters in the 2009 *Comprehensive Accreditation Manual for Hospitals (CAMH).* They also cover the NCQA's credentialing standards for HPs, MBHOs, POs, and CVOs, contained in the Standards and Guidelines for the Accreditation of HPs, Standards and Guidelines for the Accreditation of MBHOs, Standards and Guidelines for Certification of Physician Organizations, and Standards and Guidelines for the Certification of CVOs, for 2009 and 2010.

The ambulatory care chapters (Unit 2) cover The Joint Commission's credentialing standards for ambulatory care organizations, contained in the Human Resources chapter of the 2009 *Standards for Ambulatory Care (SAC).* Readers should note that where The Joint Commission's ambulatory care standards do not specifically address a credentialing aspect, if The Joint Commission's standards for hospitals do address the aspect, then that information is provided.

You can easily identify new or significantly changed standards within *Verify and Comply.* Each of these contains the date in parentheses next to the information; for example, (January 2009) or (July 2009).

How are the sections in this book organized?

Each chapter is organized by the elements (i.e., the heading for each chart) that must be covered to credential each practitioner. The first column in the chart summarizes the Joint Commission standards. The second column in the acute care and managed care sections summarizes the NCQA regulations. Where appropriate, this column indicates differences for each type of organization the NCQA accredits: HPs, MBHOs, and CVOs (CVOs should note that they not only are responsible for standards that apply to CVOs, but also for the standards that apply to their specific managed care clients). The third column summarizes the CMS *CoP* requirements.

Within each column of Unit 1 (acute care and managed care) the verification source and methodology is outlined. This section provides the options available regarding acceptable sources of verification. Thus verification from the listed sources is considered acceptable in meeting regulatory and accreditation standards. In Unit 2 (ambulatory care), the verification source and methodology options are identified in the second column.

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 has prompted many healthcare organizations to develop and maintain a credentialing process that far exceeds The Joint Commission, NCQA, CMS, DNV, and/or HFAP standards. For this reason, *Verify and Comply* 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.

Each section contains a Comments/Tips area where the author provides commentary for readers regarding special considerations to take note of.

Information contained on the CD

In order to expand the information available regarding requirements of additional accreditation organizations, the Fifth Edition of Verify and Comply has also included the standards of DNV and HFAP on the companion CD. The CD includes all of the information in the book (The Joint Commission, NCQA, and CMS) and also presents the standards for DNV and HFAP—all available in electronic format.

Thank you to our guest contributors

Our gratitude is extended to Patrick Horine, executive vice president of accreditation at DNV Healthcare, and Sally Pelletier, CPMSM, CPCS, for their assistance in assuring accuracy of the information included in the book and CD.

Keeping up to date and informed

It is important for readers to stay up to date with the latest accreditation standards and survey information. In addition, we encourage readers to access HCPro's Web site *(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 CD to be a valuable addition 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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UNIT 1

ACUTE CARE & MANAGED CARE

CHAPTER 1

Initial Appointment/ Clinical Privileges/Credentialing

PRACTITIONERS COVERED

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
All licensed independent practitioners (LIP) 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 or physician assistants:** If an advanced practice registered nurse (APRN) or physician assistant (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 and/or supervision,* 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	HPs and MBHOs must have documented credentialing policies and procedures that apply to all licensed practitioners who provide care to the organization's members (a person insured or provided coverage by a health plan) (July 2009). At a minimum, all licensed independent practitioners certified or registered by the state to practice independently and provide care to members are within the scope of the credentialing standards. HPs: The files of the following practitioners will be reviewed: • Psychiatrists or other physicians (MD, DO) • Addiction medicine specialists (July 2009) • Dentists (DDS/DMD) • Podiatrists (DPM) • Chiropractors (DC) • Other behavioral health specialists licensed, certified, or registered by the state to practice independently ***Note:*** *The credentialing requirement applies to those practitioners with an independent relationship with the organization. "Independent relationship" is defined as when the organization selects and directs members to a specific individual or group of practitioners. This would include all practitioners that members can select as a primary care practitioner (PCP).*	The governing body determines, in accordance with state law, 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 (DDS/DMD, DPM, OD, DC). The governing body may also determine other types of practitioners that may be eligible for appointment to the medical staff and/or be granted clinical privileges, such as nurse practitioners, physician assistants, certified registered nurse anesthetists, and midwives. Practitioners do not need to be members of the medical staff in order to be granted privileges. **Non-Physicians:** The CMS Surgical Services standards also address the privileging of non-physicians "performing surgical tasks." The standards delineate practitioners such as dentists, oral

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

PRACTITIONERS COVERED (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
the medical staff executive committee regarding privileges requested. **Direction and/or supervision of the APRN may be through a collaborative or supervisory agreement. A vast majority of PAs by licensure 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 (January 2009) chapter of the *Comprehensive Accreditation Manual for Hospitals* should be consulted for the methodology. These standards require the governing body approve an equivalent process (to the medical staff process) for the credentialing and privileging/reprivileging of physician assistants and advanced practice registered nurses. At a minimum, the equivalent process: • Evaluates the credentials of the applicant* • Evaluates the current competence of the applicant* • Includes documented peer recommendations • Ensures communication with and input from appropriate individuals and committees, including the medical staff executive	It is not necessary to credential practitioners who practice exclusively in the inpatient setting and provide care resulting from the member being directed to a hospital or other inpatient setting. (Examples are pathologists, radiologists, anesthesiologists, neonatologists, emergency room physicians, hospitalists, and telemedicine consultants, as well as practitioners at mammography centers, urgent care centers, and ambulatory behavioral health facilities.) This is also not necessary to credential: • Dentists who provide primary dental care under a dental plan or rider • A practitioner covering for another (e.g., locum tenens) (July 2009) MBHOs: For behavioral health professionals, files for the following disciplines are reviewed: • Psychiatrists or other physicians (MD, DO) • Addiction medicine specialists (July 2009) • Licensed or certified psychologists (MA, PhD) • Licensed or certified clinical social workers (MSW) • Licensed clinical nurse specialists (MSN) or licensed psychiatric nurse practitioners (NP)	surgeons, podiatrists, RN first assistants, nurse practitioners, surgical physician assistants, surgical technicians, etc. "Surgical tasks" are specifically defined within the standards. See the Interpretive Guidelines §482.51 *What constitutes "surgery"?* Tasks such as holding retractors, cutting or tying knots, handling instruments, are not considered performing surgery. However, suturing is considered surgery and thus requires privileging. The CMS also requires a clear delineation of what surgical procedures must be done under supervision and the degree of that supervision (to include whether or not 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.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

PRACTITIONERS COVERED (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
committee, so that informed decisions may be made regarding the applicant's request for privileges **The evaluation process is documented.*	• Other behavioral health specialists licensed, certified, or registered by the state to practice independently (examples of these practitioners would be nurse practitioners, nurse midwives, physician assistants, optometrists, etc.) ***Note:*** *The organization must have policies and procedures for additional practitioner disciplines not previously listed. These policies and procedures are reviewed, but the files reviewed are limited to those disciplines identified (July 2009).* CVOs: The contract with the HP, MBHO, or health delivery organization (e.g., physician hospital organization [PHO] or hospital) would specify the types of individuals to be credentialed.	

COMMENTS/TIPS

Although not required by The Joint Commission standards, the accrediting agency advocates the governing body approve the privileges recommended. By doing so, the organization is in full compliance with the Centers for Medicare & Medicaid Services' *Conditions of Participation (CoP)* regarding privileging practitioners (January 2009).

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

MEDICAL EDUCATION

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
Requires verification from the medical school. Accepted "designated equivalent sources" are: • The American Medical Association (AMA) Physician Masterfile for all United States and Puerto Rico medical school education • The American Osteopathic Association (AOA) Physician Database • The Educational Commission for Foreign Medical Graduates (ECFMG) for foreign medical schools ***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 (January 2009).* ★ **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: 1. Graduation from medical or professional school 2. Residency, as appropriate 3. Board certification Therefore, if a physician is board-certified, verification of board certification suffices. If the practitioner's board certification has expired, then verification of completion of the residency training program is required (July 2009). 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. • American Medical Association (AMA) Physician Masterfile. • American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report (also known as 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.	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 American Medical Association (AMA) Physician Masterfile for all United States and Puerto Rico medical school education** • **The American Osteopathic Association (AOA) Physician Database** • **The Educational Commission for Foreign Medical Graduates (ECFMG) for foreign medical schools**

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

MEDICAL EDUCATION (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	Note: *NCQA does not require verification of fellowship training. Further, verification of fellowship training does not meet the requirement for verification of residency training (July 2009). Verification of fellowship is a best practice from a quality and risk management perspective (July 2009).* If the physician did not complete a residency program, verification is required from one of the following sources: • The medical school. • American Medical Association (AMA) Physician Masterfile. • American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report (also known as AOA Physician Masterfile.)† • The Educational Commission for Foreign Medical Graduates (ECFMG) for international graduates licensed after 1986. • 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. ***Note:*** *NCQA requirements vary for dentists, podiatrists, and chiropractors. See the NCQA HP credentialing standards for specific information.*	

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

MEDICAL EDUCATION (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	MBHO/CVO: Verification for physicians is the same as 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 ★ **Correspondence with medical school** **Documented phone call with medical school** **Form from approved source as specified above**	

COMMENTS/TIPS

† According to the AOA, the document 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.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

POSTGRADUATE TRAINING (E.G., INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
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 American Medical Association (AMA) Physician Masterfile and the American Osteopathic Association (AOA) Physician Database. ***Note:*** *In certain instances, foreign institutions will not or cannot verify training. In that case, 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 who are now practicing in the United States.* ***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 (January 2009).*	HP/CVO: The highest of the three levels of education and training attained must be verified. The three levels are defined as: 1. Graduation from medical or professional school 2. Residency, as appropriate 3. Board certification Therefore, if a physician is board-certified, verification of board certification suffices. If the practitioner's board certification has expired, then verification of completion of the residency training program is required (July 2009). 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. • American Medical Association (AMA) Physician Masterfile. • American Osteopathic Association (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.	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 American Medical Association (AMA) Physician Masterfile for all United States and Puerto Rico medical school education** • **The American Osteopathic Association (AOA) Physician Database**

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

POSTGRADUATE TRAINING (E.G., INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS) (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
★ **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**	***Note:*** *NCQA does not require verification of fellowship training. Further, verification of fellowship training does not meet the requirement for verification of residency training (July 2009). Verification of fellowship is a best practice from a quality and risk management perspective (July 2009).* If the physician did not complete a residency program, verification is required from one of the following sources: • The medical school. • American Medical Association (AMA) Physician Masterfile. • American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report (also known as AOA Physician Masterfile.)† • The Educational Commission for Foreign Medical Graduates (ECFMG) for international graduates licensed after 1986. • 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. ***Note:*** *NCQA requirements vary for dentists, podiatrists, and chiropractors. See the NCQA HP credentialing standards for specific information.*	

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

POSTGRADUATE TRAINING (E.G., INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS) (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	MBHO/CVO: Verification for physicians is the same as 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 ★ **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**	

COMMENTS/TIPS

† According to the AOA, the document 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.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

BOARD CERTIFICATION

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
The Joint Commission standards do not specifically require verification of 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 some manner. In the instance that board certification (or admissibility) 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) and the American Osteopathic Association (AOA)† also are considered equivalent sources. **★ Correspondence or secure electronic verification from specialty board** **★ Documented phone call with specialty board** **The ABMS or services designated by ABMS as an Official Display Agent** **AMA Physician Masterfile Report** **AOIA Official Osteopathic Physician Profile Report (also known as AOA Physician Database)†** ***Note:*** *The AOA advises when verifying AOA board certification, contact the AOIA. Contacting the AOA specialty board results in a referral back to the AOIA directly (*www.doprofiles.org*, July 2009) for response and thus delays verification.*	HP/MBHO/CVO: The NCQA does not require board certification. If the individual is board-certified, verification may be obtained directly from the specialty board or through one of the following: • The American Board of Medical Specialties (ABMS) or services designated by ABMS as an Official Display Agent with a dated certificate of primary source authenticity available (July 2009) • The American Osteopathic Association (AOA) Physician Masterfile • AOIA Official Osteopathic Physician Profile Report† • The American Medical Association (AMA) Physician Masterfile • 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 The ABMS Certified Doctor Verification Program, available through the ABMS Web site, is for consumer reference only and is not an NCQA-recognized source for verification of board certification. Verification time limit: • HP: 180 days • CVO: 120 days	CMS standards do not specifically mention board certification. Nor is this criterion included in the Interpretive Guidelines for evaluation. 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 all of the elements (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. **★ Correspondence or secure electronic verification from specialty board** **★ Documented phone call with specialty board**

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

BOARD CERTIFICATION (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	The 180-/120-day time limitation does apply to this element, regardless of whether the board certification expires. If the certification does expire, the expiration date should be documented. If the board certification does not expire, the "lifetime" certification should be documented. ***Note:*** *NCQA requirements vary for dentists, podiatrists, and chiropractors. See the NCQA credentialing standards for specific information.* ★ **Correspondence or secure electronic verification from specialty board** ★ **Documented phone call with specialty board** **The ABMS or services designated by ABMS as an Official Display Agent** **AMA Physician Masterfile Report** **AOIA Official Osteopathic Physician Profile Report (also known as AOA Physician Database)†** **State licensing body with annual confirmation of primary source verification** ***Note:*** *The AOA advises when verifying AOA board certification, contact the AOIA. Contacting the AOA specialty board results in a referral back to the AOIA directly (*www.doprofiles.org, *July 2009) for response and thus delays verification.*	**The ABMS or services designated by ABMS as an Official Display Agent** **AMA Physician Masterfile Report** **American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report** ***Note:*** *The AOA advises when verifying AOA board certification, contact the AOIA. Contacting the AOA specialty board results in a referral back to the AOIA directly (*www.doprofiles.org, *July 2009) for response and thus delays verification.*

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

BOARD CERTIFICATION (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	MBHO/CVO: For nonphysician 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 **★ Correspondence or secure electronic verification from specialty board** **★ Documented phone call with specialty board** **The ABMS or services designated by ABMS as an Official Display Agent** **AMA Physician Masterfile Report** **AOIA Official Osteopathic Physician Profile Report** **AOA Physician Database†** **State licensing body with annual primary source confirmation**	

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

BOARD CERTIFICATION (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	Note: *The AOA advises contacting the AOIA when verifying AOA board certification, contact the AOIA. Contacting the AOA specialty board results in a referral back to the AOIA directly (*www.doprofiles.org, *July 2009) for response and thus delays verification.*	

COMMENTS/TIPS

† According to the AOA, the document 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.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

CURRENT LICENSURE

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
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). **Applicable meaning the state where the practitioner is requested/granted privileges (January 2009)* Verification of licensure is also required at expiration (January 2007). ★ **Correspondence with licensing board or verification through the state licensing board Internet site, with appropriate documentation** **Documented phone call with licensing board**	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 an Internet site is used for verification, the Web site 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 ★ **Correspondence with licensing board or verification through the state licensing board Internet site, with appropriate documentation** **Documented phone call with licensing board**	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, such verification would be an appropriate practice. ★ **Correspondence with licensing board or verification through the state licensing board Internet site, with appropriate documentation** **Documented phone call with licensing board**

COMMENTS/TIPS

A best practice is documentation of verification of all current and past state licensures (January 2009).

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

SANCTIONS AGAINST LICENSURE

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
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 to accomplish 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 Federation of State Medical Boards (FSMB), and/or the National Practitioner Data Bank (NPDB). ★ **Correspondence with or form from the licensing board or verification through Internet site, with appropriate documentation** **Documented phone call with the licensing board** **Correspondence with or form from the FSMB** **NPDB confirmation** **Application statement**	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 must be queried where the practitioner worked. For physicians, information must be obtained from one of the following: • The state licensing board (or appropriate state agency) • The Federation of State Medical Boards (FSMB) • The National Practitioner Data Bank (NPDB) • The Healthcare Integrity and Protection Databank (HIPDB) For dentists, information must be obtained from one of the following: • The state licensing board • The National Practitioner Data Bank (NPDB) • The Healthcare Integrity and Protection Databank (HIPDB)	CMS is silent regarding evaluation of licensure sanctions. However, the Interpretive Guidelines do reference privileging criteria that consider the individual's character. ★ **Correspondence with or form from the licensing board or verification through Internet site, with appropriate documentation** **Documented phone call with the licensing board** **Correspondence with or form from the FSMB** **NPDB confirmation** **Application statement**

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

SANCTIONS AGAINST LICENSURE (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	For podiatrists, information must be obtained from one of the following: • The state licensing board • The Federation of Podiatric Medical Boards • The Healthcare Integrity and Protection Databank (HIPDB) For chiropractors, information must be obtained from one of the following: • The state licensing board • The Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD) • The Healthcare Integrity and Protection Databank (HIPDB) For nonphysician behavioral healthcare practitioners, information must be obtained from: • The state licensing or certification board • Appropriate state agency • The Healthcare Integrity and Protection Databank (HIPDB) Verification time limit: • HP/MBHO: 180 days • CVO: 120 days	

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

SANCTIONS AGAINST LICENSURE (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	★ **Correspondence with or form from the licensing board or verification through Internet site, with appropriate documentation** **Documented phone call with the licensing board** **Correspondence with or form from the FSMB** **NPDB confirmation** **Application statement** **HIPDB confirmation**	

COMMENTS/TIPS

The AMA Masterfile 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.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

PROFESSIONAL LIABILITY/MALPRACTICE COVERAGE

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
Primary source verification is not required. 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 policy binder that shows dates and amount of coverage. ★ **Correspondence with the carrier** **Documented phone call with the carrier** **Copy of the applicant's current professional liability policy binder**	HP/MBHO/CVO: The applicant provides information on the application (or addendum) regarding the dates and amount of malpractice insurance or the entity may obtain evidence of coverage through a copy of the applicant's current malpractice policy binder (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.* **Exception: HP Medicare Advantage (MA) deeming remains 180 calendar days. CVOs serving these clients must negotiate an appropriate time limit for reporting to the HP.*	Primary source verification is not required. The requirement for professional liability coverage is common in healthcare organizations. Thus verification of coverage is appropriate. Verification of the coverage may come directly from the carrier or in the form of a copy of the applicant's professional liability policy binder that shows the dates and amounts of coverage. ★ **Correspondence with the carrier** **Documented phone call with the carrier** **Copy of the applicant's current professional liability policy binder**

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

PROFESSIONAL LIABILITY/MALPRACTICE COVERAGE (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	★ Correspondence with the carrier **Documented phone call with the carrier** **Copy of the applicant's current malpractice policy binder** **Applicant's attestation**	

COMMENTS/TIPS

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

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

MALPRACTICE HISTORY

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
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 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 National Practitioner Data Bank (NPDB). **★ Application statement and correspondence with the carrier*** **Application statement and NPDB confirmation**	HP/MBHO/CVO: The applicant must provide at least a five-year history of malpractice settlements or judgments on behalf of the practitioner (July 2009). This information must be verified either through written confirmation from the malpractice carrier or through the National Practitioner Data Bank (NPDB). ***Note:*** *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 correspondence with the carrier*** **Application statement and NPDB confirmation**	The CMS standards are silent regarding evaluation of malpractice history. However, CMS does require organizations be compliant with state and federal law. Query of the National Practitioner Data Bank (NPDB) is required of all organizations granting privileges to a practitioner. The NPDB contains information regarding malpractice settlements and judgments. **★ Application statement and correspondence with 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 open claims.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

WORK HISTORY

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
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 of his or her education, training, and experience. ★ **Well-constructed application or complete curriculum vitae** ★ **Verification of information as applicable to requested privileges**	HP/MBHO/CVO: The applicant must provide a minimum of a five-year relevant work history statement on either the application or curriculum vitae, which allows identification of gaps in work history. ***Note:*** *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 nonphysician 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. No verification of the work history statement is required. However, the NCQA does require that 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 file.*	CMS does not use the term "work history." However, the standards and guidelines do require examination of documented experience and supporting reference of competence. Thus, 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**

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

WORK HISTORY (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	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.* **Exception: HP pursuing Medicare Advantage (MA) deeming remains 180 calendar days. CVOs serving these clients must negotiate an appropriate time limit for reporting.* ★ **Well-constructed application or complete curriculum vitae**	

COMMENTS/TIPS

1. Acute care organizations should establish a policy defining a "gap" (i.e., 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 as long as six months. Although NCQA has defined a gap from a standards perspective, organizations may establish a more strict interpretation and policy (January 2009).

2. Over the past two decades there has been increasing numbers of physicians with contracts and/or employment status with healthcare organizations. These physicians may or may not have simultaneous membership and/or privileges. Examples include 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.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

CURRENT COMPETENCE

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
Requires verification of each applicant's professional and clinical performance through contact with appropriate teaching facilities, hospitals, or other relevant organizations. Primary source documentation must contain informed opinions of the applicant's professional performance. (See "Peer Recommendation" later in this chapter.) The Joint Commission suggests parameters for evaluation of proficiency 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 on the following page.* ★ **Correspondence/peer recommendations from primary sources or primary sources/peers complete criteria-based questionnaires that provide an assessment or recommendation** **Documented phone call with primary sources/peers**	Terminology is not used.	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 ★ **Correspondence/peer recommendations from primary sources or primary sources/peers complete criteria-based questionnaires that provide an assessment or recommendation** **Documented phone call with primary sources/peers**

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

CURRENT COMPETENCE (CONT.)

COMMENTS/TIPS

The six General Competencies, adapted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative, as stated in the 2009 *CAMH,* are:

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 team.

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 an understanding of the context and systems in which healthcare is provided, as well as demonstrate an ability to apply this knowledge to improve and optimize care.

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MEDICARE/MEDICAID SANCTIONS

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
Not specifically addressed in the Joint Commission standards. However, the Joint Commission standards specifically require query of the National Practitioner Data Bank (NPDB). Medicare/Medicaid sanctions information is available through that query. **★ The List of Excluded Individuals and Entities, maintained by the Office of Inspector General (OIG) (available via the Internet)** **★ The NPDB** **★ The Federation of State Medical Boards (FSMB)** **The AMA Physician Masterfile**	HP/MBHO/CVO: Verification of the status of Medicare and Medicaid sanctions must be done by querying one of the following: • The National Practitioner Data Bank (NPDB) • Healthcare Integrity and Protection Databank (HIPDB) • The Federation of State Medical Boards (FSMB) • The List of Excluded Individuals and Entities, maintained by the Office of Inspector General (OIG) (available via the Internet) • The Medicare/Medicaid Sanctions and Reinstatement Report (distributed to federally contracting organizations) • The Federal Employees Health Benefits Plan Program department record published by the Office of Personnel Management, OIG • The AMA Physician Masterfile • The state Medicaid agency or intermediary and the Medicare intermediary Verification time limit: • HP/MBHO: 180 days • CVO: 120 days	CMS is silent regarding evaluation of Medicare/Medicaid sanctions. However, the Interpretive Guidelines do reference privileging criteria that consider the individual's character. **★ The List of Excluded Individuals and Entities, maintained by the Office of Inspector General (OIG) (available via the Internet)** **★ The National Practitioner Data Bank (NPDB)** **★ The Federation of State Medical Boards (FSMB)** **The AMA Physician Masterfile**

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

MEDICARE/MEDICAID SANCTIONS (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	★ **The NPDB** ★ **The Federation of State Medical Boards (FSMB)** ★ **The List of Excluded Individuals and Entities, maintained by the Office of Inspector General (OIG) (available via the Internet)** ★ **The Medicare/Medicaid Sanctions and Reinstatement Report (distributed to federally contracting organizations)** **The Federal Employees Health Benefits Plan Program department record published by the Office of Personnel Management, OIG** **The AMA Physician Masterfile** **The state Medicaid agency or intermediary and the Medicare intermediary** **Healthcare Integrity and Protection Databank (HIPDB)**	

COMMENTS/TIPS

The Internet address for the OIG List of Excluded Individuals/Entities (LEIE) is *www.hhs.gov/oig*.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

ONGOING MONITORING OF SANCTIONS, COMPLAINTS, AND ADVERSE EVENTS

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
This element is not specifically addressed in this manner in the Joint Commission standards. 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.)**	HP/MBHO: There are policies and procedures for the ongoing monitoring of Medicare and Medicaid sanctions and sanctions or limitations on licensure. 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"). 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 (July 2009). If the reporting entity does not release sanction reports, the organization must query on affected practitioners 12–18 months after the last credentialing cycle (July 2009). The organization also routinely monitors (at least every six months) and evaluates (July 2009): • Practitioner complaints from members	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.)**

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

ONGOING MONITORING OF SANCTIONS, COMPLAINTS, AND ADVERSE EVENTS (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	• Information from identified adverse events (i.e., patient injury) The organization acts on important quality and safety issues as they are identified and as appropriate. 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 (July 2009). There are also policies and procedures for the ongoing monitoring of practitioner sanctions (Medicare and Medicaid sanctions and licensure sanctions) and reporting obligations. The CVO regularly obtains and reviews documentation on sanctions and licensing limitations and agrees or 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 (July 2009). If the reporting entity does not release sanction reports the organization must	

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

ONGOING MONITORING OF SANCTIONS, COMPLAINTS, AND ADVERSE EVENTS (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	query on affected practitioners 12–18 months after the last credentialing cycle (July 2009). Upon discovery or notification,* the CVO must notify appropriate client organizations of: • 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 is stated in each element (e.g., Medicare/Medicaid sanctions, licensure sanctions, etc.)** **★ Methodologies collect and review information regarding practitioner complaints and adverse events (July 2009)** **★ Internal policies and procedures should define the sources and the methodology of documenting, reviewing, and taking action**	

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

FEDERAL DRUG ENFORCEMENT AGENCY (DEA) CERTIFICATE OR STATE CONTROLLED DANGEROUS SUBSTANCES (CDS) CERTIFICATE

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
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 National Practitioner Data Bank, National Technical Information Service, AMA Masterfile, or AOIA Official Osteopathic Physician Profile Report. **★ Verification from primary source or designated equivalent** **Copy of certificates**	HP/MBHO/CVO: The organization verifies a DEA or CDS certificate in each state where the individual provides care to members (July 2009). 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 Masterfile • Confirmation through the state pharmaceutical licensing agency, where applicable ***Note:*** *DEA and CDS certificates are not applicable to chiropractors, and CDS certificates are not applicable to dentists.* The 180-/120-day time limitation does not apply to this element. The DEA or CDS certificate must be current at the time of action by the credentialing committee or transmittal by the CVO. **★ Verification from primary source or designated equivalent** **Copy of certificates**	The CMS regulations do not address this element. However, verification of DEA and state CDS certificates would be appropriate. Verification sources could be: • 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, AMA Masterfile, or AOIA Official Osteopathic Physician Profile Report **★ Verification from primary source or designated equivalent** **Copy of certificates**

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

PHYSICAL ABILITY TO PERFORM CLINICAL PRIVILEGES REQUESTED (HEALTH STATUS)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
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 postgraduate training program, chief of service, or chief of staff at another hospital at which the applicant holds privileges or by a currently licensed physician approved by the organized medical staff. In instances of doubt regarding the applicant's ability to perform the requested privileges, an evaluation by an external and/or internal source may be required. Such a request would come from the organized medical staff. **Physical** **Documented confirmation of the applicant's statement**	HP/MBHO/CVO: 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—with or without accommodation—and attesting to the lack of present illegal drug use. 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.* **Exception: HP/PPO pursuing Medicare Advantage (MA) deeming remains 180 calendar days. CVOs serving these clients must negotiate an appropriate time limit for reporting to the entity.* **Documented confirmation of the applicant's statement** **Application statement**	The current version of the Medical Staff section of the *CoP* 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*, 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. **Physical** **Documented confirmation of the applicant's statement**

COMMENTS/TIPS

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?" A best practice would be to construct a professional reference questionnaire that includes a specific query regarding the applicant's ability to perform the requested privileges.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

MEDICAL STAFF MEMBERSHIP

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
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 and/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 who is knowledgeable about the practitioner's professional performance.	HP/MBHO/CVO: The application includes a current, signed, and dated attestation statement from the applicant regarding his or her history 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. The 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.* **Exception: HP Medicare Advantage (MA) deeming remains 180 calendar days. CVOs serving these clients must negotiate an appropriate time limit for reporting to the entity.*	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 and/or privileges on any medical staff and subsequently verifying this information is a best practice. ★ **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)** **Application statement** **See Comment #3.*

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

MEDICAL STAFF MEMBERSHIP (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
★ **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)** **Application statement** **See Comment #3.*	★ **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)** **Application statement** **See Comment #3.*	

COMMENTS/TIPS

1. The credentialing industry makes a distinction between medical staff membership and clinical privileges. Legal opinions and the Joint Commission 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 (January 2009).

3. In the past few decades, a standard best practice has been to contact all previous healthcare organizations where the practitioner had membership and/or privileges. The increasing number of employed and/or 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 facilty.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

CLINICAL PRIVILEGES HISTORY

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
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.	HP/MBHO/CVO: The application includes a current signed and dated attestation statement from the applicant regarding his or her history of limitation or loss of clinical privileges or other disciplinary activity at all facilities where the individual has held or holds privileges. The 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.* **Exception: HP Medicare Advantage (MA) deeming remains 180 calendar days. CVOs serving these clients must negotiate an appropriate time limit for reporting to the entity.*	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 information related to past and current membership and/or privileges on any medical staff and subsequently verifying this information is a best practice. ★ **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)** **Application statement** **See Comment #3.*

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

CLINICAL PRIVILEGES HISTORY (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
★ **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)** **Application statement** **See Comment #3.*	★ **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)** **Application statement** **See Comment #3.*	

COMMENTS/TIPS

1. The credentialing industry makes a distinction between clinical privileges and medical staff membership. Legal opinions and the Joint Commission 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.

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 (January 2009).

3. In the past few decades, a standard best practice has been to contact all previous healthcare organizations where the practitioner had membership and/or privileges. The increasing number of employed and/or 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 facilty.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

CLINICAL PRIVILEGING SYSTEM/INITIAL GRANTING OF CLINICAL PRIVILEGES

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
The organized medical staff is responsible for planning and implementing a privileging process. 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. At the time of initial application, the practitioner must request specific clinical privileges based upon his or her licensure and/or certification (as appropriate), education, relevant training, experience, current competence,	The NCQA does not require practitioners to have clinical privileges at an acute care organization.	The governing body ensure 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. Consideration is given to: • 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. Privileges are not granted for tasks/procedures/activities that are not conducted within the hospital—regardless of the practitioner's ability to perform them.

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CLINICAL PRIVILEGING SYSTEM/INITIAL GRANTING OF CLINICAL PRIVILEGES (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
and physical ability to perform the requested privileges. Each of these elements is individually and separately defined in this section. Peer and/or 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 determines to what extent the practitioner's request for clinical privileges will be recommended/granted. ***Note:*** *Prior to January 2007, The Joint Commission used the term "setting-specific" privileging. The Joint Commission deleted this term but still 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 ability to support the requested privilege. The needed resources are to be currently available or available within a specified time frame. Further, the organization consistently determines the resources needed for each requested privilege (i.e., not all procedures,		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. The Medical Staff section of the *CoP* 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

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CLINICAL PRIVILEGING SYSTEM/INITIAL GRANTING OF CLINICAL PRIVILEGES (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
treatments, and services can or should be performed or provided in all facilities and/or 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. ★ **Prescribed privilege delineation forms and associated criteria**		privileges or whose surgical privileges have been restricted must also be retained in these areas/locations. ★ **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 the Joint Commission 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.

The second requirement pertains to the initial request for privileges and to a practitioner who already has been granted privileges and is seeking additional privileges.

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NATIONAL PRACTITIONER DATA BANK (NPDB)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
Query of the NPDB is required for initial granting of privileges. Query also is required if the 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 confirmation**	HP/MBHO/CVO: The NCQA does not require a separate query of the NPDB. However, query of the NPDB satisfies some NCQA requirements for physicians and dentists (i.e., sanctions or limitations on licensure, Medicare and Medicaid sanctions, and/or malpractice history). A practitioner self-query may not be used to satisfy these elements. ***Note:*** *The 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 confirmation**	Query of the NPDB is not addressed in the *CoP*. However, CMS does require organizations to be compliant with state and federal law. Federal law requires all organizations granting clinical privileges to query the NPDB. However, 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 and/or federal laws or regulation report these constraints to the appropriate state and federal authorities, registries, and/or databases, such as the NPDB. **NPDB confirmation**

COMMENTS/TIPS

The Health Care Quality Improvement Act of 1986 established the NPDB, thus 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, advanced practice nurses, physician assistants, 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.

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HISTORY OF FELONY CONVICTIONS

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
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. **★ 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** ***Note:*** *Some states require healthcare organizations to conduct criminal background checks through appropriate state agencies. Some organizations are voluntarily exercising this credentialing option, even if their states do not require them to do so. This verification is increasingly more common—especially in organizations that are required by the state to do so for employees.*	HP/MBHO/CVO: The application requires a statement from the applicant regarding his or her history of felony convictions. 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.* **Exception: HP pursuing Medicare Advantage (MA) deeming remains 180 calendar days. CVOs serving these clients must negotiate an appropriate time limit for reporting to the entity.* **★ 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** ***Note:*** *Some states require healthcare organizations to conduct criminal background checks through appropriate state*	CMS does not mention evaluation or verification of history of felony convictions. **★ 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** ***Note:*** *Some states require healthcare organizations to conduct criminal background checks through appropriate state agencies. Some organizations are voluntarily exercising this credentialing option, even if their states do not require them to do so. This verification is increasingly more common—especially in organizations that are required by the state to do so for employees.*

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

HISTORY OF FELONY CONVICTIONS (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	agencies. Some organizations are voluntarily exercising this credentialing option, even if their states do not require them to do so. This verification is increasingly more common—especially in organizations that are required by the state to do so for employees.	

COMMENTS/TIPS

In the experience of this author, the evaluation of an applicant's criminal background is the fastest-growing credential verification of the past 30-plus years. This is a common employment practice in many businesses and industries and has become a standard verification practice in many organizations. Therefore, organizations should give serious thought to including this step in their credentialing process.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

IDENTITY

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
The credentialing process includes a mechanism to ensure that the applicant is the same person as 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) ★ **One of the following is viewed:** • **A valid picture identification issued by a state or federal agency (e.g., a driver's license or passport)** • **A current picture hospital ID card** ***Note:*** *A process to accomplish this could be for an agent of the organization would view the document and the individual. A copy of the document would be made. The agent would attest to the process and identification by signing/initialing and dating the copied document.*	Terminology is not used.	Terminology is 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.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

ATTESTATION STATEMENT

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
Terminology is not used.	HP/MBHO/CVO: The applicant must provide a current, signed attestation statement regarding the correctness and completeness of his or her application. 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.* **Exception: HP pursuing Medicare Advantage (MA) deeming remains 180 calendar days. CVOs serving these clients must negotiate an appropriate time limit for reporting to the entity.* ★ **Application statement**	Terminology is not used.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

AGREEMENTS/CONSENTS/RELEASES

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
Terminology is not used. ***Note:*** *Prior to January 2004, The Joint Commission required that the applicant must:* • *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 to be a best practice. ★ **A well-constructed, comprehensive, legally binding document signed by the applicant**	Terminology is not used.	Terminology is not used.

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 of civil liability if the processes are performed in good faith.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

PEER RECOMMENDATION

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
There must be a peer recommendation 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 individual's current: • Medical/clinical knowledge • Technical and clinical skills • Clinical judgment • Interpersonal skills • Communication skills • Professionalism ★ **Correspondence from a peer, or a peer completes a criteria-based questionnaire that provides an assessment or recommendation** ★ **A written peer evaluation of practitioner-specific data collected from various sources to validate current competence** **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 and/or specialties or may designate separate peer review bodies for various disciplines (e.g., physicians, dentists, psychologists). For further information on the approval process and the medical director's role, see "Approval Process/Expedited Approval Process" later in this chapter. CVO: Not applicable ★ **Credentialing committee minutes** ★ **Correspondence from a peer, or a peer completes a criteria-based questionnaire that provides an assessment or recommendation**	The medical staff must have a mechanism to examine supporting references of competence. The standards do not define the qualifications of the references. ★ **Correspondence from a peer, or a peer completes a criteria-based questionnaire that provides an assessment or recommendation** **Documented phone call with a peer**

COMMENTS/TIPS

As Joint Commission-accredited organizations construct peer evaluation forms, it is suggested that the six General Competencies be evaluated for inclusion, as appropriate. See "Current Competence" earlier in this chapter. Please refer to the resources section for a sample professional reference questionnaire, which incorporates the peer recommendation requirements of The Joint Commission.

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SITE VISIT

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
Terminology is 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 through the organized medical staff.* ★ **Evidence of privileging process as appropriate and applicable**	HP: The organization establishes office site standards to include medical/treatment record keeping and performance standards and thresholds. Criteria include: • Physical accessibility • Physical appearance • Adequacy of waiting and examination rooms • Appointment availability • Adequacy of treatment record-keeping practices The organization monitors and investigates member complaints and establishes a threshold number of complaints that would trigger a site visit (also considering the severity of an issue). Site visits must be done within 60 days of a site reaching the organization's established thresholds for issues regarding physical accessibility and appearance, and adequacy of waiting and examination room space. Actions are taken to improve offices not meeting the standards expected. Improvements are evaluated every six months until standards are met and documented through a follow-up visit and full assessment of the initial complaint to demonstrate performance as expected.	Terminology is not used.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

SITE VISIT (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
	A standardized site survey form incorporating the previously stated criteria is utilized. The NCQA does not require "clinical" personnel to conduct the site survey, but does require site surveyors to be trained and meet established qualifications (July 2009). CVO: The NCQA CVO standards do not include requirements for site visits. If a CVO offers this service, the CVO would need to comply with the requirements that pertain to the particular client. ★ **Specified policy and applicable site-survey forms to include medical treatment recordkeeping**	

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

TEMPORARY PRIVILEGES/PROVISIONAL CREDENTIALING

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
Temporary privileges may be granted for a limited period of time for only two circumstances: • To fulfill an important patient care, treatment, and service need • When a new applicant with a complete application who raises no concerns is awaiting a recommendation from the medical executive committee (MEC) 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 (see Comments/Tips section for more information). The temporary privileges for patient need are time-limited as specified by the medical staff bylaws, policies/procedures, or regulations. Under the second circumstance (a new applicant without identified concerns awaiting a recommendation from the MEC and approval of the governing body), there must be evidence of verification of: • Current licensure • Relevant training or experience • Current competence	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: • 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 or HIPDB query results are obtained within the past 180 days • There is a current, signed application, with attestation within the past 365 days (exception: HP Medicare Advantage deeming status requires 180 days) • The credentialing committee or medical director considers the preceding information as it provisionally credentials the applicant • The provisional period is granted for no longer than 60 days CVO: Not applicable	Terminology is not used; concept 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.* CMS does not recognize a shortened process for privileging except for "emergency" situations such as a national disaster. Thus, temporary privileging or expedited privileging is not acceptable if the process is not in compliance with the CMS standards related to privileging.

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

TEMPORARY PRIVILEGES/PROVISIONAL CREDENTIALING (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
• Ability to perform the privileges requested • Other parameters outlined within the medical staff bylaws • NPDB query and evaluation of outcome • A complete application • No current or previously successful challenge 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 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. Furthermore, all temporary privileges are granted upon the recommendation of medical staff president or authorized designee.	**★ 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**	

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TEMPORARY PRIVILEGES/PROVISIONAL CREDENTIALING (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
★ **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** ★ **Form, with appropriate signatures, that documents the granting of temporary privileges** **Appropriate documentation in applicant's file**		

COMMENTS/TIPS

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.

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APPROVAL PROCESS/EXPEDITED APPROVAL PROCESS

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
Approval process: The governing body or delegated governing body committee has final authority to grant, renew, or deny privileges (January 2009). The governing body bases decisions regarding membership and privileges for the individual practitioner or recommendations from the medical executive committee (January 2009). Processes are outlined in the medical staff bylaws, rules and regulations, and medical staff and hospital policies. ***Note:*** *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. 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.* **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 and clinical privileges.	HP/MBHO: The organization designates a credentialing committee to make recommendations regarding credentialing decisions. 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. The practitioner may not provide care to members prior to the decision of the credentialing committee. Exception: See "Temporary Privileges/Provisional Credentialing" earlier in this chapter. ***Note:*** *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 as the decision date.* CVO: Not applicable	The governing body determines whether to grant, deny, revise, or limit specified privileges, including medical staff membership, after considering the recommendation of the medical staff. 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**

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APPROVAL PROCESS/EXPEDITED APPROVAL PROCESS (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
The organized medical staff must first develop criteria for an expedited process. In order 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 there is: • An incomplete application • A recommendation from the medical staff executive committee that is adverse to the candidate or contains limitations on the appointment and/or privileges In addition, the candidate is generally not eligible for an expedited process if there is: • 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 • An unusual pattern or excessive number of professional liability actions resulting in final judgment against the applicant	★ **Approval process is defined in credentialing committee policies and procedures**	

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

APPROVAL PROCESS/EXPEDITED APPROVAL PROCESS (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
★ **Approval process is defined in medical staff bylaws* and/or related documents** **At the time of this publication, The Joint Commission has interpreted "bylaws" to include bylaws and "related medical staff documents (i.e., policies and procedures, rules, and regulations). Several iterations of standards language have been proposed and published. A final decision date is expected in late 2009.*		

COMMENTS/TIPS

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

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DECISION NOTIFICATION

The Joint Commission (Hospitals)	NCQA Requirement (HP/MBHO/CVO)	CMS
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 outlined in medical staff bylaws* and/or related documents** **At the time of this publication, The Joint Commission has interpreted "bylaws" to include bylaws and "related medical staff documents" (i.e., policies and procedures, rules, and regulations). Several iterations of standards language have been proposed and published. A final decision is expected in late 2009.*	The organization has policies and procedures outlining the process to ensure that practitioners are notified of the initial credentialing decision within 60 calendar days. Also see "Hearing/Appeal Process" later in this chapter. CVO: Not applicable ★ **Process outlined in policies and procedures**	Standards are silent on this issue. CMS requires the medical staff bylaws to describe the privileging process. Thus, practitioner notification would be contained within the described process. ★ **Process outlined in medical staff bylaws**

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HEARING/APPEAL PROCESS

The Joint Commission (Hospitals)	NCQA Requirement (HP/MBHO/CVO)	CMS
The medical staff bylaws and related documents outline fair hearing and appellate review mechanisms for medical staff members and other individuals holding clinical privileges. At a minimum, the hearing and appeal process provides 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 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. ***Note:*** *The Joint Commission standards do not require that the hearing and appellate review mechanisms for initial applicants be the same as for existing staff members and those with clinical privileges. Nor does The Joint Commission require the same rights be afforded those applying for staff membership versus those applying for clinical privileges.*	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 and state licensing bodies. 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. The applicant has a right to be informed of the application status (upon request) and of the 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 (July 2009). Policies and procedures also describe the procedures for reporting to authorities (e.g., state licensing agencies,	Standards are silent on the provision of hearing and/or appeal. CMS requires 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. ★ **Process as outlined in medical staff bylaws**

Bold text = Verification source and methodology. ★ = "Best practice" that meets or exceeds accreditation standards.

HEARING/APPEAL PROCESS (CONT.)

The Joint Commission (Hospitals)	NCQA (HP/MBHO/CVO)	CMS
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 nonreturn, or situations prompting automatic suspensions, such as a loss of license, etc.* ★ **Process outlined in medical staff bylaws* and/or related documents** **At the time of this publication, The Joint Commission has interpreted "bylaws" to include bylaws and "related medical staff documents (i.e., policies and procedures, rules, and regulations). Several iterations of standards language have been proposed and published. A final decision is expected in late 2009.*	NPDB). See Chapter 3, Notification to Authorities. CVO: Not applicable ★ **Process as outlined in policies and procedures**	

COMMENTS/TIPS

The Health Care Quality Improvement Act of 1986 (HCQIA) and the National Practitioner Data Bank reporting mechanisms have been cited by The Joint Commission and NCQA as a benchmark for policy and procedure development. In general, healthcare attorneys advocate compliance with the multiple aspects of the act.

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LENGTH OF INITIAL APPOINTMENT/CREDENTIALING/CLINICAL PRIVILEGES

The Joint Commission (Hospitals)	NCQA Requirement (HP/MBHO/CVO)	CMS
May not exceed two years.	HP/MBHO/CVO: The initial credentialing period may be for up to 36 months. The 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.* In these instances, the organization must verify licensure before the practitioner renders care. Further, the recredentialing process must be completed within 60 days of the practitioner's resumption of practice. This exception does not apply to terminated contracts or breaks in service of more than 30 calendar days. ***Note:*** *Organizations also must observe state requirements. Some states permit no more than two years between credentialing decisions.*	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.

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CONTINUING MEDICAL EDUCATION (CME)

The Joint Commission (Hospitals)	NCQA Requirement (HP/MBHO/CVO)	CMS
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.* ★ **Copies of certificates of attendance** **Documentation by the applicant** **Computer listing of CMEs at organization**	HP/MBHO/CVO: Terminology is not used.	Not addressed related to initial appointment and/or privileges.

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TIME FRAME FOR COMPLETION OF VERIFICATION/APPROVAL PROCESS

The Joint Commission (Hospitals)	NCQA Requirement (HP/MBHO/CVO)	CMS
The medical staff bylaws* 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. **Process outlined in medical staff bylaws* and/or related documents** **At the time of this publication, The Joint Commission has interpreted "bylaws" to include bylaws and "related medical staff documents (i.e., policies and procedures, rules, and regulations). Several iterations of standards language have been proposed and published. A final decision is expected in late 2009.*	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. ***Note:*** *NCQA uses the date of the official document (date on application letter, report), not the date of receipt, to assess compliance with this requirement.* **Process outlined in policies and procedures**	CMS requires the medical staff bylaws to 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 outlined in medical staff bylaws**

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