



• MODULE 5 •
CREDENTIALING AND PRIVILEGING

5



Pennsylvania
MEDICAL SOCIETY®

module 5

CREDENTIALING AND PRIVILEGING

module 1: Values, Trust, Conduct

module 2: Assessment of Current Medical Staff Structure and
Restructuring for the Future

module 3: Engaging Physicians and Enhancing Professional Satisfaction

module 4: Communication

module 5: Credentialing and Privileging

Introduction	page 3
Pop Quiz	page 5
Gap Analysis	page 9
Credentials Committee Members Reference Guide	page 12
NPDB Querying and Reporting Requirements	page 15
Effective Privileging	page 20
Employed Physician Oversight and Files	page 21

Introduction

The purpose of this module is to explore current credentialing activities as they relate to the organized Medical Staff. Several entities credential on physicians, including health and professional liability insurers, outpatient care centers, surgery centers, but for this module, we will be looking exclusively at the requirements of Medical Staff credentialing.

Credentialing is simply the activity involved in verifying the credentials of a physician. This includes education and training, board certification if applicable, professional licensure, DEA, malpractice and work history, malpractice coverage, professional recommendations, clinical experience and other elements as determined by the Medical Staff Bylaws.

Clinical performance of Medical Staff members must be evaluated utilizing prior and current experience, clinical results and utilization practice patterns, documenting a continuing ability to provide medical services at an acceptable level of quality and efficiency and consistent with available resources, and demonstrated professional expertise.

One of the most frequently heard complaints from physicians and their staffs is the length of time it takes to become credentialed to join a medical staff. We will look at possible reasons for delays, as well as ways that could reduce the time off of the process.

Credentialing is regulated by accrediting bodies, state law, and CMS regulations. The Joint Commission (TJC), Det Norske Veritas (DNV), CMS, the National Committee for Quality Assurance (NCQA) and Healthcare Facilities Association Program (HFAP) most often affect hospital medical staff credentialing and accreditation. We will review the general requirements of these bodies as they pertain to credentialing requirements. In addition, we will look at the PA Code requirements for medical staff credentialing and how to remain compliant while streamlining the process.

The purpose of credentialing physicians and other health care providers is to determine that the physician is adequately trained, licensed and

experienced to provide high quality patient care with safety and effectiveness. Credentialing as a formal process originated from the identification of fraudulent physicians (untrained physicians who passed themselves off as doctors), as well as physicians who were dangerous, incompetent or performing procedures and treatments above their skill set. Credentialing and privileging are performed to protect both the patients and the health systems. Quality credentialing and privileging is the first step in ensuring quality patient care.

Credentialing involves the collection and verification of documents related to education and training, licensure and clinical experience and competency. These are then evaluated to determine if the physician meets the criteria established in the Medical Staff Bylaws to hold membership and/or privileges on the Medical Staff.

Privileging is determining what clinical privileges physicians may competently perform within the hospital setting based on their education, training, experience and outcome results.

Credentialing documents traditionally collected and verified (additional information may be required based on state law, hospital policy, insurance carrier requirements, or other needs):

- Education
- Residency training
- Board certification
- Licensure
- DEA
- Malpractice coverage
- Liability claims history

- Work history
- State and federal sanctions
- Peer recommendations

The applicant is responsible for providing the Medical Staff office with an application and the required documents needed for credentialing and privileging. The applicant has the burden of producing adequate information for a proper evaluation of his/her experience, training, current competence, utilization practice patterns, ability to work cooperatively with others, current health status, malpractice history, and any other relevant information required to make an informed decision regarding appointment to the medical staff. These requirements and expectations should be clearly stated in your Medical Staff Bylaws.

Each clinical department should have a written list of all privileges available within the department. This list is then given to applicants to select the privileges that they would like to be approved for. They must be able to provide supporting documentation that they have the training and experience to safely and competently perform each item selected. They may do this by providing documentation from residency programs, other hospitals where they hold privileges, or past employment. It is then up to the department chair to determine if the documentation provided supports the requested privileges.

General competencies as defined by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) are being used by most hospitals today as additional elements in assessing the physician's professional performance. These competencies are:

- Patient care
- Medical/clinical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills

- Professionalism
- Systems-based practice

Evaluation of these competencies provides assurance that all information relevant to the provider's ability to provide high quality patient care is assessed and used in determining medical staff membership and privileges. It is important to make sure that your credentialing process provides documentation to address each of these competencies.

The Credentials Committee is responsible for reviewing the application, the supporting documentation, the recommendations from the department heads and/or division heads, and any other relevant information available to it. The Committee is responsible for making a recommendation regarding membership and privileges, or the continuation of such, to the Medical Executive Committee.

The Medical Executive Committee will review the reports and recommendations from the Credentials Committee. The report of each individual or group required to act on an application should include recommendations as to approval or denial of, and any special limitations on staff appointment, category of appointment, and clinical privileges. The MEC then forwards its recommendations to the governing body for final action.

It should be noted that the credentialing activities performed by health insurers generally differ from those performed by hospitals. The requirements of the hospital accreditation agencies differ from those of accrediting health insurers, and should generally take less time for completion and require less documentation provided for credentialing activities. In addition, health insurers do not engage in privileging.



NAME _____

DATE _____

Credentialing and Privileging Requirements

1. Under current Pennsylvania law, physician assistants may not be members of the medical staff.

ANSWER: _____

2. Under current Pennsylvania law, physician assistants may not be granted clinical privileges by the medical staff.

ANSWER: _____

3. Provisional staff appointment status is optional for new members of medical staff. If a medical staff chooses to make provisional appointments, it must be outlined in the bylaws.

ANSWER: _____

4. In order to receive favorable recommendation for appointment or reappointment, members of the medical staff must always act in a manner consistent with the highest ethical standards and levels of professional competence.

ANSWER: _____

5. Under current Pennsylvania law, every hospital must have an active medical staff.

ANSWER: _____

6. Initial provisional staff appointment is only required for members of the active medical staff. Other staff categories (i.e., associate, courtesy) are not required to have a provisional period.

ANSWER: _____

(Continued on page 6)



NAME _____

DATE _____

Credentialing and Privileging Requirements

continued

7. Under current Pennsylvania law, smaller hospitals, if they choose, may forgo having a formal Credentials Committee, and allow the Medical Executive Committee to perform those activities.

ANSWER: _____

8. The only actual Joint Commission requirement for medical staff membership is board certification.

ANSWER: _____

9. Per The Joint Commission, ongoing professional practice evaluation includes collecting data on requests for tests and procedures.

ANSWER: _____

10. Per The Joint Commission, the Medical Executive Committee has the authority to make all final membership and/or privileging decisions related to the medical staff.

ANSWER: _____

(See answers and citations on following pages)

Pop Quiz Answers: Credentialing and Privileging Requirements

1. True
2. False

28 PA Code § 107.2

The medical staff shall be limited to physicians and dentists who have made application in accordance with the bylaws, rules, and regulations of the medical staff and with the bylaws of the hospital. Each member of the medical staff shall be qualified for membership and the exercise of clinical privileges granted to him. The medical staff must define in bylaws the requirements for admission to staff membership and for the delineation and retention of clinical privileges. The governing body of the hospital, after considering the recommendations of the medical staff, may grant clinical privileges to other qualified, licenses practitioners in accordance with their training, experience, and demonstrated competence and judgment. Members of the medical staff and those granted clinical privileges shall currently hold licenses to practice in this Commonwealth.
3. False

28 PA Code §107.4 (d)

Applicants approved for membership on the active, associate, or courtesy staff shall serve an initial provisional staff appointment. During this appointment, they must be assigned to departments/services where their clinical competence and their ethical and moral conduct may be observed by a designated member of the active medical staff until such time as the probationary requirements established by the medical staff have been fulfilled.
4. True

28 PA Code §107.3 (a)

In order to receive favorable recommendation for appointment or reappointment, members of the medical staff must always act in a manner consistent with the highest ethical standards and levels or professional competence.
5. True

28 PA Code §107.4 (a)

Every hospital shall have an active medical staff to deliver the preponderance of medical services within the hospital. The active medical staff shall be responsible for its own organization and administration and should perform all significant duties pertaining thereto. Every member of the active medical staff shall be eligible to vote at staff meetings and to hold office.
6. False

28 PA Code §107.4 (d)

Applicants approved for membership on the active, associate, or courtesy staff shall serve an initial provisional staff appointment. During this appointment, they must be assigned to departments/services where their clinical competence and their ethical and moral conduct may be observed by a designated member of the active medical staff until such time as the probationary requirements established by the medical staff have been fulfilled.
7. False

28 PA Code §107.26 (b)(1)

(b.) The following additional committees are mandatory:

(1) A credentials committee which shall make recommendations for staff appointments and reappointments, promotions, demotions, and clinical privileges. The credentials committee shall be advisory and investigative and shall report to the executive committee of the medical staff.

8. False

TJC MS.06.01.07(2)

The hospital, based on recommendations of the organized medical staff and approved by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a requested privilege. *Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.*

9. True

TJC MS.08.01.03

The ongoing professional practice evaluation allows the organization to identify professional practice trends that impact on quality of care and

patient safety. Such identification may require intervention by the organized medical staff. The criteria used in the ongoing professional practice evaluation may include the following: Requests for tests and procedures.

10. False

TJC MS.06.01.07 (8)

The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges.

module 5

CREDENTIALING AND PRIVILEGING

Gap Analysis

QUESTION	ANALYSIS	DESIRED OUTCOME	ACTION OR FOLLOW UP
Are your credentialing requirements regularly reviewed for relevance? For example, has your Medical Staff implemented sexual predator checks? Are there other things that are relevant that need to be added to your credentialing policies? Does your credentialing process require information/ documents, etc., which are no longer required by any law or regulatory body, and no longer serve any useful purpose?			
When was the last time your Medical Staff Bylaws had a major review and/or revision relative to Medical Staff credentialing, membership and privileges?			
On average, how long does it take a new practitioner to be credentialed at your facility (not including granting of temporary privileges)?			
“Clean” (no relevant issues)			
“Review” (issues requiring additional information)			
In your opinion, are those time periods appropriate/acceptable?			
What can be done at your institution to shorten the credentialing period for initial physicians, while still being thorough, meeting the requirements of state law, Joint Commission and CMS?			

module 5

CREDENTIALING AND PRIVILEGING

Gap Analysis

QUESTION	ANALYSIS	DESIRED OUTCOME	ACTION OR FOLLOW UP
Does your Medical Staff office track credentialing turnaround times, and is that information routinely shared with the Credentials Committee and/or the Medical Executive Committee?			
How does the department chair ensure that prior to granting specific clinical privileges, the resources, equipment and/or appropriate personnel to support the request exist?			
Are your privilege lists routinely reviewed to delete procedures that are no longer relevant, performed or available in the hospital?			
Are your privilege lists routinely and/or automatically reviewed to add new procedures as they become available within your hospital system?			
Have your Medical Staff categories been re-evaluated for current Medical Staff practice trends and/or legal or regulatory requirements?			
Does your Medical Staff office work with hospital recruiters (whoever does the actual recruiting of physicians - could be formal recruiter, or HR personnel)?			
Is there a formal, written workflow for hiring new physicians? If so, does it include active involvement of the Medical Staff office with the recruiter and/or HR department?			
Does the Medical Staff office do any type of "pre-app screening" during the interview process? (Check license, board cert, run NPDB, check for federal sanctions, etc.)			

module 5

CREDENTIALING AND PRIVILEGING

Gap Analysis

QUESTION	ANALYSIS	DESIRED OUTCOME	ACTION OR FOLLOW UP
Do you know if there are any duplications of services currently between the HR department and the Medical Staff office, for example, duplicate criminal background checks, which could be shared between the two?			
Does your facility hire and pay physicians before they are fully credentialed?			
Are your Medical Staff professionals in the Medical Staff office being used to their full, expert capabilities? Are their opinions and comments solicited when considering changes to processes, policies, bylaws, etc.?			

Credentials Committee Members Reference Guide

Introduction

The role of the Credentials Committee of the organized Medical Staff is a critical one. The Committee evaluates applications for initial appointments, as well as reappointments. This includes an unbiased review of privileges granted by the Department Chair. The Committee is charged with providing an impartial, educated review of credentials to determine if that individual meets the requirements to provide quality patient care in the health system as defined in the Medical Staff Bylaws of the system. This review is then forwarded to the Medical Executive Committee for final recommendation before being sent to the Board of Directors for final approval.

Role of Credentials Committee Members:

- Effectively and efficiently review physician applications in such a manner as to lead to quality outcome. Thoughtful deliberation and discussion is important
- Make recommendations regarding appointment, reappointment, staff status and clinical privileges to the Medical Executive Committee
- Contribute to the development of clinical privileging criteria
- Take an active role in FPPE/OPPE activities
- Come to the meetings prepared, having reviewed the agenda and previous minutes, etc., as well as files, if able
- Chairman should come to the meeting having reviewed the agenda, previous minutes, and any files that have areas of concern
- Meetings must have a quorum to vote on (as defined in Medical Staff Bylaws) action items
- Observe strict confidence of information, discussions and decisions made during the committee meetings

The Credentials Committee will review all applications for Medical Staff membership and privileges. They will determine that each application contains sufficient information to make a recommendation. The Committee may request additional information when

it is warranted to support a decision. The Credentials Committee must be able to make decisions based on objective evidence.

The Credentials Committee should follow standard meeting protocol—agenda, approval of minutes, review and discussion of initial applicant files, review and discussion of reappointment files, policy and procedure reviews, etc.

Regulations

Following are rules and requirements as outlined in The Joint Commission, Pennsylvania Department of Health regulations, NCQA, CMS and NPDB requirements.

Joint Commission MS.06.01.05

All of the criteria used are consistently evaluated for all practitioners holding that privilege.

Before recommending privileges, the organized medical staff also evaluates the following:

- Challenges to any licensure or registration
- Voluntary and involuntary relinquishment of any license or registration
- Voluntary and involuntary termination of medical staff membership
- Voluntary and involuntary limitation, reduction, or loss of clinical privileges
- Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
- Documentation as to the applicant's health status
- Relevant practitioner-specific data as compared to aggregate data, when available
- Morbidity and mortality data, when available

The hospital has a process to determine whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege.

MS.06.01.07

The hospital, based on recommendations by the organized medical staff and approval by the governing

body, develops criteria that will be considered in the decision to grant, limit, or deny a requested privilege.

Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.

Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of clinical privileges.

The hospital's privilege granting/denial criteria are consistently applied for each requesting practitioner.

MS.06.01.09

In the case of privilege denial, the applicant is informed of the reason for denial.

The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to all appropriate internal and external persons or entities, as defined by the hospital and applicable law.

The process to disseminate all granting, modification, or restriction decisions is approved by the organized medical staff.

The hospital makes the practitioner aware of available due process or, when applicable, the option to implement the Fair Hearing and Appeal Process for Adverse Privileging Decisions.

MS.10.01.01

Mechanisms for fair hearing and appeal processes are designed to allow the affected individual a fair opportunity to defend herself or himself regarding the adverse decision to an unbiased hearing body of the medical staff, and an opportunity to appeal the decision of the hearing body to the governing body. The purpose of a fair hearing and appeal is to assure full consideration and reconsideration of quality and safety issues and, under the current structure of reporting to the National Practitioner Data Bank (NPDB), allow practitioners an opportunity to defend themselves.

Recommendations for File Review

The following items should always be impartially reviewed and discussed by the Credentials Committee:

- Current challenge or previously successful challenge to licensure or registration;
- Involuntary termination of medical staff membership at another hospital;
- Involuntary limitation, reduction, denial or loss of clinical privileges;
- Unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant;
- NPDB adverse action reports;
- Unanswered or incompletely answered pertinent questions on application, that provider will not give complete or sufficient responses to.

Commonwealth of PA Code

TITLE 42 – THE PUBLIC HEALTH AND WELFARE

CHAPTER 117 – ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

SUBCHAPTER II – REPORTING OF INFORMATION

Sec. 11133. Reporting of certain professional review actions taken by health care entities

(a) Reporting by health care entities

(1) On physicians – Each health care entity which -

(A) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days;

(B) accepts the surrender of clinical privileges of a physician -

(i) while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or

(ii) in return for not conducting such an investigation or proceeding; or

(C) in the case of such an entity which is a professional society, takes a professional review action which adversely affects the membership of a physician in the society, shall report to the Board of Medical Examiners, in accordance with section 11134(a) of this title, the information described in paragraph (3).

(2) Permissive reporting on other licensed health care practitioners - A health care entity may report to the Board of Medical Examiners, in accordance with section 11134(a) of this title, the information described in paragraph (3) in the case of a licensed health care practitioner who is not a physician, if the entity would be required to report such information under paragraph (1) with respect to the practitioner if the practitioner were a physician.

(3) Information to be reported - The information to be reported under this subsection is -

(A) the name of the physician or practitioner involved,

(B) a description of the acts or omissions or other reasons for the action or, if known, for the surrender, and

(C) such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate.

(b) Reporting by Board of Medical Examiners - Each Board of Medical Examiners shall report, in accordance with section 11134 of this title, the information reported to it under subsection (a) of this section and known instances of a health care entity's failure to report information under subsection (a)(1) of this section.

(c) Sanctions

(1) Health care entities - A health care entity that fails substantially to meet the requirement of

subsection (a)(1) of this section shall lose the protections of section 11111(a)(1) of this title if the Secretary publishes the name of the entity under section 11111(b) of this title.

(2) Board of Medical Examiners - If, after notice of noncompliance and providing an opportunity to correct noncompliance, the Secretary determines that a Board of Medical Examiners has failed to report information in accordance with subsection (b) of this section, the Secretary shall designate another qualified entity for the reporting of information under subsection (b) of this section.

(d) References to Board of Medical Examiners - Any reference in this subchapter to a Board of Medical Examiners includes, in the case of a Board in a State that fails to meet the reporting requirements of section 11132(a) of this title or subsection (b) of this section, a reference to such other qualified entity as the Secretary designates.

Reporting to other licensing boards - Information required to be reported under section 11133(b) of this title shall also be reported to the appropriate State licensing board in the State in which the health care entity is located if it is not otherwise reported to such board under subsection (b) of this section.

Always consult your attorney for final determination of reporting requirements.

Do Your Homework

Criteria for medical staff membership and clinical privileges are delineated in your medical staff bylaws. As a member of the Credentials Committee, you must be well versed in this area.

The Credentials Committee should follow Robert's Rules of Order.

NPDB Reporting and Querying Requirements

Title 45: Public Welfare; Part 60 – National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners.

Reporting

Adverse Actions (§ 60.11). A health care entity must report an adverse action to the Board within 15 days from the date the adverse action was taken. The Board must submit the information received from a health care entity within 15 days from the date on which it received this information. If required under § 60.11, this information must be submitted by the Board simultaneously to the appropriate State licensing board in the State in which the health care entity is located, if the Board is not such licensing Board.

§ 60.6 Reporting errors, omissions, and revisions.

- (a) Persons and entities are responsible for the accuracy of information which they report to the NPDB. If errors or omissions are found after information has been reported, the person or entity which reported it must send an addition or correction to the NPDB or, in the case of reports made under § 60.11, to the Board of Medical Examiners, as soon as possible.
- (b) An individual or entity which reports information on licensure, negative actions or findings or clinical privileges under §§ 60.8, 60.9, 60.10, or 60.11 must also report any revision of the action originally reported. Revisions include reversal of a professional review action or reinstatement of a license. Revisions are subject to the same time constraints and procedures of §§ 60.5, 60.8, 60.9, 60.10, and 60.11, as applicable to the original action which was reported.

§ 60.11 Reporting adverse actions on clinical privileges.

- (a) Reporting to the Board of Medical Examiners —
 - (1) Actions that must be reported and to whom the report must be made. Each health care entity must report to the Board of Medical Examiners in

the State in which the health care entity is located the following actions:

- (i) Any professional review action that adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days;
 - (ii) Acceptance of the surrender of clinical privileges or any restriction of such privileges by a physician or dentist—
 - (A) While the physician or dentist is under investigation by the health care entity relating to possible incompetence or improper professional conduct, or
 - (B) In return for not conducting such an investigation or proceeding; or
 - (iii) In the case of a health care entity which is a professional society, when it takes a professional review action concerning a physician or dentist.
- (2) Voluntary reporting on other health care practitioners. A health care entity may report to the Board of Medical Examiners information as described in paragraph (a)(3) of this section concerning actions described in paragraph (a)(1) in this section with respect to other health care practitioners.
 - (3) What information must be reported. The health care entity must report the following information concerning actions described in paragraph (a)(1) of this section with respect to a physician or dentist:
 - (i) Name,
 - (ii) Work address,
 - (iii) Home address, if known,
 - (iv) Social Security Number, if known, and if obtained in accordance with section 7 of the Privacy Act of 1974 (5 U.S.C. 552a note),
 - (v) Date of birth,

- (vi) Name of each professional school attended and year of graduation,
 - (vii) For each professional license: the license number, the field of licensure, and the name of the State or Territory in which the license is held,
 - (viii) Drug Enforcement Administration registration number, if known,
 - (ix) A description of the acts or omissions or other reasons for privilege loss, or, if known, for surrender,
 - (x) Action taken, date the action was taken, and effective date of the action, and
 - (xi) Other information as required by the Secretary from time to time after publication in the Federal Register and after an opportunity for public comment.
- (b) Reporting by the Board of Medical Examiners to the National Practitioner Data Bank. Each Board must report, in accordance with §§ 60.4 and 60.5, the information reported to it by a health care entity and any known instances of a health care entity's failure to report information as required under paragraph (a)(1) of this section. In addition, each Board must simultaneously report this information to the appropriate State licensing board in the State in which the health care entity is located, if the Board is not such licensing board.
- (c) Sanctions —(1) Health care entities. If the Secretary has reason to believe that a health care entity has substantially failed to report information in accordance with this section, the Secretary will conduct an investigation. If the investigation shows that the health care entity has not complied with this section, the Secretary will provide the entity with a written notice describing the noncompliance, giving the health care entity an opportunity to correct the noncompliance, and stating that the entity may request, within 30 days after receipt of such notice, a hearing with respect to the noncompliance. The request for a

hearing must contain a statement of the material factual issues in dispute to demonstrate that there is cause for a hearing. These issues must be both substantive and relevant. The hearing will be held in the Washington, DC, metropolitan area. The Secretary will deny a hearing if:

- (i) The request for a hearing is untimely,
- (ii) The health care entity does not provide a statement of material factual issues in dispute, or
- (iii) The statement of factual issues in dispute is frivolous or inconsequential.

In the event that the Secretary denies a hearing, the Secretary will send a written denial to the health care entity setting forth the reasons for denial. If a hearing is denied, or if as a result of the hearing the entity is found to be in noncompliance, the Secretary will publish the name of the health care entity in the Federal Register. In such case, the immunity protections provided under section 411(a) of the Act will not apply to the health care entity for professional review activities that occur during the 3-year period beginning 30 days after the date of publication of the entity's name in the Federal Register

- (2) Board of Medical Examiners. If, after notice of noncompliance and providing opportunity to correct noncompliance, the Secretary determines that a Board has failed to report information in accordance with paragraph (b) of this section, the Secretary will designate another qualified entity for the reporting of this information.

Querying

§ 60.12 Information which hospitals must request from the National Practitioner Data Bank.

- (a) When information must be requested. Each hospital, either directly or through an authorized agent, must request information from the NPDB concerning a physician, dentist or other health care practitioner as follows:

- (1) At the time a physician, dentist or other health care practitioner applies for a position on its medical staff (courtesy or otherwise), or for clinical privileges at the hospital; and
- (2) Every 2 years concerning any physician, dentist, or other health care practitioner who is on its medical staff (courtesy or otherwise), or has clinical privileges at the hospital.
- (b) Failure to request information. Any hospital which does not request the information as required in paragraph (a) of this section is presumed to have knowledge of any information reported to the NPDB concerning this physician, dentist or other health care practitioner.
- (c) Reliance on the obtained information. Each hospital may rely upon the information provided by the NPDB to the hospital. A hospital shall not be held liable for this reliance unless the hospital has knowledge that the information provided was false.

Definitions

Adversely affecting means reducing, restricting, suspending, revoking, or denying clinical privileges or membership in a health care entity.

Affiliated or associated refers to health care entities with which the subject of a final adverse action has a business or professional relationship. This includes, but is not limited to, organizations, associations, corporations, or partnerships. This also includes a professional corporation or other business entity composed of a single individual.

Clinical privileges means the authorization by a health care entity to a physician, dentist or other health care practitioner for the provision of health care services, including privileges and membership on the medical staff.

Dentist means a doctor of dental surgery, doctor of dental medicine, or the equivalent who is legally authorized to practice dentistry by a State (or who, without authority, holds himself or herself out to be so authorized).

Formal peer review process means the conduct of professional review activities through formally adopted written procedures which provide for adequate notice and an opportunity for a hearing.

Formal proceeding means a proceeding held before a State licensing or certification authority, peer review organization, or private accreditation entity that maintains defined rules, policies, or procedures for such a proceeding.

Health care entity means:

- (a) A hospital;
- (b) An entity that provides health care services, and engages in professional review activity through a formal peer review process for the purpose of furthering quality health care, or a committee of that entity; or
- (c) A professional society or a committee or agent thereof, including those at the national, State, or local level, of physicians, dentists, or other health care practitioners that engages in professional review activity through a formal peer review process, for the purpose of furthering quality health care.

For purposes of paragraph (b) of this definition, an entity includes: a health maintenance organization which is licensed by a State or determined to be qualified as such by the Department of Health and Human Services; and any group or prepaid medical or dental practice which meets the criteria of paragraph (b).

Health care practitioner means an individual other than a physician or dentist, who is licensed or otherwise authorized by a State to provide health care services.

Hospital means an entity described in paragraphs (1) and (7) of section 1861(e) of the Social Security Act.

Negative action or finding by a State licensing authority, peer review organization, or private accreditation entity means:

- (a) A final determination of denial or termination of an accreditation status from a private accreditation entity that indicates a risk to the safety of a patient(s) or quality of health care services;
- (b) Any recommendation by a peer review organization to sanction a health care practitioner, physician, or dentist; or
- (c) Any negative action or finding that under the State's law is publicly available information and is rendered by a licensing or certification authority, including, but not limited to, limitations on the scope of practice, liquidations, injunctions and forfeitures. This definition excludes administrative fines or citations, and corrective action plans, unless they are:
 - (1) Connected to the delivery of health care services, or
 - (2) Taken in conjunction with other licensure or certification actions such as revocation, suspension, censure, reprimand, probation, or surrender.

Organization name means the subject's business or employer at the time the underlying acts occurred. If more than one business or employer is applicable, the one most closely related to the underlying acts should be reported as the "organization name," with the others being reported as "affiliated or associated health care entities."

Organization type means a description of the nature of that business or employer.

Peer review organization means an organization with the primary purpose of evaluating the quality of patient care practices or services ordered or performed by health care practitioners, physicians, or dentists measured against objective criteria which define acceptable and adequate practice through an evaluation by a sufficient number of health practitioners in such an area to ensure adequate peer

review. The organization has due process mechanisms available to health care practitioners, physicians, and dentists. This definition excludes utilization and quality control peer review organizations described in Part B of Title XI of the Social Security Act (referred to as QIOs) and other organizations funded by the Centers for Medicare and Medicaid Services (CMS) to support the QIO program.

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine or surgery by a State (or who, without authority, holds himself or herself out to be so authorized).

Professional review action means an action or recommendation of a health care entity:

- (a) Taken in the course of professional review activity;
- (b) Based on the professional competence or professional conduct of an individual physician, dentist or other health care practitioner which affects or could affect adversely the health or welfare of a patient or patients; and
- (c) Which adversely affects or may adversely affect the clinical privileges or membership in a professional society of the physician, dentist or other health care practitioner.
- (d) This term excludes actions which are primarily based on:
 - (1) The physician's, dentist's or other health care practitioner's association, or lack of association, with a professional society or association;
 - (2) The physician's, dentist's or other health care practitioner's fees or the physician's, dentist's or other health care practitioner's advertising or engaging in other competitive acts intended to solicit or retain business;
 - (3) The physician's, dentist's or other health care practitioner's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis;

- (4) A physician's, dentist's or other health care practitioner's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional; or
 - (5) Any other matter that does not relate to the competence or professional conduct of a physician, dentist or other health care practitioner.
- (a) To determine whether the physician, dentist or other health care practitioner may have clinical privileges with respect to, or membership in, the entity;
 - (b) To determine the scope or conditions of such privileges or membership; or
 - (c) To change or modify such privileges or membership.

Professional review activity means an activity of a health care entity with respect to an individual physician, dentist or other health care practitioner:

Effective Privileging

Thoughtfully determining the clinical privileges given to each physician on the Medical Staff is a significant step in providing high quality patient care in your health system. In addition, careful review of each physician's request for specific privileges by analyzing training and experience protects patients and protects the health system from potential liability down the road.

The process, rules and responsibilities associated with the granting of clinical privileges must be clearly documented and defined in your Medical Staff Bylaws. Stating that privileges will be granted based upon relevant training, experience or competence is no longer enough. Specific clinical criteria must be listed for each privilege. For example, in order to be granted privileges for performing a colonoscopy, # of colonoscopies must have been performed by the physician in the last two years, in addition to formal residency training program by an ACGME or AOA accredited residency program in Gastroenterology. Be clear, be specific and be consistent. Well thought out, objective criteria will ensure consistency and remove any room for subjectivity. Another example—cholecystectomy vs. laparoscopic cholecystectomy—does the physician have the necessary skills for both, or only one. They must be clearly stated. The process will be simple for both the applicant and the Department Chair granting the privileges. This process will ensure that anyone at your health system who is performing a specific procedure is competent to do so, thereby providing quality health care to all patients.

It also has to be remembered that hospital privileges and clinical privileges are not the same thing. Hospital privileges are admitting privileges—the right to admit a patient to the hospital. Clinical privileges define

Practical Pearls

- **Caution** — clinical privilege forms should never be designed with the intent of targeting specific physicians in order to limit their clinical practice for economic or competition purposes.

what procedures a physician may perform. Admitting privileges may be given to a physician without granting clinical privileges.

Medical Staff Bylaws must state how often privileges are reviewed, and this timeline must be adhered to. Failure to regularly review and document physician outcomes and privileges may lead to bad patient outcomes and expose the physicians and health system to liability risk.

The Bylaws must also clearly state how privileges will be revoked, restricted or limited, who will be notified and how (i.e., operating room or nursing floors), and the physician's right to due process.

Anytime a physician is scheduled to perform a procedure or deliver a service, whether in the operating room, on the floor, or in an outpatient setting, the hospital must always be sure that the physician is approved for privileges necessary for the procedure to be performed. Again, failure to do so puts patients at risk and exposes the health system to risk.

Employed Physician Oversight and Files

Employed physicians (those employed by the health system) present a unique situation when it comes to who maintains information on the physician and who is responsible for the actions of the physician. Typically, there will be a human resources (employee) file, and a Medical Staff (membership) file. Information in an HR file is discoverable, so any information (i.e., peer review information) that is protected from discovery should not be maintained in these files. These two files may contain some of the same information, but there are certain rules that should be followed:

- Peer review documents should not be shared with Human Resources. To do so makes them part of the HR file, and therefore, discoverable. They will then lose the peer review privilege that they maintain as part of the Medical Staff file.
- Reports of the NPDB may not be shared with HR. This would be a violation of Federal law.
- Clinical information, such as privileging forms, should be maintained in the Medical Staff file.
- Any information related to corrective actions related to clinical practice, including any fair hearing or due process documentation should not be included in the files.

If there is any concern over which file should contain what documents, always consult your attorney for final direction.

Oversight of the employed physician (who is responsible for addressing issues), really depends upon the issue itself. The hospital HR department as well as the Medical Staff department should develop written policies that address what types of issues will be handled by HR and what will be handled by the Medical Staff department.

Examples of issues that should be handled by the Medical Staff department include clinical quality issues, clinical competency concerns, disruptive behavior situations.

Examples of issues that should be handled by the Human Resources department include harassment complaints by other hospital employees, concerns regarding illegal behavior such as thefts or misuse of hospital property, attendance issues.

In general, policies that the HR department maintains that pertain to employee conduct should apply to employed physicians. The Medical Staff department should maintain policies that pertain to issues that need to be addressed on that level.

Again, any concern over which department maintains responsibility for oversight of the employed physician should be discussed with your attorney for direction.

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